Residential Care for Frail and Marginalised Older People in Hong Kong 1990-2006: targeting and efficiency?

CHOW Kit Ling Lina

PhD Personal Social Services

March 2015

Abstract

Rapid growth in the number and proportion of older people in Hong Kong is shown to have taken place since the late nineties. The substantial increase in the number of older people (particularly the old-olds) and their declining ability levels accelerated the need for long-term care, including residential care. This has exerted heavy financial pressure on the government. Subsequently a new policy - the 'Standardised Care Need Assessment Mechanism' (SCNAM) - for elderly services was introduced in November 2000; giving rise to both intended and unintended consequences.

In this cross-sectional and longitudinal study of the populations of two older peoples residential homes, the focus is on evaluating the outcome of the policy (SCNAM), which intended to target care on older people 'in greatest need'. It explores how the profile of residents in long-term care has changed since this policy implementation. Specifically, the dependency characteristics of residents (including their physical health, functional status, cognitive levels, and degree of frailty) in two care homes of the Helping Hand charity in Hong Kong between 1990 and 2006 are compared. Moreover, the study explores whether the changed populations in these homes suggest greater efficiency and effectiveness in the allocation of residential care. It examines impacts on the costs of care, particularly relating to staffing and funding across a 16-year interval. Furthermore, the outcomes of residential care are assessed in terms of the quality of interaction between staff and residents, and participation in various kinds of social activities within the home.

Efficiency is judged not by cost per person alone, but by the ratios of costs

to outcomes. Findings in the study show that the quality of publicly-funded residential care in Hong Kong fell over the period, and this evidence puts any suggestion of greater efficiency in doubt. Most importantly, the quality of life of residents has been adversely affected and this is an 'unintended consequence' that needs to be taken into account by the policy-makers.

Throughout its recent history Hong Kong has adopted a residual model of welfare, in which the government's paramount focus has been on economic development. This is clearly reflected in the provision and financing of long-term residential care homes as operated under 'a mixed economy of welfare' system, in which the government only assumes a role as a funder. Other crucial issues such as the quality of care by front-line personal care staff as well as the quality of life of residents are largely outside of its policy concerns. Current evidence shows that better targeting and lower unit costs have been achieved in the two Care Homes of the Helping Hand, but at the expense of the effectiveness of care. The policy shift has produced new winners and losers. A focus on controlling the costs of public support for older people amounts to what Titmuss (1968, p.133) called a price that some pay 'for the costs of other people's progress'.

Acknowledgement

First of all, I would like to express my heartfelt gratitude to my Supervisor, Professor John Baldock, who offered me expert guidance and valuable advice throughout. I am most thankful for his continuous unfailing support and great patience in reading through and editing thesis chapters cautiously, even when he acts as the Pro Vice-Chancellor for Research in the University. He gave me inspiration in reflecting over policy issues on social care.

My sincere gratitude also extends to the late Rev. Father Sean Burke, who was one of the founders of The Helping Hand (a non-governmental organisation) in Hong Kong. Without his kind approval and strong support, the research could not be conducted smoothly in the two residential care homes. Furthermore, I owe lots of thanks to the two Home Superintendents, Mr Anthony Iun and Mr C.K. Leung, for their kind assistance in arranging interviews with the residents and providing supplementary information about the home operation and staffing levels. To all the dedicated staff (including social workers, nurses, programme workers, personal care workers) as well as residents in the two Care Homes, I would like to say a big 'thank you' for their helpfulness, co-operation and active participation during the face-to-face contacts. Certainly, all of them have contributed significantly to this research.

Last but not the least, my special thanks go to all who have kept my spirit up - including the Church Priests and Sisters, the Senior Management and Social Work students of my University, friends, relatives, and parents. I am most grateful for the affectionate care and concern from my husband as well as two lovely

children. Truly, all of their holy prayers, blessings, words of encouragement, and love have always kept me alive throughout the journey of my postgraduate study.

Table of Contents

Introduction: The Broad Policy Background

Long-term care outcomes depend on a complex interplay of the supply of services with patterns of dependency, need-generating circumstances and risk factors. An apparently simple aim: to 'maintain the best possible quality of life, with the greatest possible degree of independence, autonomy, participation, personal fulfilment and human dignity' (Larizgoitia, 2003), is in practice complex because of the multidimensional ways in which need, demand and service supply interact with one another. Even each dimension is complex, and each dimension differs in precise nature and importance between individuals; including between dependent older people themselves and their carers, whose interests do not perfectly coincide.

In Hong Kong, in the context of a youthful population, the number of very old people was comparatively small in the 1990s. Initially, the government of Hong Kong could continue a relatively lax admissions policy for those older persons who applied for publicly funded residential care. With the Asian financial crisis in 1997, the economy began to decline sharply and fewer resources were available for the provision of social services. During this period Hong Kong experienced substantial changes in the population and employment structure. The rapid growth of the elderly population, in particular the increasing numbers of very old, began to exert increasing demand on long-term care and create fiscal pressure upon the government.

Economic development has always been considered as the highest priority by the Hong Kong government while social welfare is treated as of less importance. Social services are provided or funded only for persons with limited means. Hong

Kong has adopted a residual welfare approach: public social welfare institutions intervene 'only when the normal structures of supply, the family and the market break down' (Wilensky and Lebeaux, 1965, p.138). Most social services (including services for older people) in the territory are not provided directly by the government, namely, the Social Welfare Department (SWD). Instead the non-governmental organisations (NGOs) and private providers have taken up the major responsibilities for developing and delivering social welfare services. As a major funding provider, the SWD provides capital and recurrent funds. In this way, the government acquires greater flexibility and can keep the size of civil service down. It does not need to shoulder responsibilities for the fringe and retirement benefits of staff in the NGOs.

In 2000, in the face of growing demand, the government of the Hong Kong Special Administrative Region (HKSAR) adopted significantly stricter assessment criteria for those applying for publicly funded care placements. Starting from November 2000 onwards, a new policy called the 'Standardised Care Need Assessment Mechanism' (SCNAM) was introduced; aiming to slow the admissions of older applicants seeking long-term residential care. The justification was that assessments would become more objective and efficient, by using a standardised assessment tool for better targeting. Only those, aged 65 and over, assessed as having 'moderate levels of impairment' were eligible to enter residential care homes and receive public funding. For those assessed as having 'mild impairment' levels, formal community support services might be provided so as to assist them to remain in the community. This is a non-means-tested scheme with no income threshold. All

older people, rich or poor, can apply for government-subsidised long-term care services (including residential care). It is based on the result of the Standardised Care Need Assessment Mechanism that appropriate services be matched and allocated in accordance with the different care needs of older people.

In this study, the focal concern is to evaluate the impact of the new policy (SCNAM) upon two residential care homes run by the Helping Hand charity in Hong Kong; to explore what kind of changes have been taken place in the homes during the 1990-2006 period. It is hypothesised that the greater selectivity policy would have impacts on both staff and residents. An 'intended' aim of achieving greater target efficiency in long-term care was stated explicitly by the government. This research began by hypothesising that the policy might have 'unintended consequences' such as negative impacts on the effectiveness of care, or reduce the well-being of residents and staff. Furthermore, this study has sought to explain whether and why the government neglected some likely consequences while planning and implementing the policy. Are there any implicit or underlying values that may affect policy-making by the government in Hong Kong? The goal of long-term care is usually justified in terms of assisting people who need help in daily living 'to maintain the best possible quality of life' (Larizgoitia, 2003, cited in Brodsky, Habib and Hirschfeld 2003, p.228). To what extent has this fundamental goal of long-term care been achieved in the two residential care homes under study over the period following the change in selectivity policy?

The focus and scope of this research and its significance

The focus of this research interest is on the policy impact of the major changes that have occurred from the period 1990 to 2006 in two residential care homes run by the Helping Hand, a charitable non-governmental organisation (NGO) in Hong Kong. These homes are publicly-funded, with care places purchased and subsidised by the government under the 'Bought Place Scheme' (BPS). The study was conducted across a critical time period, during which Hong Kong experienced striking socio-demographic changes and became an older society with a higher elderly dependency ratio. Approaching the new millennium there was continuous rising demand for long-term care of older people. The research hypothesised that the implementation of the new policy (SCNAM) since 2000 would have impacted on those applying for, and receiving care, in residential facilities. Across the whole 16-year period of the study, it is anticipated that the dependency level of residents, daily interaction and social participation, the finance and staffing arrangements of the two residential homes would have undergone considerable change, especially after the implementation of the new policy reform.

This piece of research is timely and significant, with its aim of evaluating the degree of success of a key policy initiative. It investigates whether the implementation of this formal 'gatekeeping' mechanism was effective in admitting only those older people with genuine need for residential care and whether 'better targeting' (Davies and Challis, 1986; Walker, 2005) or service matching could be achieved. In other words, it looks into whether a principle of needs-based equity could be well addressed in publicly-funded long-term residential care provision for

older adults in Hong Kong. Furthermore, the study examines whether the dependency characteristics of the residents, staffing levels, the costs and outcomes of care, and social participation by older residents changed during the period between 1990 and 2006. In respect of these factors, the important concept of the 'efficiency of care' (Bebbington and Davies, 1983; Knapp, 1984) in the two residential homes is addressed.

As the literature review of long-term residential care for older people shows, existing studies of Hong Kong focus on: various aspects of the provision and quality of residential care (Race, 1982; Kwan, 1988); long-term care needs and the ageing population (Chan et al., 1993; Ngan et al., 1996); the effectiveness of assessment instruments (Bartlett, 1995); choice and attitudes towards long-term care (Lee, D.T.F., 1997; Lee, R.P.L. et al., 1997; Lee and Lo, 2005); the continuity of care (Sim and Leung, 2000); risk factors for institutionalisation (Woo et al., 2000b); and the growing trend towards integrated provision of health and social care (Chi, 2002; Leung, E.M.F., 2002; Phillips and Chan, 2002). In contrast, this study attempts to evaluate the impact of a formal 'gatekeeping' policy upon the admission of residents to the two Care and Attention homes of Helping Hand within the 16-year period under study. Certain key policy issues such as efficiency and effectiveness of long-term residential care for older people will be examined.

There is an absence of research studies evaluating the changing dependency characteristics of residents after their admission to care homes in Hong Kong, not to mention the lack of comparable data across time periods. Up to the present, no study has been found which examines changes in residents' characteristics or residential

life after the introduction of the 'gatekeeping' mechanism in 2000. The present study seeks to reveal the positive and/or negative impacts upon the two care homes after the new policy implementation, and to find out who are the winners and losers following this policy shift. Factors assessed include changes to the demographic and dependency characteristics of the residents, social participation, staffing and financing that have taken place in the two local residential homes over a period of sixteen years.

Additionally, the research evaluates the rationales for changes that occurred in the two residential homes between 1990 and 2006, and the degree to which those changes are likely to be found in the whole Hong Kong population of publicly-funded people in care homes. It is hoped that these observations will be of use to agency administrators, helping professionals, and front-line care workers in both policy planning as well as service implementation of long-term care. As Goldberg and Connelly (1981, p.13) suggest, it is important to measure the outcomes of service or caring activity on the well-being of its users.

In Hong Kong, most of previous studies have been conducted at one point in time or within a very short time span. To date, few researchers have carried out cross-sectional studies, not to mention longitudinal ones. This research is unusual in that it compares aspects of change in the two institutional care facilities across a lengthy period from 1990 to 2006. Thus it is possible to assess changes that occurred in the care homes well before and after the introduction of the new policy reform in 2000. This study seeks to replicate similar studies conducted in other countries, particularly the UK (Grundy, 1992; Darton and Miles, 1997; Netten, et al., 2001b;

Wittenberg et al., 1998 and 2004; Grundy and Glaser, 2000; Comas-Herrera et al., 2003) and the United States (Hanley et al., 1990; Wiener et al., 2001). The approach to issues concerning the efficiency of long-term care for frail old people is influenced by the literature (Davies and Knapp, 1981; Knapp, 1984; Davies and Challis, 1986; Davies et al., 2000; Davies, 2005; Walker, 2005, Knapp et al., 2010). In this study, various terms such as 'residential homes', 'care homes', 'Care and Attention homes' are used interchangeably.

A description of the research and its presentation

This cross-sectional and evaluative study focuses on major changes that have taken place in the two Care and Attention homes run by the Helping Hand charity in Hong Kong during the period from 1990 to 2006. It seeks to compare and contrast the dependency characteristics of the residents including their physical health, functional status, cognitive levels, and degree of frailty before and after the introduction of the new policy - the 'Standardised Care Need Assessment Mechanism' (SCNAM) after November 2000. Furthermore, the study attempts to explore if the changed population in these homes represents greater efficiency in the long-term residential care of older people in Hong Kong. It examines the impacts on the costs of care, particularly relating to the staffing and finance across the interval of 16 years. Last but not the least, the outcomes and effectiveness of long-term residential care will be discussed, particularly on the quality of interaction between staff and residents, the relationship among fellow residents, and the level of participation in various kinds of social activities within the home.

In terms of content, this thesis begins with an Introduction which highlights the changing socio-political context for long-term care policy for older people in Hong Kong. It first gives an account of the societal context and contributing factors to the emergence of the new policy reform and how this 'gatekeeping' initiative impacted on the two Care and Attention homes across the 1990-2006 period. Chapter 1 presents the socio-demographic background, especially concerning the maturing of the older population within the past decade. It describes the changing dependency characteristics as well as multiple health problems arising from the rapid growth of the older population, which gives rise to the increasing need and demand for long-term care. Furthermore, the different types of living arrangement of older persons also exert influence over the demand for long-term residential care (Chapter 2). The study also shows how, in the context of limited resources and provision, the socio-economic characteristics of older people serve as a key determinant affecting their choices about residential care services.

Chapter 3 provides an overview of long-term care policy for older people in Hong Kong, along with the declared principles of 'care in the community', 'ageing in place', and 'continuum of care'. Great emphasis has been put on the family's basic obligation to care for its older members, while the government only performs an 'enabling' role. As clearly reflected in various policies concerning fiscal and housing aspects, different measures have been taken to encourage the family to live with and look after their elderly relatives in the community. The provision of formal and informal community care services aims at meeting a wide range of long-term care needs of older people. At the same time, some very frail and marginalised older

people are still perceived as in need of long-term residential or nursing care, in spite of the expansion of community support services after 2000. Chapter 4 describes the provision and delivery modes of residential care in Hong Kong. A unique 'mixed economy of welfare' approach has been adopted in the territory, and implemented under a residual model (Titmuss, 1963). The study explores how far any set of values dominates the society as a whole, affecting the attitudes of both the government as well as its citizens towards providing and receiving social welfare.

Chapter 5 focuses a key element of the new policy reform - the 'Standardised Care Need Assessment Mechanism' (SCNAM); highlighting the development and implications of the targeting and need assessment procedures. The changing role of residential care homes are distinguished before and after the implementation of the new policy (SCNAM) in November 2000. It describes significant changes in the screening processes for those applying for residential care services before and after the introduction of this selectivity policy initiative in late 2000. As the current study falls across this critical period, the older residents living in the two Care and Attention homes in 2006 are therefore hypothesised to be much older, and with higher functional dependency, than those in 1990. Moreover, it is hypothesised that the selectivity policy have effects on residents and staff. Specifically, it examines both the intended as well as unintended consequences that may arise from this policy shift. It discusses how the population living in community changes in parallel with that of care home population, and how the new policy affects those who are 'beneficiaries' and 'losers'.

Chapter 6 describes the collection of empirical data for this study;

specifying the methodology, rationale for its choice, research design and questions, and the sampling within the two chosen Care and Attention homes. The subsequent three chapters focus on the major research findings that highlight and analyse the changes that have taken place in the two residential homes across the 16-year period. Chapter 7 compares and contrasts the changing dependency characteristics of older residents in the two care homes before and after the policy reform. It examines whether this represents greater target efficiency in the provision of care and the use of public funds to support older people with higher dependency characteristics. Chapter 8 considers the costs of care: whether there were changes in the financial situation and staffing conditions of the two homes; whether improved cost efficiency had been achieved after the inception of the new policy as well as any impact that followed. Chapter 9 describes the changes (if any) in the social participation of the residents, their daily interactions and relationships with staff and fellow residents. This section addresses the outcomes and effectiveness of care, particularly in relation to the quality of life of residents in the two Care Homes. Chapter 10 presents the overall conclusions of the research, and suggests further thoughts about the significance of target efficiency, cost efficiency, and effectiveness, as well as the implications for future policy-making and long-term care provision for older people in Hong Kong. A bibliography, appendix, and list of tables appear at the end of the thesis.

Chapter 1 Hong Kong: An Ageing Population, Changing Health and Ability Levels, and Long-term Care

This chapter describes the changing socio-demographic background, especially the maturing of the older population during the last decade. It highlights the changing dependency characteristics and multiple health problems that arise in the older population (including the very old: 85 and over). These changes affect need and demand for long-term care in the territory.

Demographic change and an ageing population

The Hong Kong population is ageing rapidly, including a substantial increase in the number and proportion of older people. Over two decades, the Hong Kong population increased more than 29 per cent from a total of 5,183,400 in 1981 to 6,708,389 in 2001 (Table 1.1). It grew by 32 per cent to 6,857,100 in 2006, and had reached 7,071,576 in 2011. Amongst the elderly population, growth was at even faster rate of over 147 per cent between 1981 and 2006. The number of older people (aged 65 and above) increased from 344,300 in 1981 to 747,052 in 2001. In 2006, the figure reached 852,100, and 941,312 in 2011.

In 1981, older people (aged 65 and above) comprised almost 7 per cent of the total population. By 2001 over 11 per cent (747,052 individuals) were older people and more than 12 per cent (852,100) in 2006. According to the Census and Statistics Department (2011), the proportion of older people in the total population rose from 3 per cent to over 13 per cent between 1961 and 2011. It is projected to rise to 19 per cent in 2021, 26 per cent in 2031, and 30 per cent in 2041. As for the

dependency ratio (defined as the number of persons aged ‘under 15’ and ‘65 and over’ per 1000 persons aged between 15 and 64), this was 333 in 2011 and is projected to rise to 511 in 2026 and 645 in 2041.

Life expectancy

The striking demographic transitions to an older and larger population are due to increased longevity as well as decreasing mortality rates over the last two decades. To a certain degree, the prolonged ageing process is reflected in the improvement in the median age of the whole population. In 2006 the median age of the entire population was 39.6 years old, as compared to that of 26.3, 31.6 and 36.8 in 1981, 1991 and 2001 respectively (Census and Statistics Department, 2007 and 2011). The ageing trend continues with an increasing median age of the population, being 41.7 in 2011, 45.1 in 2021, 47.7 in 2031, and 49.9 in 2041.

Over the last three decades, average life expectancy at birth has moved steadily upward. Male life-expectancy at birth was 78.4 years in 2001, while it was only 68 in 1971 (Table 1.2). For females, the figure had increased further from 75.6 in 1971 to 84.6 in 2001. By 2011, average life expectancy at birth rose to 80 and 87 for men and women respectively. For both sexes, an increase of around 10 years was observed during the period from 1971 to 2006, with male longevity showing a faster rate of change. Furthermore, the life expectancy at age 60 for older men was 19.3 years in 1991 rising to 21.7 years in 2005 (Table 1.3). Women’s life expectancy reached 23.4 years and 26.2 years in 1991 and 2005.

People are living longer, some with lengthy years of disability and

dependency. At 80 in 2005, life expectancy for men was on average 8.1 years and 10.1 years for women. Put it the other way, older men (80 years old) will live up to an average of 88.1 years old. Meanwhile, their female counterparts can expect to live on average about 90.1 years. The number of very frail elderly persons is likely to increase, adding to dependency in the long-term care facilities.

The demand for long-term care might not increase proportionately with the rise of age. To a certain extent, the ageing process has been postponed by healthy lifestyles, better disease control and health enhancements. According to the paradigm of 'compression of morbidity' (Fries, 1980 and 2005; Fries et al., 2011), if the average age at first infirmity rises, the period of morbidity and mortality will be compressed and postponed before life comes to an end. If the postponement of onset of chronic diseases at old age is greater than increases in life expectancy, it may help to reduce 'the lifetime burden of illness' as well as the cost of health care. This hypothesis of 'compression' was renamed by some as a 'postponement of morbidity', connoting 'the decreasing amounts of illness for increasingly long life spans' (Hessler et al., 2003, p.213). However, these patterns are complicated by cultural changes such as lower tolerance of disability, and so increased reporting; and by higher expectations of care at particular disability thresholds.

Mortality rates

Along with advances in medical and health care, an emphasis on healthy lifestyles and improved socio-economic conditions, the industrialised world in countries like the UK, the United States, Japan has experienced declines in mortality

(except for some post-Soviet countries). Hong Kong is no exception, with the mortality rates for all ages falling significantly over the last two decades. As revealed from the statistics in Hong Kong, the mortality rates for those aged 60 to 84 have declined (Census and Statistics Department, December 2007). Reduced mortality rates for both men and women are most clearly visible in the age groups of 60-64, 65-69, and 70-74 between 1981 and 2005. For example, the decreasing mortality rate for the age group 60-64 was nearly 49 per cent amongst men compared to 53 per cent amongst female (Table 1.4). In the age group 65-69, the fall for men was close to 45 per cent compared to 55 per cent for women. The rate of decrease of both sexes was similar (around 41 per cent) for those aged 70-74. Hence older couples are able to spend longer years of marital life together now. Put differently the chances that older men will receive care from their spouse has risen. On the other hand, joint living may postpone the age of older women being admitted for institutional care.

Decreasing mortality rates were particularly pronounced among the very old (85 and over) between 1991-2001, compared with that a decade before. Briefly put, the overall age-specific mortality rates of older people have fallen substantially over the past two decades.

Between 1981 to 2006, the mortality rate for men 85+ rose by some 8 per cent amongst men but fell approximately 20 per cent amongst women (Table 1.4). Men have a higher chance of death in their 80s. This is attributed to their vulnerability to diseases like neoplasm (Hong Kong Cancer Registry, 2007). Other contributing factors include behavioural aspects and lifestyle consequences like

smoking-related diseases and accidents (*Demographic Trends in Hong Kong 1981-2001*). However, the main outcome is that older people of advanced age are able to live longer than before.

Longevity has been rising faster amongst men, but has not yet caught up with women. For instance in 2006, in the 85+ age group, there were 28,500 older men (7%) compared with a greater number of 62,200 older women (nearly 14%) (Census and Statistics Department, 2007a). As shown, the oldest-old age cohort is over-represented by women. Within the older population, the growing number of frail older people with care needs and years of disability probably generates most of the rising demand for long-term care. Because of longevity and family structures it is older women who are more likely to seek residential care at a highly advanced age (Ho et al., 1997; Woo et al., 2000b).

Changing age structure within the older population

Coupled with the total growth of the older population, changes can also be detected within the age structure of older cohorts in Hong Kong during the recent two decades. In 1981, the total number of the younger cohort of older people (aged 65 to 69) has almost doubled, from a total of 144,500 to 249,011 in 2001 (Table 1.1). The older cohort of those aged 75 to 79 has grown by more than 60 per cent, to a total of 142,736 in 2001 as compared to that of only 56,600 in 1981. Furthermore, the substantial increase in the number of the very old (aged 85 and above) has been the most rapid. The aggregate number of this oldest age segment of the whole population has increased sharply from 16,400 to 61,727 between 1981 and 2001; an

extremely fast growth of 276 per cent. This growth of the very old was a long-term outcome of the sudden influx of young immigrants (mostly male) from Mainland China in the 1950s, who came looking for job opportunities in the territory. This cohort reached 90,700 in 2006, representing some 11 per cent of the 65+ population or over one per cent of the entire Hong Kong population. In 1991, the corresponding proportions were just six per cent (28,763 persons) of the 65+ population, and only half per cent of the total Hong Kong population.

Precisely put, in a similar way to other developed economies, changes have occurred within the age distribution of the older population in Hong Kong over the past two decades, with faster growth in the numbers of 80+ compared to the 65-74 year olds. This rising trend is comparable to the situation in the UK. According to projections, the proportion of British people 65+ will rise to nearly 40 per cent by 2030. The size of the older cohorts (aged 80 and above) will almost double (Economic and Social Research Council, 2007). Such rapid increases in the oldest age stratum in both Hong Kong and the UK deserves prompt attention. Referring to local statistics, the elderly dependency ratio (the number of persons aged 65+ per 1000 persons aged between 15 and 64) increases from 135 to 163 in 1994 and 2004 respectively (*Hong Kong Annual Digest of Statistics, 2005*). Hence the growing number of old-olds coupled with care needs and severe impairment levels will impact on the demand for long-term care.

In Hong Kong, the number of men likely to need care has risen faster than the number of women: between 1981 and 2006; in the 80-84 age cohort, the number of men rose 446 per cent within twenty-five years, compared with 213 per cent for

women (Table 1.1). The corresponding changes in the number of all older people, 65+, were 93 per cent and 151 per cent respectively. These demographic transitions can be explained by longer life expectancy. Additionally, the growing numbers and proportion (relative to the working age population) of older people will have far-reaching effects upon long-term care as well as significant financial implications.

Past studies suggest that age correlates strongly with the risk of entering residential care facilities (Kane et al., 1983; Weissert and Scanlon, 1983; Hanley et al., 1990; Gibson et al., 1993; Wiener et al., 1993; Wittenberg et al., 1998; Grundy and Jitlal, 2007). Greater longevity if it is coupled with more years of disability accelerates the demand for long-term care of older people. As human beings grow older, their dependency levels as well as the possibility of lack of spousal support (especially for the older women) are likely to be greater. In consequence demand for long-term care has been rising since 1990.

According to projections by Wittenberg and others (1998 and 2004), the future demand for long-term care in the UK would depend much upon the interplay of various factors, including changes in the numbers of older people, changes in their dependency levels, possible changes in their household circumstances, rising expectations about the quantity as well as quality of care, the supply and availability of informal care. All these factors are likely to be similarly relevant in Hong Kong. As shown in the local statistics (Table 1.1), the number of old-olds (age 80 and above) rises drastically from 73,162 in 1991 to 203,400 in 2006 (Census and Statistics Department, 2007). This will probably increase the need and demand for long-term care. In Hong Kong, older people often expect to be cared for by female

members in the family. However, changes in living arrangements as well as more females joining the work force may affect the supply and availability of informal care provision. Besides, higher expectations from the society at large of the provision of a wide variety of long-term care services, as well as their preference for greater choice are all factors likely to influence the demand for social care in this territory.

Changes in the sex ratio amongst older people

Apart from age, gender is also one of the factors that influences the receipt and demand for both care generally and for residential care. As well as the expansion in the total number of older people, significant changes have occurred in gender distribution of the population aged 65 and over. The 65-69 age cohort, a key carer group, is now a smaller proportion of the total 65+ population.

To summarise, the Hong Kong population has aged rapidly over the last two decades, with fastest growth in the numbers of older men, and of the 80+age group. Nonetheless women continue to outnumber men in older age groups. Women also represent a larger group amongst residential home residents in every age group (Wingard et al., 1987; Shapiro and Tate, 1988b; Gibson et al., 1993; Grundy and Jitlal, 2007). This is also true in the context of Hong Kong. Two main reasons account for this phenomenon: one being the general increased longevity of women, the other being that widowhood is accompanied by the loss of spousal support. As revealed from local statistics, the proportion and number of widows (aged 75-84, 85 and above) represent approximately 65 per cent (being 84,738) and over 77 per cent

(being 32,911) respectively in 2001 (Census and Statistics Department, 2002). On the other hand, the corresponding proportions and numbers occupy only 22 per cent (being 21,279) and 40 per cent (being 7,618) amongst their male counterparts. This explains the longer period of spousal care by older women. Coupled with that, older women are more likely to receive residential care in very old age.

Local studies (Ho et al., 1997; Woo et al., 2000b) show how older people, in particular those aged 80 and above, are likely to become dependent and frail in aspects of physical and/or mental health. This pattern is echoed by Crosby and others (2000), showing how the institutionalisation rate in the UK is particularly high for the very old people. Late-age mortality has become an increasingly significant component of overall mortality (Grundy, 1997). The declining mortality rate may give rise to the development of a prolonged ageing process, which ultimately creates new challenges and demands for long-term health and social care provision for older adults

Health and old age

Conventionally, one image of older people is that of disability, dependency, and frailty. The images of wrinkles, bald heads, white hair, slow gaits, impaired hearing, blurred eyesight, weak health often come to mind when mentioning old age. This image depicts only part of the truth for the older generations. In reality, many older adults are healthy, vigorous, independent, both physically and mentally. They are able to maintain high levels of functioning during the very late stages of the human life cycle. It is not difficult to find older people who participate actively as

volunteers and members in social centres, as well as offering various kinds of assistance to their own families.

Old age should not necessarily connote ill health or frailty. Nevertheless, the prevalence of illnesses tends to increase with age. Notwithstanding the unique and varied conditions and coping skills of each individual, ageing is often closely associated with a decline in the physical and/or mental capabilities of the older people. As constructed by Verbrugge and Jette (1994, pp.1-14), the Disablement Process Model describes the main pathways from pathology to impairments, to functional limitations, and eventually to disability. Within this framework, two significant groups of factors are distinguished: intra-individual (behaviour and lifestyle changes, psychosocial attributes and coping) and extra-individual (medical care and rehabilitation, medication, external supports, physical and social environment). All these psychological, social, and environmental factors change or impact on the process as a person becomes older.

Put in the other way, the disablement process is characterised by pathology (chronic diseases or co-morbidity), which creates impairments (dysfunctions in the physiological, mental, social aspects) of older adults. These can, but do not necessarily, cause functional limitations in basic abilities, both physical (lifting objects, climbing stairs) and mental (short-term memory, orientation in time and space, produce intelligible speech). Functional limitation is ‘a precursor of disability’ (Verbrugge and Jette, 1994). For instance, a 80-year old woman suffering from diabetes, heart disease, or stroke would be impaired in her musculoskeletal, cardiovascular, neurological systems. As a result, she would be restricted in

functional performance such as walking, climbing stairs, and lifting objects. Her speech may be hard to follow, and she may be disoriented in place and time. In everyday life, she may require assistance in performing activities of daily living (ADLs) like bathing, toileting, eating and instrumental activities of daily living (IADLs) such as household management. Disability can lead to the subsequent dependency of older people (Gill et al., 1998), causing handicaps (World Health Organisation, 1980) in carrying out social roles as spouse, parents, or grandparents. There develops 'a gap between personal capability and environmental demand', but this may be reduced where older people adapt through a process of 'gradual adjustment' and 'personal choice' (Verbrugge and Jette, 1994, pp.9-11). Disability is to some extent both personally and socially constructed (Pope and Tarlov, 1991).

Mortality rates and disease

Partly because of enormous advances in medical technology, human beings live longer despite illness. This can be demonstrated by the declining mortality rates for nearly all diseases, such as of the circulatory system, and respiratory system for those aged between 45 to 64 over the forty years to 2000. For instance, the mortality rates for neoplasm have reduced from 263.6 to 208.3 per 100,000 population between 1961 and 2000 (Table 1.6). Concerning diseases of the circulatory system, the decrease was even more distinct with the mortality rate falling from 298.7 to 79.6 per 100,000 population by 2000. Amongst those aged 65 and above, mortality rates also dropped from 1639.4 to 1262.2 and 1120.1 per 100,000 population in 1961, 1991 and 2000 respectively (Table 1.7). In short, the age-specific mortality rates for some common fatal diseases have declined significantly for the 45-64 age cohort,

and for those over 65. All these show that diseases have reduced effects on mortality at lower ages.

On the other hand, there have been sharp increases in mortality rates for some disease groups: 'neoplasm', 'endocrine, nutritional, metabolic immunity disorder and blood diseases' over the past forty years. Older cohorts, particularly those aged 85 and above, were most vulnerable to the attack from neoplasm (Table 1.5). Hence medical care can delay mortality to older ages. It can, by eliminating earlier sources of disease and death, increase the effect of others. Not only have new medical developments extended years to human life, but also increased the probability of some sources of illness and death in older age groups.

Similarly, mortality rates of diseases of the circulatory system and respiratory system dropped significantly between the age of 60 and 84 with medical developments. For example, in the 70-74, 75-79 age cohorts, older men suffering from heart disease experienced the fast falling mortality rates of 53 per cent and 40 per cent respectively between 1981 and 2001 (Table 1.8). Nevertheless, for those aged 85 and over, mortality rates increased in the above two disease groups, except for females in the case of the respiratory system. For example, for circulatory disease the number of deaths for males per 100,000 population was 3,499 in 1981, and rose to 4,513 in 2001 (Table 1.8). For women, the corresponding figures also increased from 3,985 to 4,200 in the respective years.

In the case of respiratory diseases, the number of deaths per 100,000 population for men (aged 85 and above) moved upward from 3,330 in 1981 to 4,525 in 2001, a sharp increase of some 36 per cent (Table 1.9). Yet for their female

counterparts, a slight decrease of 9 per cent was identified, reducing from 3,247 in 1981 to 2,957 in 2001. Thus the age of 85 has become a less reliable indicator for mortality rates in some disease groups.

In conclusion, a decline in age-specific mortality rates for some major diseases (neoplasm, circulatory system) can be identified among some age groups. The older cohorts (aged 85 and above) are now more likely to suffer these diseases, with higher mortality rates from them in both sexes. The care needs tend to be most prominent in the oldest-old age group, posing a greater demand for long-term care in Hong Kong.

Different views on morbidity

Alongside new advances in medical technology and improvements in living standards, more older people are able to live a longer life with less or no disability. People with disease are living longer reflected in declining mortality rates from major diseases of the circulatory system, respiratory system in the past two decades (Table 1.8, Table 1.9, Table 1.10). Both age-specific as well as disease-specific mortality rates have fallen. This is consistent with the hypothesis of Fries (1980 and 2005), that mortality is postponed to the very late years of life prior to death due to medical developments and healthier lifestyles. However, there is a lack of data showing the length of disease.

On the other side, there are rising trends in morbidity rates for some leading diseases in Hong Kong between 1981 to 2005. As observed in Table 1.11, numbers suffering from cancer, cerebrovascular disease, or diabetes mellitus experienced an

increase of 131 per cent, 69 per cent and 79 per cent respectively for over two decades. Following Fries, 'compression' of morbidity occurs later in life. It is therefore likely that there will be, with population growth and longevity, an increasing number of very elderly people having to live with some diseases. Unfortunately, there is insufficient data to conclude that in Hong Kong these large numbers will be combined with a compression in the number and proportion of years lived with disease.

There is an opposing view that contends older people live more years of ill health or chronic disability prior to death (Schneider and Brody, 1983). According to this 'expansion of morbidity' hypothesis, morbidity is extended across a longer period despite lengthened survival. With the high prevalence of chronic non-fatal diseases like dementia, and stroke, more and more older people may live with longer years of disability. This is termed as 'the failure of success'. However, the reducing mortality rates of major diseases in Hong Kong undermine this 'expansion' hypothesis. It remains unclear in Hong Kong, as elsewhere, whether greater longevity will be accompanied by more or fewer years of illness and hence need for care.

The need and demand for medical treatment

In Hong Kong, heart disease, malignant neoplasm, cerebrovascular diseases, and pneumonia are identified as some of the leading diseases commonly found among elderly persons aged 65 and above (Census and Statistics Department, 2005; Department of Health, 2006; *Hospital Authority Statistical Report 2005-2006*). The

percentage of people having such illnesses remained unchanged from 1971 to 2001. Mortality rates fell for most illnesses until 80 and above.

Comparatively, the chances that older persons (aged 65 and above) will suffer from various types of ailments, which require long-term medical follow-up, are generally higher than those in the younger age groups. A higher proportion (57%) of older people suffers from heart disease, whereas it is around 33 per cent in the younger age group of 45-54 (Table 1.12). Likewise, about 9 per cent in the older population suffers from lung disease, while a lower rate of 5 per cent occurs in the corresponding younger age group. Eye disease, including cataracts, is also commonly found in the case of older individuals, occupying close to 15 per cent. The corresponding rate is less than 4 per cent in the younger age group of 45-54.

Similarly, the percentage and number of older people (aged 65 and above) suffering from diseases like hypertension, and diabetes that require long-term medical follow-up increased between 2000 and 2002. As observed in the *Thematic Household Survey Reports No. 3 and 8*, a higher prevalence of certain diseases has occurred, in that about 45 per cent (being 164,500) and 24 per cent (being 87,100) of older people suffered from hypertension and diabetes respectively in 2002 (Table 1.13). The corresponding figures have moved upward, compared with the former rates of 43 per cent (being 147,900) and 23 per cent (being 76,700) of older people in 2000. In other words, there is a growing number and proportion of elderly people having to live with diseases that require long-term medical follow-up. Furthermore, the onset of some chronic non-fatal illnesses now begins at an earlier age than previously. This implies longer years of ill health and greater economic impact over

long-term medical and health care for at least a proportion of older people.

Chronic illness

During later life, older people are often met with challenges of coping with chronic disease and co-morbidity such as chronic bronchitis, eye disease, and mental disorder. Of a sampled 266 older respondents (aged 70 and over), around 41 per cent had one disease, 22 per cent and 15 per cent lived with two and three or more diseases respectively (Chi and Boey, 1994). In a local survey by the Census and Statistics Department (2005), close to 72 per cent out of the sampled 10,000 respondents lived with one or more chronic illnesses. Among them, 21 per cent and approximately 12 per cent of older people suffered from two and three types of chronic illnesses respectively (Table 1.14). Using the total elderly population of 852,100 in 2006 for a projection, there would have been 613,512 persons (72%) having to cope with one or more illnesses. When compared with an estimated figure of 347,068 persons in 1991 (with an elderly population of 482,040), this points to higher dependency or greater disability in old age. It is likely that pressures on the provision and funding of long-term medical, health and social care will continue to rise.

Chronic illnesses are strongly correlated with both age and inability to perform ADLs and IADLs independently. Older respondents with at least one chronic disease had a 1.4-fold increased risk while those with two or more diseases had 2.3 times risk of mobility decline (Ho et al., 1997). Their ability in carrying out ADLs and IADLs is affected adversely. The prevalence of chronic illnesses and

functional dependence demonstrates gender differences. Females tend to report suffering from hypertension, arthritis, and osteoporosis whereas males more often experience higher rates of heart disease, and impairment in vision and hearing.

Use of hospital services

The rising proportion of older people with chronic diseases could well be reflected in the use of hospitals. Although the majority (over 85%) of older people have not been admitted to hospital in the past twelve months, there is still some 10 per cent having to be hospitalised once or more (Table 1.15). Moreover, close to 5 per cent have experienced two or more episodes of hospitalisation within the last year. A recent local study of older people in the community (Chu et al., 2008) echoed these findings, in that close to 15 per cent of the sampled subjects experienced one or more times of hospitalisation due to falls and recurrent falls during a one year of follow-up. Notwithstanding the small percentage of hospital admission, hospital demand is likely to increase with growth in the population of older people.

The proportion of hospital beds occupied by older people has been rising. In 1996 there were 131,189 older persons utilising public hospital services, comprising around 27 per cent of the total number of patients of all ages (Table 1.16). The figure mounted to 194,017 in 2005, representing 34 per cent of the total number of patients of all ages. Throughout the 1996-2005 period, number of beds occupied by those over 65 rose by 48 per cent, but constituted 16 per cent among the total patient population of all ages (Table 1.17).

The available statistics do not indicate the use of hospital beds by different old age cohorts. It can be speculated that the majority of the patients would be those at a highly advanced age. Again, the rate of change (nearly 24%) among the elderly population from 1996 to 2005 is most significant. Older people have increasingly become the heavy users of health care services (*Hospital Authority Statistical Reports, 1998-2006*).

Furthermore, older women outnumbered their male counterparts throughout 1996 to 2005, with a steadily increasing number consuming hospital care services every year. Public hospital services are heavily subsidised by the government in Hong Kong. With the ageing of the population, long-term medical and health expenditure will rise, accelerating fiscal demand upon the HKSAR government.

The relationship between subjective health and old age

Research shows that objective health condition is related to a person's subjective perception about his/her own health. As suggested by Grundy and Glaser (2000), a change in disability is found to be associated with one's self-reported health status. Those with poor self-perceived health are more likely to utilise residential care services, as indicated in a study of nursing home admissions in Canada (Shapiro and Tate, 1988a). Similarly, self-rated health contributes as a strong risk factor for falls among the elderly population in Hong Kong. Those with poor self-ratings had an 80 per cent increased risk of falls (Ho et al., 1996). Subjective health is linked with social support amongst Chinese older persons, and with no gender difference (Cheng and Chan, 2006). For those of lower socio-economic

status, their self-rated health tends to be more negative (Cheng et al., 2002).

In a local survey conducted by the Census and Statistics Department (2001b), among 970,300 older persons, around 39 per cent and 4 per cent regard their health as good or very good respectively. Meanwhile, there are still 22 per cent judging themselves as 'not very good' and with one per cent being 'not good at all'. Another survey also conducted by the Census and Statistics Department (2003b) presents a more thorough picture about the health condition subjectively rated by different age groups. Compared with other younger age groups, older adults (aged 65+) generally hold a more negative view of their health status (Table 1.18). Nearly a quarter (23%) of the elders perceive their own health conditions as 'poor', whereas the comparable rates were much lower in the younger age groups of 15-24, 25-34, 35-44 and 45-54, being merely 2 per cent, 3 per cent, 4 per cent and 6 per cent respectively. Therefore, an individual's subjective rating of health is also positively connected with age.

By comparison, the younger-old cohort (55-64) tends to perceive own health status more positively, with 9 per cent and close to 31 per cent rating as 'very good' and 'good' respectively. Meanwhile, some 46 per cent of older people consider their health as 'fair', and with 26 per cent rate 'good'. Not surprisingly, very few older persons consider their own health as 'very good' and 'excellent', being slightly over 5 per cent and not even up to one per cent respectively. The subjective rating of older persons about health condition may serve as a strong predictor of morbidity, functional capacity and mortality (Ho et al., 1996). Their lower self-rating of health is closely linked with the declining health status or

functional disability as often accompanied by higher age.

Ability levels and old age

Despite the great improvements in the field of medicine, degenerative diseases and senility still exist nowadays. As a consequence, the ability levels of older individuals to cope with the activities of daily living (ADLs) will be adversely affected. Ultimately this may lead to functional deficiencies and growing dependency. The prevalence of disability and long-term care needs often rise sharply with highly advanced age, particularly among the oldest-olds. In this sense, the development of medical care may defer, reduce or bring changes to the demand of long-term care for the older people. Hence the need and demand for long-term care also increase, though not necessarily be in a proportionate manner.

Ageing can generally be viewed as a gradual process of accumulating decline or loss of functional ability. Functional status or dependency reflects the influence of three factors (that may not be mutually exclusive): physical functioning, cognitive states, and functional ability of older persons. The level of dependency is often measured in terms of the ability to carry out activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Both ADLs and IADLs are frequently adopted to assess the need of an individual for different types of care, including residential care.

In Hong Kong, the Census and Statistics Department has adopted the concept of ADLs to assess the ability of a person to perform the activities in daily living concerning personal care. The six items of ADLs measured include bathing,

dressing, eating, toileting, mobility, transferring between a bed and a chair. Through counting the number of ADLs that an individual manages to perform independently, the functional status can be classified into four levels, with level 1 being 'having no ADL impairment' and level 4 (unable to carry out 5-6 ADLs independently) being 'the most seriously impaired'. IADLs are used to assess the ability of a person to perform some day-to-day tasks, such as preparing meals, doing housework, shopping, managing finance, administer medications, using phone, transportation. Through the two measurements of ADLs and IADLs, the extent of functional abilities of older people can be described, indicating the long-term care demand.

As argued by Wittenberg and others (1998, p.47), the need for help from others is 'substantially a function of dependency' which creates 'the need' for a range of services that compensate for the impaired capacity of individuals to perform activities of daily living (ADLs) as well as instrumental activities of daily living (IADLs). However, in practice, the need recognised by formal care services is often a function of the volume and nature of informal care they are receiving. The functional needs of those with, sometimes very burdened, family carers may be discounted.

Each older person has a different degree of dependency which will give rise to various risk factors and drive the demand for different forms of care provision. Individuals with mild impairment levels of ADLs and IADLs can often manage to live by themselves or with other relatives in the community. Under certain circumstances, those with severe functional deficiencies such as having double incontinence, dementia at a very late stage may not be able to obtain adequate care

in the community. It is likely a consequence that some of them may receive long-term care in residential or nursing homes. At the same time, there may still be more high dependency people living in the community. The literature shows that it is often the case that the higher the functional need, the less likely formal help may be, and the tasks are disproportionately borne by informal care. However, the relationship between dependency and other need-related or risk-creating circumstances and access to services and their beneficial outcomes is problematic and complex, as studies of the productivity patterns of service illustrate (Davies et al., 2000). This is in part because access to services rarely correlates strongly with measures of need.

According to a local Thematic Household Survey conducted by the Census and Statistics Department (2005), a majority (approximately 94% and 79%) of the elderly population living in domestic households required no assistance in performing ADLs and IADLs respectively. Close to 7 per cent have ADL impairments ranging from level 2 to 4. Those aged 75 and above are more functionally disabled, occupying a higher proportion in having ADL impairments; being 14 per cent. Among them, close to 8 per cent, 2 per cent, and 4 per cent suffer from ADLs impairment levels of 2, 3, and 4 respectively. While in the 65-69 age cohort, the comparable rates are merely two per cent, one per cent, and one per cent accordingly.

Referring to Table 1.19, there are some 9 per cent and 12 per cent in the older-old cohort (aged 75 and above) being incapable of performing 3-4 and 5-7 IADLs respectively on their own, whereas these constitute just around one per cent

and two per cent for those aged 65-69. All in all, the older-olds are over-represented amongst the most frail. Using the rate of 14 per cent for projection, there were 53,480 older persons (aged 75 and above) functionally restricted in everyday lives in 2006. That equates to an increase of 2.4 times, on a comparable figure of 22,682 in 1991.

Functional disability is an important factor in assessing the future needs of older people for long-term care, but that alone is not a sufficient condition in itself (Wittenberg et al., 1998 and 2004). Previous studies indicate that older people with severe disability levels utilise residential care services heavily, significant numbers and proportions remain supported informally. However, the more serious the impaired level, the higher is the risk of institutionalisation (Cohen et al., 1986; Foley et al., 1992; Choi, 1999; Hui et al., 2004). Both physical as well as cognitive impairment serve as significant predictors of residential home entry.

The literature shows that while more dependent people are more likely to receive residential care, residents in homes are a heterogeneous group of people with a wide range of different physical and cognitive ability levels (Garber and MaCurdy, 1989; Liu and Manton, 1989; Hancock et al., 2002; Grundy and Jitlal, 2007). Dependency in feeding or toileting is a significant predictor of residential home utilisation for older persons (Weissert and Scanlon, 1983) and is associated with difficulties in performing self-care activities and ADLs such as bathing, dressing, and locomotion.

To sum up, the prevalence of dependency tends to rise significantly with age, regardless of the fact that many of even the very old are still capable of

self-care. Moreover, the demand for long-term care is often positively associated with increased dependency or functional capacity levels of older persons but not necessarily with the rise in age. It is also mediated by access to informal, largely family, care. That helps explain why some less dependent people may be found in residential care. The literature also shows that access to care can be a function of other factors than physical or mental dependency.

Functional dependence is associated with female gender and age factors (Ho et al., 2002). For example, stroke and falls commonly found in older women may give rise to ADL dependence, which is closely linked with IADL impairment and subsequently affects the quality of life of older adults. Age is found to be an important and independent predictor for the change in ability levels.

Age-related dependency is identified in the study by Wittenberg and others (1998). Cognitive or mental impairment such as dementia is also an important predictor of residential home admission. Functional disability has great impact over the receipt of formal services especially in relation to health services (Bowling, 1997; Hancock et al., 2002).

Mobility

Mobility is related to the loss of strength or problems with balance. Older adults may need to use walking aids, wheelchairs or be confined to bed. Mobility decline is closely related to age, increasing dependency and greater chance for home admission. Women of very high age experience a higher risk of mobility decline when compared with their male counterparts, with almost 18 per cent of men and 34

per cent of women in the cohort of aged 90 and above (Ho et al., 1997). Out of the sampled 1,483 respondents, about 8 per cent of men and 13 per cent of women experienced mobility difficulties at 18-month follow-up.

In Hong Kong, any persons being assessed by a medical practitioner as suffering from physical handicap, visual, and/or hearing impairment are entitled to receive Disability Allowance (DA). As reported by the Hospital Authority, those within the oldest-old cohort (80 and above) are over-represented amongst DA recipients (Table 1.20, Table 1.21, Table 1.22). Comparatively, the rate for those receiving DA due to physical handicap (over 55%) is much higher than that in other younger age groups of 65-69 and 70-74, being 8 per cent and 11 per cent respectively in 2005 (Table 1.20). Very elderly people are more likely to experience physical or functional disabilities of various kinds. Throughout the years from 1996 to 2005, the aggregate number of DA recipients amongst the younger-old age groups has declined. Nevertheless, the figures may not exactly reflect true level of disability and need to be treated with caution.

Incontinence

In a study by Nelson and others (2001), urinary incontinence (UI) is found often to coexist with faecal incontinence (FI) in residents, yet UI and FI differ in their relation with age, gender, body mass. Loss of ADLs, dementia, impaired vision, being female gender, stroke are significantly associated with UI. Likewise, the study of Brandeis and others (1997) suggests that impairment in ADLs and being restrained are associated with an increased risk of urinary incontinence. These lead

to need for assistance in different aspects of daily living and mobility. Rising levels of higher dependency implies greater costs of care, in terms of money and staffing, particularly in long-term residential care.

Communication difficulties

Owing to difficulties in vision, hearing and speech in their daily lives, older adults may come across obstacles in interaction and communication with others, as well as in active participation in social activities (Resnick et al., 1997). These factors may affect the development of a healthy sense of well-being adversely and reduce the quality of life among the aged home residents. Research studies (Horowitz, 1994; Sturgess et al., 1994) point out the close relationship between visual impairment and functional deficits in daily personal care activities among residents. With the rise of advanced age, the prevalence of blindness tends to be higher (Tielsch et al., 1995).

Poor visual functioning is identified as a common disability among old age home residents. It is found to be related to old age, ADL limitations, hearing impairment as well as the prevalence of disruptive behaviours in the study by Horowitz (1997). Nursing home residents are detected to have higher rates of blindness and visual impairment than community-dwelling older people. Older women are likely to have higher rates of both blindness and visual impairment than their male counterparts.

In Hong Kong, the percentage of those of advancing age (80 and above) and receiving Disability Allowance due to visual impairment is much higher than in other younger old age cohorts. In 2005 the rate was approximately 58 per cent for

those 80 and above, whereas this constituted only 8 per cent and 9 per cent in the younger age cohorts of 65-69 and 70-74 respectively (Table 1.21). The rates of those receiving Disability Allowance fell steadily in different age groups (except for those aged 80+) during 1996-2005. This is partly due to the prevalence of higher disability levels that accompanies the advancing age of older people. The growing number being affected within a decade should not be underestimated, as this may exert pressing demand upon long-term residential care.

Apart from above, impaired hearing can also reduce daily interaction and communication with other people. As seen from Table 1.22, the percentage of older persons receiving Disability Allowance due to hearing impairment has increased considerably among the oldest age cohort (80 and over), from approximately 28 per cent in 1996 to 35 per cent in 2005. Hearing impairment is more commonly found among the oldest-olds. Again, the increasing number being affected within a decade should not be disregarded as this signifies the rising cost of social care.

Summing up, advanced age, physical disability, functional deficiencies and the receipt of residential care services are strongly correlated. As evidenced, the home care population is anticipated to include older persons with multiple pathology and multiple problems of all kinds (Bauld et al., 2000; Davies et al., 2000). All these imply the intensive care and level of support that are required in the residential facilities for elderly persons, who are likely to have been faced with growing levels of dependency and severely impaired functioning in daily living.

Cognitive status and old age

When assessing the abilities levels of older individuals, there is also need to explore their cognitive states in addition to the physical abilities. Cognitive functioning refers to the mental ability of the elderly persons, particularly their capacity to know or respond to current information. Advanced age and female gender are identified as independent factors closely connected to cognitive impairment in the local research studies (Liu et al., 1993; Ho et al., 2001). On top of that, having no formal education, slow gait time as well as institutionalisation increase the risk of cognitive impairment in both older men and women. It is well researched in other studies (Gill et al., 1996; Smits et al., 1997; Nikolova et al., 2009) that there is a positive association between cognitive status and functional abilities among older adults in performing ADLs and IADLs. The 'Disablement Process' (Verbrugge and Jette, 1994) posits that a decline in cognitive states of elderly people will affect their functional limitations and subsequent disabilities in everyday living.

According to a longitudinal study in Hong Kong (Ho and Woo, 1994), among the sampled 1,667 aged respondents, 25 per cent showed deterioration in their functional status, whereas 67 per cent showed no change and 8 per cent an improvement. Cognitive impairment is closely related to the functional dependence of older adults. There is a higher prevalence of dementia and stroke and which may cause restrictions to older persons in performing ADLs or IADLs entirely on their own (Woo et al., 1998).

In Hong Kong, the prevalence of cognitive impairment (especially dementia) rises with age. Although the vast majority of older people do not suffer

from mental disability, the prevalence of impaired cognitive functioning in the older-old age cohorts (aged 75 and over) is higher. According to a local survey by the Census and Statistics Department (2001c), the rates for those having no mental disability comprise some 92 per cent and 78 per cent in the age groups of 70-74 and aged 75 and above respectively (Table 1.23). Under the category of 'sometimes confused', the prevalence is highest in the cohort of those aged 75 and over, occupying more than 12 per cent. The comparable rates are lower in the two age cohorts of 65-69 and 70-74, being approximately 8 per cent and 6 per cent respectively. Similarly, it is the older-old cohort (aged 75 and above) which is represented more often amongst those classified as 'always confused but not disruptive to others', comprising 4 per cent. Furthermore, marked difference can be identified in that over 6 per cent within the over-75 age cohort are 'always confused and disruptive to others', whereas less than one per cent occurs in other younger-old age groups.

Apart from above, the estimates for the percentage and number of older people under the two periods of time can present a rough measure of rising demand for long-term care. Using the rate (12.4%) of those over-75 elderly population being 'sometimes confused' (Table 1.23) for projection, the estimated numbers would be 20,090 and 47,368 in 1991 and 2006 respectively. The number increases to more than double, with a fast growing rate of 136 per cent within the two periods of time. For those 'always confused and disruptive to others', the increase is again very significant. Using the rate (6.2%) of those over-75 elderly population for estimation, there would be 10,045 persons in 1991 as compared to 23,684 in 2006 being

affected. Again, the impact of such an increase in the number of cognitively impaired older population within one and a half decade is likely to have impacted on long-term care planning and service provision.

Older adults with severe levels of cognitive impairment are more likely to be placed in residential care homes. Greater numbers with mental disabilities and with difficulties in communication and interaction with others will add to care needs. Coupled with the growth of the oldest-old cohort, the higher prevalence of cognitive impairment in the advanced old age population, need for long-term care provision (especially residential care) will be higher in 2006 than in 1990.

Research studies in other countries suggest similar outcomes to those carried out in Hong Kong. Higher prevalence of cognitive impairment and behaviour problems is detected with the rise of age (Jagger and Lindesay, 1997), with a substantial proportion being placed under residential care (Challis and Hughes, 2002; Schneider et al., 2003). Females are found to have greater risk of delusions or hallucinations, while males are more likely to exhibit aggressive behaviours (Jackson et al., 1997). A majority of nursing home residents may suffer from mental disorder, mostly being dementia (Rovner, 1986; Hing, 1987). Older residents are more likely to be disoriented to time and place and require greater assistance with the activities of daily living (ADLs). Orientation and memory items are identified to be the strongest predictor of cognitive status (Gill et al., 1997). Behaviours such as wandering, active aggression, and noisiness are more frequently found among those with delusions and hallucinations. Most incontinent residents are found to be suffered from cognitive impairment including dementia (Ouslander et al., 1982;

Tobin and Brocklehurst, 1986). Briefly put, older adults suffering from memory loss, mental confusion and disorientation to time, place and person and inability to take medications are more likely to be institutionalised (Kane et al., 1983; Shapiro and Tate, 1988b; Garber and MaCurdy, 1989). However the data always indicate that large numbers with high levels of need are cared for informally in the community.

In the UK, mental disability and physical dependency are more commonly prevalent in nursing homes than in the community populations and increase with length of residence (Darton and Miles, 1997; Netten et al., 2001b). Almost half (48%) of all surviving residents two and a half years after admission are found to experience deterioration (Netten et al., 1998). This group suffers from higher levels of cognitive impairment as compared to the time at admission. Likewise, the age-specific dependency phenomenon is also identified in the study of Roos and others (1993) whereby the health status of aged residents in Manitoba, Canada is compared at both 1971 and 1983. Residents were living longer in 1983 but with health conditions more severe than 12-years earlier, in terms of mental status, functional abilities and hospitalisation rates for serious co-morbid disease. This finding is consistent with the hypothesis about 'expansion of morbidity'.

Access to institutional care does not correlate in uncomplicated ways with need. In a study by Bravo and others (1998), despite a large sample of residents (approximately 39%) in 'unlicensed' care facilities (most being profit-making organisations) suffering from severe cognitive impairment, they were found to be less physically disabled than those in the 'licensed' facilities. However, international data show increasing dependency levels in institutional care as population structures

become older. The demands on care staff in residential homes have therefore tended to increase.

A survey conducted by the Census and Statistics Department (2001b) showed that close to 3 per cent of older persons (aged 65 and above) in Hong Kong suffer from physical impairment. Taking the entire old age population in 2001 (being 747,052 persons) for projection, it is estimated about 22,411 elderly persons would suffer from physical impairment. Furthermore, around 12 per cent (89,646 elders) will have cognitive and/or physical impairment. While for those aged 75 and over, the corresponding proportions are much higher, being 8 per cent and close to 26 per cent respectively. Rising numbers and levels of functional dependency will have far-reaching financial implications for long-term care.

Chapter summary

With new developments of medical technology, people lived longer in the late twentieth century. In Hong Kong, there has been a big increase in the number of the very old population during the past two decades. Ageing populations bring a greater prevalence of illness and disability. Mortality rates of some common diseases such as heart disease and neoplasm have declined considerably amongst younger age cohorts of 45-64 during the past few decades. Amongst older people (85 and above), mortality rates have moved upward for some conditions, particularly for males. Amongst women, the age of 85 is a less good indicator of illness and disability as many stay healthy beyond that age.

The onset age for some diseases like cancer has been deferred to 75 and

above for men and more commonly over 80 amongst women. To a certain degree, this supports the 'compression of morbidity' paradigm as proposed by Fries and others (2011). Nevertheless, there is a lack of detailed statistical data about the onset of different types of disease in Hong Kong. Concerning the functional ability and cognitive status of older persons, again it is the oldest-old cohort that has the highest levels. Old age serves as a significant predictor of the onset of disability, functional limitation, and institutionalisation (Grundy, 1997; Grundy and Glasser, 2000). In a context of the greater life expectancy, it is hypothesised that residents in the two local residential homes in 2006 would be older, more frail and functionally dependent than the population of residents in 1990. The findings of a more recent local survey by the Census and Statistics Department (2005) show that the majority of those in institutions were female, with almost 51 per cent at the age of 80 and above. Twenty-four per cent of female residents were 90 and above, and had ADL impairment at high levels.

Long-term care is 'a by-product of societal ageing and chronic disease' (Kane and Kane, 2005, cited in Johnson et al., 2005, p.638). The HKSAR government has not been able to ignore these changes as they have manifested themselves in rising demand for long-term care and consequently growing public expenditure. It has become less possible for public authorities to remain inactive, but it remains open to investigation as to how far changes justified in terms of 'ageing in place' and establishing a 'continuum of care' are driven by principles of welfare or by fiscal pressure.

Chapter 2 Living Arrangements and the Economic Circumstances of Older People

The core focus of this thesis is on the consequences of a policy change designed to change the allocation of access to publicly supported institutional care so that it is focussed on people defined as in higher need. However, a policy change such as this takes place in the wider context of a complex matrix of existing choices that may or may not be available to older people living in Hong Kong. Whether or not people apply for entry into the two homes studied depends on their preferences and the availability of alternatives, such as family care or other support in the community. This chapter reviews available evidence on the circumstances and choices available to relevant populations of older people living in Hong Kong.

This chapter highlights the various types of living arrangement of older people in Hong Kong, and explores the availability of informal care provision as well as the demand for long-term care. In particular it describes how financial resources are a central factor affecting the care choices dependent older people make.

Changing living arrangement in relation to informal care provision

Along with rapid industrialisation and urbanisation, considerable changes have taken place in family structure in Hong Kong. The traditional extended families experienced a great decline. Instead the nuclear family has emerged to become the most predominant form in the territory. The average household size has decreased from 3.9 persons in 1981 to 3.4 in 1991 and further to 3.1 in 2001 (Census and

Statistics Department, June 1993 and 2002b). It has levelled down and remained steady to 3.0 since 2004 (*Hong Kong Annual Digest of Statistics*, 2007 Edition).

The nuclear family of fewer people has, by definition, a reduced capacity for informal care. Consequently the supply and availability of informal care for older adults has fallen because of changes in family structure. A form of 'modified extended family' has supported the tasks and informal care continues among different generations in contemporary Hong Kong (Lee, M.K., 1991 and 1995). The findings of Lee, R.P.L. and others (1997) suggested that younger generations continued to render assistance and support to their older parents, a reduced size of the available family. Filial obligation continues to be a strong ethic in various and new forms (Chow, 2001; Kwan et al., 2003; Chow and Lum, 2008).

The availability and degree of support that elderly people obtain depends largely on types of living arrangement. These include living with spouse, living with spouse and children, living with children only, and living alone. According to the findings by the Deloitte and Touche Consulting Group (1997), some 76 per cent of older people in the community prefer to stay and age at home in spite of the increased disability, and with about 66 per cent of their carers agreed with these views.

As revealed in the *Hong Kong 2006 Population By-Census Main Report: Volume One* (Census and Statistics Department, 2007c), there was a substantial increase in domestic households with elderly members, in terms of number and proportion. In 2006 there were 594,730 such households, as compared to 470,298 in 1996, being an increase of nearly 27 per cent. Out of these domestic households,

some 28 per cent (being 166,911) constituted those living with elderly persons solely in 2006. The corresponding proportion was just around 24 per cent (being 111,275) in 1996.

Another striking change has been the number of two-person wholly elderly households, which has risen significantly from 37,722 (nearly 34%) to 67,094 (over 40%) between 1996 and 2006 (Census and Statistics Department, 2007c). In conjunction with this, a tremendous growth can be identified in the aggregate number of older persons living in these households, moving rapidly from 75,444 to 134,188. This rising trend is in fact due to increased life expectancy especially amongst men, resulting in more elderly couples being able to live longer years of marriage life more than ever. Behind this 'happy scene' lies the potential risk of advanced-age institutionalisation. When the health or functional ability of one of the older persons deteriorates, they may become the vulnerable ones and in urgent need of long-term care.

At the same time, this developing pattern of living arrangement might be due to more care of the very old by the younger in Hong Kong. For example, it is quite common to find the younger-old child (usually a daughter) caring for a very frail, disabled elderly parent (usually the mother) and living together under one roof, particularly with the increased longevity. However this pattern may generate practical limitations during informal care provision in daily living, especially if the young-olds themselves are not physically and/or functionally 'fit'. This is another reason why the issue of caregiving has become a major concern of the government as well as individual family relatives by the 2000s.

In Hong Kong, the overwhelming majority of older people lived with their families in the community with or without formal community care services throughout 1991-2001. As indicated in the *2001 Population Census Thematic Report: Older Persons* (Census and Statistics Department, 2002c), close to 94 per cent (being 452,250) of the old age population lived in the community in 1991. Despite the falling rate, the figure has moved up to 679,097 (about 91%) living in domestic households after a decade. Furthermore, local statistics show that there were 534,559 domestic households accommodating one or more older persons under the same roof, comprising 26 per cent of the total domestic households (being 2,053,412) in 2001 (Table 2.1). As at 2006, the figure has moved up to 594,730. The comparable rates were only 23 per cent (being 366,522 households) in 1991. Living arrangements and household structure have direct impacts upon the availability of informal caregiving and the rates of institutionalisation. The next section focuses on available evidence about availability and use of informal care.

Different types of living arrangement in Hong Kong

Living with spouse

To a large extent, the living arrangements of older people are affected by their marital status. Those who are married (vs. those never married) are more likely to receive spousal care and support. On top of this, the potential of gaining care from adult children is higher. Among the elderly population in 2001, close to 60 per cent (being 447,260) were married while 34 per cent (being 253,471) were widowed (Census and Statistics Department, 2002c) (Table 2.2). The corresponding rates were

about 58 per cent (being 277,727) and 36 per cent (being 173,840) respectively in 1991. By comparison, females of advanced age are more likely to be widowed. For example, in 2001 some 65 per cent and 77 per cent in the respective 75-84 and over-85 female age groups were widowed. On the other hand, the corresponding rates were much lower in their male counterparts, being 22 per cent and 40 per cent respectively. In other words, older men were more likely to receive spousal care and support during their later years of life.

As observed from Table 2.3, the number of older individuals living with a spouse indicated an upward move. In 1991, there were some 71,139 older persons living with spouse, while the figure reached up to 137,590 in 2001. Within a decade, the number has been doubled, with a fast rising rate of over 93 per cent. Viewing this, spousal living has emerged to become a distinctive type of residence arrangement in Hong Kong towards the twentieth century. Likewise, in the UK spousal support was also detected to be comparatively longer than previously, particularly with the longer life expectancies of both sexes (Harper, 2003). This trend of informal care by spouse is likely to increase substantially for the coming three decades (Pickard et al., 2007).

Increasing life expectancy has meant that older men now have more years of marital life than previously. Under the traditional Chinese culture, wives are expected and obliged to take care of their husbands as long as they live. Therefore older males are more likely to receive more spousal care and support, even at very advanced years of life. In 2001, there were approximately 24 per cent (being 7,963) of older men in the 80-84 age cohort and 19 per cent (being 3,643) in those aged 85

and above living with spouse (Census and Statistics Department, 2002c) (Table 2.4). By contrast, elderly women seldom obtain spousal support at a highly advanced age. The corresponding rates for their female counterparts were merely 7 per cent (being 3,493) and 2 per cent (being 973) respectively. In this respect, the caring obligations may delay the home admission of older females. It is speculated that by the time these older women are admitted to residential care, they may have become very elderly and impaired.

In the UK, the growth of spousal care was evident between 1985 and 1995, with the number doubling to 200,000 spousal carers (aged 75+) (Pickard et al., 2000). This means there is an increased likelihood of elderly married couples (aged 75 and over) providing care to their spouses. The presence of supportive network such as the availability of spousal support is central in reducing the risk of institutionalisation of older men (Freedman et al., 1994).

Living with spouse and children

Apart from above, there has been a rise in the number and percentage of older persons living with both spouse and children in Hong Kong. This may be due to the 'priority housing schemes' around the eighties, which reflected the government's intention to encourage families to reside with the elderly members. For example, adjacent or neighbouring public housing flats are provided for young families to enable them to live close to dependent parents or relatives in two separate flats in the same block within the same estate. This has allowed more opportunity for care of the elderly close relatives whose health may deteriorate some day. As shown

from the *2001 Population Census Thematic Report: Older Persons* (Census and Statistics Department, 2002c), the number of older persons living with spouse and children grew to 239,680 (slightly over 32%) in 2001, compared with only 137,141 (approximately 29%) in 1991 (Table 2.5). Within a decade, there was a substantial increase of almost 75 per cent.

Owing to the longer life span, a greater proportion of older men in the 2000s was able to reside with their spouse and children, even at very old age. Local statistics indicate that close to 30 per cent and 22 per cent of older men in the age cohorts of 80-84, aged 85 and above respectively were residing with spouse and children in 2001 (Table 2.6). On the contrary, the probability of their female counterparts living with a spouse and children was much lower, being 6 per cent and 2 per cent respectively. This can be well explained by the greater longevity of females whose later years of life are often spent with widowhood.

At times of need, frail old people are inclined to seek support from their informal care network in the first place. Co-residence with the primary caregiver will reduce the institutionalisation rate of elderly persons. In the two local researches (Chi and Lee, 1989; Chi and Boey, 1994), there was an upward trend in older persons co-residing with their adult children, in-laws, and grandchildren. Some older men indicated a wish for independent living alone, living with spouse, entering residential homes, while older women preferred co-residence with children instead (Chi, 1998). However, these ‘choices’ are related to the cost and availability of different forms of family and other care. Freedman and others (1994) suggested that the availability and opportunity of care was related to gender. Older males can more

often use spousal support, whereas females either prefer or have to turn to care by adult children, and which lowered the institutionalisation rate. Nonetheless greater complexity is involved in the choice of care. For instance, there will be no choice of spousal care if the spouse has died.

To conclude, the contributing factors of marital status, number of children, quality of relationship between caregiver and older people, contact with family and friends all affect the availability of informal care (Grundy, 1992; Freedman et al., 1994; Wittenberg et al., 1998). Furthermore, the receipt of informal care and support is closely related to age, gender, household composition, functional disability of older persons (Allen et al., 1992; Wenger, 1992).

Living alone with children

A different scenario is where older people live with children only. Local statistics show that the proportion has decreased from approximately 29 per cent in 1991 to 25 per cent in 2001 (Table 2.7), in spite of the growing number from 138,685 to 184,328 during this period. There was a greater likelihood of older women within different age cohorts living with children only: some 43 per cent, 41 per cent and 35 per cent in the female age cohorts of 75-79, 80-84, and those aged 85 and above respectively in 2001 (Table 2.8). The number of older women living with children in 2001 was almost four times as much as that of older men. In the 75-79 age cohort, there were 34,389 older females living with children as compared with merely 8,466 men. The proportion of older men living alone with their children was lower, being 13 per cent, 18 per cent and 19 per cent respectively. This can be

explained by the longer life expectancies of females and hence the greater probabilities of their being widowed and/or single.

Older respondents were most likely to be co-residing with only one of their adult children. This type of living arrangement was consistent with their choice of preference and the cultural expectation towards family obligation (Lee, R.P.L. et al., 1997). Being brought up under the traditional Chinese culture, the value of filial piety has been deep-rooted in the minds of the younger generations. They are often expected and obliged to support their parents as the latter become old. It is a usual practice that adult children live with their older parents even after marriage. Co-residence may also be due to practical considerations such as costly housing rentals in Hong Kong. Some types of living arrangement clearly facilitate intergenerational care and support.

Late marriage

Since the 2000s there was a growing trend of later marriage amongst women in Hong Kong. To some extent, this will affect the availability and supply of informal care for older relatives. As shown from the statistics, the median age of first marriage for women has risen from 23.4 in 1976 to 24.9 in 1985 and 28.1 in 2004. This implies a greater chance of unmarried adult children living with their parents and possibly providing them with some kind of informal support. Although nowadays the younger generations cherish much the values of privacy and personal autonomy, some still live with their older parents under one roof. Intergenerational co-residence is often because of practical concerns such as financial constraints,

household care support and tendency towards late marriage (Ting and Stephen, 2002).

Living with non-immediate family members

Apart from the above types of living arrangement, a small proportion of older people live with persons other than immediate family members. As revealed from the *2001 Population Census Thematic Report: Older Persons* (Census and Statistics Department, 2002c), the rate was decreased considerably from around 9 per cent (being 44,284 older persons) in 1991 to 4 per cent (being 32,736 older persons) after a decade (Table 2.9). In every old age cohort ranging from 65-69 to those aged 85 and above, the percentage of older women residing with non-immediate family members was higher than their male counterparts. This will be a function of the higher incidence of widowhood amongst women. In 2001, about 10 per cent of older women in both age groups of 80-84 and those aged 85 and above, compared with only approximately 4 per cent and 5 per cent respectively in their male counterparts co-resided with persons other than immediate family members (Table 2.10). This living pattern may involve informal support through communal living. These co-residents may be more distant relatives or siblings.

Older persons living with non-elderly persons in domestic households

The majority of older adults were living with non-elderly persons in domestic households, representing over 69 per cent (being 531,135) of the total number of elderly people living in domestic households in 2006 (Table 2.11). Among them, those living with one, two and three non-elderly persons represented a

very striking proportion and number. For instance, the aggregate number of these three kinds reached 277,711 (approximately 47%) in 1996. A remarkable increase was identified a decade later, constituting more than 52 per cent (being 402,317). This suggests that either co-residential family care is both preferred and becoming more feasible, or alternatively that family care has increased because of a decline in the availability and affordability of other sources of support.

Concerning the non-elderly members, this may include the spouse, adult children, siblings or persons other than immediate members. For an older person living with 'one' non-elderly member, this would most likely be the younger spouse (wife), since it has been a local practice for some 'older' men (having difficulties to seek marital partner in Hong Kong for various reasons) to marry young girls in China years ago. Meanwhile the non-elderly member may also include full-time domestic helpers who are entitled to live under one roof, but the statistics did not specify. Older people living with others may be a consequence of the availability and cost of institutional care. However, the range of possible alternatives and their availability to older people is clearly very complex and affected by changes in demography, economic resources and culturally influenced preferences.

Living alone

Many research studies have shown that older people living alone are at higher risk of institutionalisation than those living with others. This kind of living arrangement is a critical factor affecting the demand for long-term care (Woo et al., 1994a and 2000b; Wittenberg et al., 1998; Crosby et al., 2000; Scott et al., 2001; Lee

and Lo, 2005). In Hong Kong, the percentage of older adults living alone had fallen from 12.7 per cent in 1991 to 11.5 per cent in 1996 (Table 2.12). It then levelled to some 11.4 per cent and 11.6 per cent in 2001 and 2006 respectively (Census and Statistics Department, 2002c and 2007c). Despite the relatively small proportion, the number of 'solo-living' elders increased considerably from 61,001 in 1991 to 98,829 in 2006. This fast-growing rate of 62 per cent within the 15-year period may create heavy demand over long-term care provision and cost in the future.

Older females living alone outnumbered their male counterparts in every age cohort (except those aged 65-69). For example, in 2001, within the age group of 75-79, there were 12,230 older women (slightly over 15%) and 7,248 older men (nearly 12%) living alone (Table 2.13). The corresponding figures were 4,712 (over 11%) and 1,929 (being 10%) in the oldest-old group (aged 85+). This could be accounted for by the increased longevity of females who had greater chance of receiving institutional care at later age. It is also a factor of men marrying women younger than themselves.

It was interesting to note a percentage of older men (aged 60 and above) living alone being 'never married', as shown in *'A profile of elderly persons aged 60 and over living alone'* (Census and Statistics Department, 1999a, p.54). This comprised some 29 per cent (being 11,300 older men), as compared to 12 per cent in their female counterparts (being 5,300) (Table 2.14). However, the proportions of older persons 'never married' were found to be low among the elderly population, occupying 5 per cent in male and 3 per cent in female (Census and Statistics Department, 2002c). Viewing from the above two studies, it can be speculated a

greater proportion of older men being ‘never married’ tended to be living alone. These male aged singletons may be more likely to be offered residential care than their female counterparts. They may have a higher probability of entering care homes. This is mostly due to the lack of relatives in caring for them at advanced old age.

Though the proportion of older individuals living alone is small, their long-term care needs deserve special attention. Local statistics (Table 2.15) indicate that the living alone arrangement may be due to several reasons, including ‘never married’ (nearly 20%), ‘having no children or having no children living in Hong Kong’ (almost 30%). While over 34 per cent had ‘children living apart after marriage’, the statistics do not disclose whether these children provided care to their older parents. As mentioned earlier, a considerable number of older persons could still receive some kind of support from their adult children though not co-residing under one roof (Lee, R.P.L. et al., 1997). Clearly, ‘living alone’ does not connote that they must be experiencing ‘isolation’ or ‘loneliness’. By comparison, the solo-living pattern of older individuals in this territory was markedly different from that in the UK or the States. In a compact society like Hong Kong, older people can more easily obtain informal support and assistance from their close relatives who live adjacently within the same housing estate or district. Furthermore, transportation and communication networks are convenient and well-developed.

Owing to the classification of living arrangement by the Census and Statistics Department, there are limitations in the data which fails to present a comprehensive picture about the real situation in Hong Kong. For instance, there is a

lack of information on nuclear families that are closely connected and who live nearby their older relatives in the same building block or housing estate within the same district. In real situations, adult children often provide care and support for the older parents in times of need. They may choose to live adjacent to their parents, though in different domestic households and not under the same roof. In this light, the nature and extent of informal support cannot be fully understood from the available data on intergenerational co-residence.

Current patterns

To conclude, older individuals living by themselves and those living with another older person in domestic households constitute a very large proportion and number in Hong Kong. Within a decade or more, there has been a very substantial growth in the number of single and joint older person households. These two groups represented over 30 per cent (being 233,017) among older persons living in these entirely elderly households in 2006 compared with less than 25 per cent (being 147,558) in 1996 (Table 2.16). These two kinds of living arrangement have wide implications for long-term care demand from the very frail and marginalised elderly population. It is likely that older person households may have less access to informal care, and a greater preference or need for institutional alternatives that earlier generations where co-residence with children was more often the norm.

Furthermore, the extended co-residence of elderly spouses has currently become a predominant pattern in Hong Kong. Under the Chinese traditional culture, older men tend to receive care from their spouse. While this may postpone the

institutionalisation of the older women, when they are admitted to residential care they are more likely to be very old and frail. Elderly females, with highly advanced age, never married or widowed, and without living children have been identified as the most disadvantaged and vulnerable persons in society. Consequently they may seek and receive institutional care during their end stage of life.

The substantial growth of older persons living in non-domestic households

It is clear that the vast majority of older people are living in domestic households within the community, and under different types of living arrangement. Some are being looked after with or without the support of various formal community care services. As revealed from the *2001 Population Census Thematic Report: Older Persons*, there remains a relatively small proportion of older people living in non-domestic households such as residential care homes, hospitals, penal institutions (Census and Statistics Department, 2002c). This number and proportion has been moving upward. In 1991 the rate rose from around 6 per cent (29,790 older persons) and reached more than 9 per cent (67,955 older persons) in 2001.

Among those living in non-domestic circumstances, the rates were comparatively much higher in the two very advanced age groups of 80-84 and 85+, being around 19 per cent (15,631 persons) and 35 per cent (21,646 persons) for both male and female respectively (Census and Statistics Department, 2002c). On top of that, females also outnumbered their male counterparts in this type of living arrangement. For example, in the 85+ female age group, there was about 40 per cent (being 16,860) staying in institutions. While for their male counterparts, a lower rate

of 25 per cent (4,786 persons) was identified. Similarly, there was a higher rate of 21 per cent (10,834 persons) in the 80-84 female age cohort, compared with the corresponding rate of 14 per cent (4,797 persons) in the male counterparts. This is consistent with the more recent findings in another local survey (Census and Statistics Department, 2005), in that over half of the care home residents were found to be very old females (aged 80 and above), and only some 39 per cent were men. From this perspective, there is a large number of very elderly women who are at high risk of institutionalisation.

Economic circumstances of older people

The use of care alternatives is affected not only by their supply but also by demand which is often a function of economic circumstances and capacity to pay. Regarding the impact of the distribution of income or wealth within older populations upon the rates of home admission, there is limited consensus in the literature. Some studies indicate that in most countries the institutional populations were over-represented by those living on low incomes (Weissert and Scanlon, 1983; Cohen et al., 1986; Liu and Manton, 1989). At the same time the evidence is that nursing home residents have higher incomes (Scanlon, 1980; Lamberton et al., 1986; Newman et al., 1988). This can be explained by the higher rates being charged to private-pay residents.

To date, in Hong Kong research shows no clear relationship between economic capacity and the choice of care. Clearly, those with monetary resources will have a wider range of alternatives and better options. It is a common practice in

this territory for wealthier older individuals to rely on foreign or local domestic helpers for assistance in daily living. Some very wealthy older persons or families may employ private nurses for intensive personal and nursing care. While for those with only meagre or no income, there will be fewer choices when health or functional status turns worse.

Data on older people's incomes is unreliable. Many of them feel hesitant to respond directly to questions relating to income, property ownership or financial assets. Some may be reluctant to disclose the actual situation, for fear this may adversely affect their applications for financial need, housing assistance, or undermine self-image or dignity. Data on education, occupation, home ownership can present a crude picture of the general economic situation of the older adults. It is also necessary to discover how far they are being financially supported by adult children, living or not living with them.

Older people with substantial means

In the current study, elderly persons with substantial means or financial resources in Hong Kong refers to those who can afford to hire full-time domestic helpers. Formally employment regulations require prospective employers of domestic staff to have a monthly household income of HK$15000/m (US$1923/m) or more, or comparable assets throughout the contractual period. Apart from that, they have to offer accommodation with privacy. According to a local survey by the Census and Statistics Department (2005), approximately 13 per cent of family households containing older persons employed full-time domestic helpers.

Educational level

To a certain extent, educational attainment may be used as a marker for the socio-economic status of older people. Research shows a positive relationship between low education levels, lower social mobility, poorer health and health behaviour patterns as well as access to health and social services (Guralnik et al., 1993; Berkman et al., 1993). This is matched by the findings of a local study (Ho et al., 1997), in which no formal education was found to be positively related with mobility decline and cognitive impairment.

The higher the age, the lower is formal educational achievement. This is most applicable to the older females. Amongst women aged 85 and above, 74 per cent had experienced no schooling or kindergarten. The corresponding rates are lower for the younger old age cohorts of 70-74, 75-79, and 80-84, being 59 per cent, 62 per cent, and 68 per cent respectively in 2001 (Table 2.18). Again, it is not surprising to find males generally acquiring higher education levels than their female counterparts. For instance, in the 80-84 age group, about 19 per cent and 5 per cent of older men had attained secondary and tertiary education levels respectively compared with seven per cent and one per cent amongst women in 2001. These gender differences in educational attained levels will be associated with different levels of income. Overall, the evidence suggests that future cohorts of older people will be more likely to have incomes and savings that can contribute to demand for residential care.

Traditionally, females receive less or no education than males in Chinese society. This may account for higher percentages of older females (aged 65 and

above) reporting no schooling or only kindergarten levels than male counterparts. For example, over 79 per cent and 70 per cent of females were illiterate or had only attended kindergarten, whereas the proportions were lower amongst men, being 26 per cent and 30 per cent in 1981 and 1991 respectively (Table 2.17). The difference between genders receiving education had lessened by 2001, being approximately 59 per cent and 23 per cent in the two respective periods. Along with the remarkable socio-economic changes in Hong Kong after the mid-nineties, females were gradually given more opportunities for education, albeit the proportions were still comparatively lower than their male counterparts. Future older cohorts will be better educated than the current ones. This may give rise in the very longer term to the higher expectations of long-term care provision.

For many decades, males have enjoyed greater educational opportunity. For example, around 18 per cent and 5 per cent of older men had completed secondary and tertiary levels of education respectively in 1991 (Table 2.17). The outcomes for women are lower: merely seven per cent and one per cent. In 2001, the corresponding rates had reached to 21 per cent and 6 per cent for older men, and with only 9 per cent and 2 per cent having completed secondary and tertiary education respectively amongst women. Nevertheless the proportions for elderly persons attaining tertiary levels of education have continued to rise, reaching approximately 10 per cent and 4 per cent for older men and women respectively in 2006. It is assumed that older men who are generally more educated tend to earn higher income than females.

Employment

Alongside the higher education backgrounds since the early 2000s, more older people have histories of professional or managerial employment. For example, more have worked as 'managers and administrators', approximately 16 per cent (being 8,412) in 2001 compared to 10 per cent (being 6,774) in 1991 (Table 2.19). For those working as 'professionals', or 'associate professionals', the percentage also moved upward to nearly 3 per cent (being 1,481) and 5 per cent (being 2,698) respectively within a decade. There is a growing proportion and number of older persons with occupational histories that may affect demand for care in the future.

Home ownership and assets

Home ownership can be one of the important sources of purchasing power, as well as a key determinant of preference and choice. The international literature shows that home ownership is positively related to lower utilisation rates of nursing home (Newman et al., 1988; Garber and MaCurby, 1989). Older people with wealth assets are more inclined to utilise home care instead of residential services. These better-off older persons show a greater reluctance to leave their homes. Grundy and Jitlal (2007) have shown that institutionalisation rates to be lowest for owner occupiers and higher for tenants. On the other hand, financial status has been found to be a poor predictor of institutionalisation (Hanley et al., 1990). Likewise, Hancock (2000) showed that amongst the very elderly (aged 80 and above) and living alone, there are people who face the intensive need for long-term care despite their housing wealth.

In Hong Kong data show that the proportions of older persons owning real property without mortgage are higher than other age groups in the entire population. The rates were close to 82 per cent and 83 per cent in 2001 and 2006 respectively, compared with just 49 per cent and 52 per cent for the whole population in Hong Kong (Table 2.20). A considerable number and proportion of older people own accommodation without a mortgage. Among the entire old age population in 2001 (being 747,052), the proportion of older people (aged 65 and above) being owner occupiers represents some 23 per cent. This comprises of 19 per cent (being 139,083) without mortgage and 4 per cent (being 30,186) with mortgage. The corresponding proportions reduce to 16 per cent (being 134,157) and 3 per cent (being 26,755) in 2006, equating to 19 per cent of the elderly population being owner occupiers.

Data in Hong Kong show that the overwhelming majority of older people (96%) rely on cash or savings or fixed deposits for daily living (Table 2.21). Some 24 per cent had self-occupied properties, and over 2 per cent received rental income. Property is a very source of wealth amongst older people. However, the degree to which it can be used to find residential care may vary.

Older adults can be found between two polar positions in terms of financial assets. At one pole, some have large disposable incomes or monetary resources which facilitate choice in daily life. At the other extreme, some very poor and vulnerable older persons have to live apparently without means. For instance, close to 3 per cent (26,800 persons) did not own any assets (Table 2.21). These older individuals are more likely to rely on Comprehensive Social Security Assistance (CSSA) for daily maintenance during their later years of life, causing heavy fiscal

pressure upon the government of Hong Kong.

Financial support from children

Older people may receive contributions from younger generations. According to a local survey (Census and Statistics Department, 2005), over 59 per cent of older persons were supported financially by their children. Using the old age population of 747,052 in 2001 for calculation, there were about 442,255 elders being financially supported by the younger generations. This was broadly consistent with the findings in another local survey about the characteristics of dependent parents (Census and Statistics Department, 2003a), in which close to 54 per cent of parents were financially supported by living children, and some 22 per cent were supported by non-living children (Table 2.22).

On the other side, the scenario appeared to be different when the children (aged 15 and above) were asked if they contributed any monetary support to their dependent parents in the past twelve months. Out of the total 5,583,900 respondents, only 30 per cent gave a positive answer (Table 2.23). Here in this case the parents referred to may have included younger parents. About 32 per cent in the children age group of 40-49 offered financial support to their older parents, whereas the proportion in the 50-59 children age group is comparatively lower, being 16 per cent.

In the meantime, a great majority (almost 70%) expressed to provide no financial support to their parents, broadly including parents-in-law, step-parents, and grandparents (Table 2.23). This may also be due to the fact that a dependent parent

of the former older generations usually has more than one child, unlike those of the future older generations. For instance, in a family consisting of two to six children, there is the possibility that only one or two children provide monetary assistance to their elderly parents, while the remaining children (for whatever reasons) do not do so. Adult children belonging to younger or middle age cohorts of 20-29, 30-39, 40-49 showed higher rates of supporting their dependent parents, at about 51 per cent, 50 per cent, 32 per cent respectively (Table 2.23). For those belonging to higher age cohort (aged 60 and above), only about two per cent made financial contribution to their very elderly parents. This is an odd statistic suggesting this includes those who do not have surviving parents. Furthermore, it is noteworthy that people generally retire at the age of 60 or 65 in Hong Kong and there was no compulsory pension scheme before 2000. It may be particularly difficult for retired children to continue giving financial support to their parents. Additionally, more employees were being forced into early retirement due to adverse economic situation in the territory during the nineties. All these factors may account for the tiny proportion of this age group (2%) that provides financial support to their elderly parents.

Another interesting finding is revealed in Table 2.22, showing a correlation between age and receipt of help from children. Despite the low overall proportion, the number (150,700 older persons) being supported by living children was still considerable. Intergenerational co-residence tends to be associated with more social support for the elderly members. Out of the total 1,117,000 dependent older parents, close to 54 per cent (being 597,400 persons) gained support from the children whom

they resided with. Less than a quarter (approximately 22%) of older persons (being 240,000 persons) were supported by children living apart. Within the 65-69 age group, there were 80,200 older people (over 13%) being supported by younger generations living with them. The number reduced sharply to 45,700 (19%) for those older parents who lived apart from children. Likewise, this also occurred in the over-70 age group, with 150,700 (25%) and 109,400 older persons (over 45%) in the two respective categories.

Regarding the monetary amounts of support, around 24 per cent (237,600 persons) provided an annual sum of less than HK$12000 (US$1538) for supporting their parents and some 26 per cent (260,500 persons) with that of HK$12001-$24000 (US$1539-$3077) (Census and Statistics Department, 2003a). Put in the other way, financial support from children appears to serve as a supplement to the daily maintenance of older parents. In the meantime, close to 20 per cent (198,100 persons) supported their parents with a larger amount of more than HK$48001 (US$6154) annually.

Hence, whether living together or apart, the majority of elderly people were financially supported by their adult children. This reflects the traditional cultural value of filial piety is still cherished in Hong Kong (Chow, 1996 and 2001). To a certain degree, it continues to influence the thinking and behaviour of individual members in the Chinese families, with the younger generations still likely to pay respect, provide care, and offer monetary support (on regular or irregular basis) to older people.

Cultural values and choice of care

When the health status of older adults declines, the probability they will seek institutional care in the first place remains low, especially for those owning monetary resources. This seems to be the common and perhaps universal preference for people at advancing age. According to the Chinese culture, filial piety is treasured as a kind of good virtue in which the younger generations are expected to look after and repay their older parents who have raised them. To the family, it is often perceived as a 'shame' to let older relatives receive care at residential homes (Lee, D.T.F., 1997). In the meantime, older adults also aspire to stay at home for proper care. As well-evidenced in a local household survey (Census and Statistics Department, 2005), about 97 per cent (being 958,400) of older individuals expressed no intention to receive residential care even when they became frail and impaired (Table 2.24). Furthermore, some 81 per cent (being 775,400) preferred to remain living at home with care by others (Table 2.25). Likewise, in a recent study of 435 elders utilising long-term care services, close to 74 per cent express a view that 'receiving care at home is better than that at residential facilities' (Lou et al., 2009). Hence under most circumstances, older persons prefer to age and be cared at their own homes.

In Hong Kong, it is common for 'better-off' older people to hire full-time domestic helpers for performing household chores and personal care tasks. As at 2001, there were about 63,600 households with older people employing full-time domestic helpers (Census and Statistics Department, 2001c). With only a very small sum of money, round the clock personal care services can be rendered wholly within

the household. Another option for these well-off persons is to employ private nurses for intensive personal and nursing care at home, often at a higher cost. This ensures the high level of privacy as well as reducing the stigma that often associated with receiving care in residential facilities. The stigma is similar to that attached to the process of claiming benefits (Cook et al., 2004).

Hiring domestic helpers is very costly and is not commonly practised in countries such as the UK and the United States. Older individuals get used to living alone prior to home admission. When there are changes in their functional ability levels, they tend to choose to utilise domiciliary care or admit to residential homes, where less or no stigma is attached. As reported in the study by Netten and Darton (2003, p.494), self-funders in the UK have more control over own resources and enjoy more preference, 'a choice denied to those dependent on public funding'. A lower level of dependency was detected among self-financed residents when compared with those being publicly funded, in terms of their mobility, continence, activities of daily living (ADLs), and cognitive state.

For affluent older persons in Hong Kong who prefer to enter residential facilities, there is still a variety of options. Under many circumstances, they will not choose to enter government-funded care homes where the living styles are extremely different from their usual patterns and expectations. The lack of privacy as well as the labelling effect often deter them from moving to these government-funded care homes. Some personal storage space may be provided but broadly privacy is very limited. During home life residents need to share rooms and toilet facilities with roommates (about 4 to 8 persons in each room). For security purposes, bedroom

doors are usually left open. Older residents will bathe (usually with staff assistance) behind curtains or closed doors without lock. In this kind of group living a sense of self and dignity of each individual person is not heavily emphasised. It is understandable that the wealthier often show reluctance to enter into those government-subsidised care homes. Instead they will choose to stay in private residential homes that offer high standards of quality care up to their expectations. Or they will opt to receive care in private hospitals or nursing homes, albeit with highly expensive charges.

The most vulnerable: older people without means

In the contemporary society older persons have been increasingly becoming more educated, engaging in better occupations, and acquiring more wealth. However there still exists a significant proportion and number living without means in the territory. For many years public policy in Hong Kong has concentrated on developing a social infrastructure which facilitates economic success, in relation to various aspects of housing, health care, and education. On the other hand, the transfer or cash payments available to older persons (including pensions, Comprehensive Social Security Assistance, Old Age Allowance, Disability Allowance) lag far behind compared to the rapid economic growth in this territory (Chow, 1981; MacPherson, 1994).

Most social services have been found to be inadequate in meeting the needs of older people especially those low income single older people, in spite of the policy aim of ‘ageing in place’. La Grange and Yung’s study (2001) shows that in

the context of the residual approach to welfare in Hong Kong, the provision of medical care, financial assistance, domiciliary as well as residential care is rather limited. In this survey of 402 low income single elderlies in Hong Kong, a vast majority often utilised public health services that were heavily subsidised by the government. In some situations, they chose to delay (30%) or avoid (22%) medical consultations to reduce health care expenses. Concerning food consumption, a large proportion (46%) of older people used one third or more of their total income on food. Over half (52%) would use and divide the food for one meal into two, about 49 per cent seldom or never dining out, and some 35 per cent consume poor quality food in order to reduce daily living costs. Meanwhile there was 'little community support' to augment the income support of the aged singletons, who were over-represented by females and those at highly advanced age. With the uneven distribution of societal resources, these impoverished and marginalised older persons were deprived of many aspects of daily living and subject to social exclusion. They have to struggle with many kinds of restrictions in daily life. Hence the low sense of self-worth, diminished control over circumstances, psychological strain as caused by financial insecurity and dependency probably follows resulted (Cook et al., 2004). In the following sections, the conditions of the poorest older people are explored in terms of their labour force participation rates, income levels, and need for financial assistance.

Job participation rates

During recent decades, the labour force participation rates of elderly persons have fallen considerably with the rise of old age. To a certain extent, this

might be due to the changing economic environment in Hong Kong resulting in the growing trend to 'early retirement' around the late nineties. In the 65-74 older male cohort, participation rates fell from 28 per cent in 1991 to 17 per cent in 2001 (Table 2.26). Amongst women 10 per cent fell to nearly 4 per cent in the same period. In advanced age, older adults are less likely to be engaged in work. Among the very old (85 and above), only about two per cent (male) and less than one per cent (female) took up jobs in 2001.

Nonetheless within the elderly population (aged 65 and above), there remained more or less 10 per cent who participated in the labour force during the period 1991 to 2001 (Table 2.26). It can broadly be assumed that those with some means or financial assets would not be engaged in work generally at such age. The working older people were more often paid low wages. As remarked by Chow and Chi (2000, pp.75-79), the state of poverty of elderly individuals could be accounted by their limited earning power at old age. Worse still, the current older generations in Hong Kong cannot usually access the benefits of pension funds. Despite public debates for years, the Mandatory Provident Fund (MPF) scheme only started its implementation after 2000. It will take some thirty years or so to realise its full potential and the benefit will go to future older generations. Following this line of thinking, the current older generations are more likely to be poor without means towards their later years of life. With no other support, when they become frail and disabled, they have to seek care in the government-subvented homes.

The scenario appears to be rather different in other countries like the UK and the States. In the UK, the implementation of the NHS and Community Care Act

in 1993 led to significant changes in the provision of care services, and a shift in the balance of care. Health services are provided free of charge by the National Health Service (NHS), while social care services (as provided by the local government or bought privately) are charged in all places except Scotland, according to the financial assets or income of the service-users (Bell and Bowes, 2006). In the United States, people have to contribute through mandatory participation in the social insurance system (the Medicare programme). The wealthy pay for social services including home care and residential care. While large numbers access services through Medicaid, which is a means-tested social assistance programme funded by general taxation. In Germany, all eligible individuals are entitled to benefits from a national health insurance system without being means-tested. Therefore they do not face about the same choices in long-term care that older people in Hong Kong usually come across (Glennerster, 1998; Glendinning et al., 2004; OECD, 2005).

Income levels

In Hong Kong, income levels may not serve as a strong predictor of the socio-economic status of older persons particularly with the phenomenon of 'early retirement' in the late nineties. As envisaged, older Chinese women have attained lower educational standards and have lower incomes than men. In 1991, some 48 per cent and 39 per cent of older women earned a monthly income of HK$2000-$3999 (US$256-$513) and less than HK$2000 (US$256) respectively (Table 2.27). The respective rates were 45 per cent and 14 per cent on the male side. Coupled with a rise in better education achievements in the twentieth century, older adults of both sexes have been able to earn and generate better income. In 2006

close to 16 per cent of older men and 10 per cent of older women could earn a monthly income of HK$20000 (US$2564) or more. Within one and a half decade, the median monthly income of elderly people doubled.

Notwithstanding the rising number of older people receiving higher incomes in the 2000s, a small proportion of them is still taking up very low-paid jobs. For instance, some 6 per cent and 14 per cent in older men and women respectively maintain their basic living with a very low income of less than HK$2000 monthly in 2001 (Table 2.27). The literature from other countries (Marmot and Wilkinson, 2001) shows the positive association between financial assets and health status. In other words, those with more monetary resources are more likely to experience lower rates of morbidity and mortality. On the contrary, in a local study (Woo et al., 2000) no significant association between income and dependency or mortality was detected among older respondents. Because those on the lowest incomes do have access to health and social services at 'low or no cost' in Hong Kong, income is a weak indicator of access to health care.

Those earning between HK$2000-$3999 monthly occupied 11 per cent and 26 per cent respectively in both sexes (Table 2.27). Still there were some corresponding 24 per cent and 29 per cent in both sexes earning HK$4000/m-$5999/m in 2001. All these constituted the considerable number of elderly individuals living on very limited means in Hong Kong. By 2006, the difference in the proportions of older men and women earning lower income had lessened.

Furthermore, income and material resources (including bonds, investments,

home ownership) can be shown to be associated with physical health and functional abilities of older people in Hong Kong. Low income has been shown to be associated with poorer psychological health (Chou and Chi, 2001). Older women are particularly disadvantaged by income, earning lower wages than their male counterparts. As shown in a local study (Ho et al., 2001), income dependency on relatives or the government is associated with a higher risk of cognitive impairment amongst older women while this is not applicable to men.

The incomes of older people are more likely to be lower than those of the general working population. For example, older men and women earned the median income of HK$6500/m (US$833/m) and HK$4200/m (US$539/m) respectively in 2001 (Table 2.27). The amount was comparatively far below that of the total working population, equating to HK$10000/m (US$1282/m). By 2006, the median monthly income has moved upward to HK$7000/m (US$897/m) and HK$5500/m (US$705/m) for both older men and women respectively. However, the amount still lagged behind when compared with that of the whole population (being HK$10000/m). This pattern of low incomes has clear implications for financing of long-term care for older people in the local situation.

The increase in CSSA recipients

In Hong Kong, the Comprehensive Social Security Assistance (CSSA) scheme is non-contributory financial assistance from the government to help maintain the basic living of needy individuals. It acts as a safety net for the poor. Those applying for CSSA must not possess income and assets exceeding limits up to

HK$34000 (US$4359) for aged single people, and HK$51000 (US$6538) for elderly couples. In 2007, the standard payment rates under the CSSA scheme for older persons (aged 60 and above) are paid within the range from HK$2150/m (US$276/m) to HK$3885/m (US$498/m). If using the median income of the whole population of HK$10000/m (US$1282/m) for calculation, this represents around 22 per cent to 39 per cent. Under the social security scheme, older persons 65-69 can apply for the Normal Old Age Allowance (NOAA) which amounts to HK$625/m (US$80/m) and is means-tested. Those aged 70 and above are eligible to receive the Higher Old Age Allowance (HOAA) at HK$705/m (US$90/m) without being means-tested. When individuals suffer from disability, they are entitled to receive the Normal Disability Allowance (NDA) of HK$1170/m (US$150/m) or the Higher Disability Allowance (HDA) of HK$2340/m (US$300/m) as at February 2008, depending on the medical diagnosis about the severity of disability level. Older individuals can apply for either the Old Age Allowance or the Disability Allowance on top of the CSSA they receive.

As an example, if a 70-year-old person (receiving CSSA and HOAA or HDA) is in need of residential care, he/she will not be able to opt to enter private Care and Attention homes of satisfactory standards. Briefly put, the fees charged at private homes in the territory vary a great deal from about HK$5000/m (US$641/m) to HK$30000/m (US$3846/m) or more, depending on the location, provision of professional and caring staff, and levels of care. With a sum of financial assistance ranging from HK$4590/m (US$588/m) to HK$6225/m (US$798/m) received from the Social Welfare Department, the older individuals on benefits have only limited

choice and are likely to have to accept in cheaper private homes providing very basic care.

In Hong Kong the rise in the poverty rate in the nineties was more rapid than that in the eighties (Mok, 1999). It could be well evidenced from the greater numbers of elderly recipients of the Comprehensive Social Security Assistance (CSSA) scheme. As at end of 2004, this constituted 51 per cent (being 149,821) of the aggregate number of cases, and close to 75 per cent were singleton elderlies (Table 2.28). Among the total 294,204 cases in 2006-07, old age cases accounted for approximately 52 per cent. A declining rate of change (21%) was identified, in that the proportions of older CSSA recipients were reduced from 66 per cent in 1991-92 to 52 per cent in 2006-07. Nevertheless the substantial increase in the total number of older CSSA recipients should not be overlooked. During this period, the rapid growth of the number of cases rose from 48,020 to 152,918, being 3.2 times as much. This amounts to an increase of over 218 per cent from 1991 to 2007.

The aggregate number of CSSA cases (categorised under old age) constituted approximately 18 per cent of the entire elderly population (being 852,100) in 2006. This was a considerably increased proportion compared with 10 per cent among the old age population (being 482,040) in 1991. The rise in the proportion as well as the number of elderly CSSA recipients indicates the rising public cost of long-term care is likely to continue.

In addition, a significant growth of the older 'yet-to-be Hong Kong permanent residents' receiving CSSA has also been detected within the recent decade. Coupled with the continuing daily quota of people coming from the

Mainland China and holding a One-way Permit, the demand for public welfare (including CSSA applications) has been sharply upward and in the foreseeable future seems likely to continue to grow. All these factors are likely to increase the demand for long-term care in the territory and generate a heavier fiscal burden for the government in the long run. At the same time, the older people without means or sources of informal help will have little choice. It is this category of poor, frail and marginalised older people who are the potential service-users for the government-subsidised care and attention places in homes such as the Helping Hand institutions studied in this research.

Chapter summary

Substantial changes in household structure have occurred alongside rapid industrialisation and urbanisation in Hong Kong. This has affected the types of living arrangement as well as informal care provision for older people. The choice of long-term care is driven by the income circumstances of dependent older people and their families. Information on the educational attainment, occupation, and home ownership of older people has been used to describe patterns of economic and social circumstances and the care choices these produce. Put most crudely but with some accuracy, in terms of access to forms of care older people in Hong Kong are dichotomised into two extremes of rich and poor.

With improving educational levels among older adults from the 1990s to the 2000s, the number of those having greater disposable incomes and wealth has increased too. Those with economic resources can choose the kind of care they

prefer. Statistical evidence indicates that a majority prefer to age and stay at home. Well-off older persons can hire domestic helpers or private nurses for intensive care at their own residences. If they wish to receive long-term care in residential facilities, they can also choose to enter private nursing homes with high service standards, but also with high charges.

Frail older people without means have fewer options. Where family financial or care support is insufficient, they have to rely upon financial assistance from the government, including the Comprehensive Social Security Assistance (CSSA) and other types of allowance such as the Old Age Allowance or the Disability Allowance. These financial supports are not sufficient to allow poorer people to apply for care in private homes with a better quality of care. Once when their health declines, they are likely to become the service-users of care homes in the government-subsidised sector. If they become impaired unexpectedly and have not reached the top of the long Central Waiting List of the Social Welfare Department, they have no other choice but to accept what is immediately available with public support. In cases of emergency, they will rarely be faced with any choice of home. However from the point of view of the Hong Kong government the policy problem has been seen almost entirely in terms of containing and growing source of demand for publicly supported institutional care.

Chapter 3 Long-term Care Policy

This chapter describes the development of long-term care policy for older people in Hong Kong, set in a context of principles and themes largely emerging in western nations: such as 'community care', 'ageing in place', and a 'continuum of care'. The Hong Kong government has always placed great emphasis on the primary moral obligations of the family to care for its older members, with the state assuming only an 'enabling' role. Policies have developed that are designed to encourage the family to reside with and care for their dependent elderly members. The paramountcy of family responsibility has been clearly reflected in fiscal policy, housing policy, and the employment policy on foreign domestic helpers. Social welfare policy, especially in the provision of community care services, has been developed and modified during the past two decades in ways that similarly emphasise family responsibilities and the rationing of public assistance. Publicly funded residential care has come to be defined as a service of last resort for older persons with high functional disability levels. What were more varied forms of residential care, responding to a greater range or eligibility criteria, were phased out and consolidated in the early 2000s, leaving only Care and Attention Homes and Nursing Home places for those with high levels of measured dependency.

An overview of long-term care

In the context of global population ageing, long-term care for older people has become a key political and practical question. Long-term care is 'the provision of services for persons of all ages with long-term functional dependency' (Brodsky et al., 2003, p.247). It 'encompasses a broad array of primarily low-tech services

provided by paid professionals and paraprofessionals - as well as unpaid family members and other informal helpers - to individuals with chronic, disabling conditions who need help on a prolonged basis with daily activities of living' (Kodner, 2003, p.91). Similarly, Kane and Kane (1987, p.4) describe long-term care as 'a range of services that addresses the health, personal care and social needs of individuals who lack some capacity for self-care'. To put it simply, long-term care involves a wide variety of health care and social services intended to meet the various needs of older people with physical and/or cognitive disabilities. In general, long-term care services are needed and utilised by people with 'long-standing physical or mental disability' of all ages, and who are 'dependent on assistance with basic activities of daily living' (OECD, 2005, p.15). In this study, the discussion of long-term care is confined to older people aged 65 and over.

The literature reporting research into long-term care is large. A significant proportion is focused on examining risk, especially health-related need factors associated with the institutionalisation of older people (Shapiro and Tate, 1988b; Hanley et al., 1990; Woo et al., 2000b), and the dependency characteristics of residents of care homes and nursing homes (Butler et al., 1998; Choi, 1999; Challis et al., 2000; Crosby et al., 2000). Other work has concentrated on exploring the ageing process, and the links between length of stay, mortality rates, changing conditions of residents over time, resident mix, outcomes and costs of care (Bebbington et al., 1999; Netten et al., 2001a; Wiener et al., 1993 and 2001). There is a large literature (Wingard et al., 1987; Greene and Ondrich, 1990; Wolinsky et al., 1992; Andersen et al., 1983) exploring risk factors associated with the utilisation of

health services by older people. These highlight predisposing characteristics such as age, gender, marital status, functional ability and living arrangements (Jagger et al., 1993; Carpenter, 1997; Woo et al., 1998; Hui et al., 2004).

Over the last two decades many developed countries have paid special attention to the phenomenon and consequences of fast growing ageing populations, and governments have sought to contain public expenditure by setting up new mechanisms for financing long-term care. Policy initiatives have also been focused (including in Hong Kong) on devising programs enhancing 'healthy ageing', 'positive ageing', 'active ageing' as well as 'social inclusion and independence' (WHO, 2002; OECD, 2005). Preventive measures are seen as an important contribution to postponing older persons receiving residential care. For instance, the Program of All-Inclusive Care for the Elderly ('PACE') in the United States was able to demonstrate a shift in the balance of care from institutional towards more home and community-based provision. In most cases, the ultimate purpose of policy reform has been to shift the financial burden of providing long-term care from the government to other sources. Hong Kong is no exception.

The role of the family

Hong Kong began to be an ageing society in the 1990s. Generally the government has not responded in a proactive way to the increasing care needs of a growing population of older people. Instead it has preferred to stress the basic role of family and its primary caring responsibilities for senior members. As stated explicitly in the 1965 *White Paper* entitled *'Aims and Policy for Social Welfare in*

Hong Kong', the objective of elderly care services is 'by encouraging the natural family unit [and] its moral responsibility to care for the aged or infirm ..... everything possible must be done to support or strengthen the sense of family responsibility' (Hong Kong Government, 1965, p.5).

Caring for older people continued to be defined as the sole and major responsibility of family in the seventies. In line with traditional Chinese cultural values, the government has reiterated the caring function for older people as a 'moral' obligation of a family. In a 1977 *Green Paper*, it was stated as important for the community to 'preserve and foster the caring role of the family despite existing pressures on traditional family ties. ….. The provision of services will act as support or re-inforcement to the family when it is faced with the strain of looking after an elderly member' (Hong Kong Government, 1977, p.3). It was made clear that the government is there merely to 'enable', and not to 'provide an entirely satisfactory solution to the problems of old age'. Older people are expected to be cared for by their family members and stay in their 'accustomed' community for as long as possible. Residential care is not encouraged. A prime policy imperative has been to avoid government becoming directly and actively in providing care and support for the elderly.

In *'Social Welfare into the 1990s and Beyond'*, the government emphasised once again that it is a family's 'virtue to honour and respect' and to 'look after the older members as far as possible' (Hong Kong Government, 1991, p.30). This role and function of the family was reaffirmed by the Ad Hoc Committee of the Elderly Commission (1998) supporting a state role as 'to encourage and assist families to

take care of their older members' (p.5). The Committee made recommendations to enhance communication between the older and the younger generations through various means, such as schools, family education, civic education and the media that would 'encourage the younger generation to respect the elderly and to look after their older family members, and at the same time help the older generation to understand the younger generation' so that the two generations can 'get along harmoniously' under one roof (p.6). Hence no matter whether the stated principle is 'care in the community', 'care by the community', or 'ageing in place', these have generally represented a single theme - the family acting as the primary caregiver to its dependent older members.

At the beginning of the new millennium, the HKSAR government increasingly considered the long-term health and welfare needs of the elderly persons in terms of their financial implications. Emphasis is placed on promoting 'active and healthy ageing', coupled with the two principles of 'ageing in place' and a 'continuum of care'. The focus of the state was to allow people 'to remain living in the community for as long as possible' (Social Welfare Department, December 2009), while leaving the major caring tasks to the family itself.

Fiscal policy

The Hong Kong government has used 'fiscal welfare' such as tax reliefs and income and housing benefits to support family caring (Titmuss, 1974, pp.137-8). For example, fiscal policies were introduced to encourage adult children to live with their older parents within the same household. From 1990-91, a claimant could be

granted a Dependent Parent Allowance of HK$12,000. If he/she co-resides with a parent for at least a continuous period of six months, a further allowance of HK$3,000 is given. The amount of Dependent Parent Allowance was increased up to HK$20,000 in 1994-95, with an additional allowance of HK$3,000 being granted to the claimant in cases of co-residence. In 1998-99, the amount of Dependent Parent Allowance rose to HK$30,000, coupled with a further allowance of an additional HK$30,000 for co-residence cases. As the Elderly Commission (1998) recommended, the government increased tax allowances for taxpayers living with their elderly dependents in order to 'encourage people to live with the elderly' (p.6). In 2013-14, this benefit rose to HK$38,000, with an additional grant of HK$38,000 in cases of co-residence. In addition, since the 2005-06 year of assessment, allowances are granted for any 'maintained parent aged between 55 and 59'. This tax relief represents HK$19,000 for the 2013-14 year of assessment.

Certain restrictions are applied to eligibility for the Dependent Parent Allowance. Firstly, the parent must be a resident in Hong Kong, and aged 60 or above or, if under 60, must be eligible to claim an allowance under the Government's Disability Allowance Scheme. Secondly, the parent is regarded as 'maintained' if the parent resides with the claimant and his or her spouse 'for at least a continuous period of six months', or the claimant or his wife contributes at least HK$1,200 in money towards the maintenance of the parent in the relevant years of assessment. The necessary contribution rose to at least HK$12,000 in the 1998-99 year of assessment. Thirdly, a parent refers to a natural parent, an adoptive parent, a step-parent, the natural mother of the claimant or his or her spouse, or a parent of a

deceased spouse of the claimant and can satisfy any one of the above four descriptions. No ‘dual claim’ of each parent is granted in any case.

To further enhance the principle of ‘community care’ for older people, a new fiscal policy was introduced since the 1994-95 year of assessment. Under the Dependent Grandparent Allowance Scheme, a taxpayer (or the spouse) who maintains a grandparent of his or her spouse can obtain an allowance of HK$20,000. If the claimant co-resides with a grandparent for at least a continuous period of six months, there will be an additional allowance of HK$3,000 in respect of each grandparent. In 1998-99 the amount of Dependent Grandparent Allowance increased sharply to HK$30,000 and a further allowance of HK$30,000 in cases of co-residence. Starting from the 2005-06 year of assessment, allowances are available to any ‘maintained grandparent aged between 55 and 59’, with the allowance reaching HK$19,000 in the 2013-14 year of assessment. In order to qualify for this Allowance, the grandparent must be a resident in Hong Kong, and aged 60 or above, unless he or she is eligible to claim an allowance under the Government’s Disability Allowance Scheme. Secondly, the grandparent is regarded as maintained by the claimant or his or her spouse ‘if either the grandparent resides with the claimant and his or her spouse ‘for a continuous period of not less than six months’, or the claimant or his or her spouse contributes at least HK$1,200 in money towards the maintenance of the grandparent in the 1994-95 year of assessment. The amount of money contribution rose to HK$12,000 in 1998-99. Thirdly, a grandparent refers to a natural grandparent of the person or his or her spouse, an adoptive grandparent, a step grandparent, or in the case of a deceased spouse, a person who would have been

considered a grandparent under any one of the above three descriptions had the spouse not died. Again, there is no 'dual claim' of each grandparent in any case.

These forms of fiscal welfare (Titmuss, 1974, pp.137-8) response to the growing care needs of Hong Kong's ageing population take the form of tax reliefs rather than positive intervention by the government and are detailed in order to demonstrate a long established and mode of policy response focused on minimising state intervention, even at the cost of generating increased inequalities by using income tax related subsidies or reliefs.

Housing policy

The government also introduced housing policies designed to promote family care and community care for older people in Hong Kong. For instance, a Families with Elderly Parents Priority Scheme was first implemented in October 1982. To qualify for this reallocation, the family must be a nuclear unit with at least one elderly parent/grandparent aged 60 or above, living with or dependent on the applicant's family. Under this scheme, families awaiting rehousing together with their elderly parents or dependent relatives can have their housing allocation advanced by one year. Later this waiting list advantage was increased to three years. By 12,600 families had benefited from this scheme since its implementation (*Report of the Elderly Commission*, 1998, pp.23-24).

In keeping with a principle of 'ageing in place', the Elderly Commission (1998, p.6) recommended the government 'consider providing adjacent or neighbouring public housing flats' for older people who need to co-reside and be

cared for by their adult children. The Special Scheme for Families with Elderly Persons was introduced in the 1990s, and allows families with elderly parents or dependent relatives to apply for two separate flats in the same block in new towns, the waiting time being further reduced by two years instead of one year. This housing scheme was later extended to non-nuclear families with elderly members, allowing the daughters/sons or relatives who are primary carers to co-reside with the elderly members under the same roof.

A Sheltered Housing for the Elderly scheme is designed to enable 'self-reliant and independent' older people to live in the community. Under this scheme, a standard domestic flat is divided into self-contained bedrooms for privacy reason. To enhance social interaction among the tenants, it is equipped with common room facilities. The first Sheltered Housing project began in November 1987, with an alarm system and Warden Service being provided in case of emergencies.

The Estate Social Services for the Elderly Scheme began in 1990. This aims to establish contact by the Housing Authority with older people living alone in public housing estates, identify their needs and resources required, encourage their participation in social activities as well as volunteer work, and establish support networks. In order to encourage families to look after elderly members with disabilities, the Ad Hoc Committee (1998, p.26) introduced a range of enhancements in terms of waiting times and housing offers for people aged over 75.

Employment policy on foreign domestic helpers

Employment policy on foreign domestic helpers (FDH) in Hong Kong has

been used to encourage paid care for older people. Findings in a recent local study (Chong et al., 2014) show that domestic helpers act as a 'mediator' not only for elderly people, but also for caregivers whose stress are reduced.

As Titmuss (1974) pointed out, social policy has to be analysed in a 'broad political and geographical framework', and the welfare system of a country often reflects its 'dominant cultural and political characteristics' (pp.21-22). Titmuss used an example of Turkish 'guest workers' in Germany in the 1960s but a similar example can be found in Hong Kong. Since the 1970s the government has used an employment policy on foreign domestic helpers (FDH), who are allowed to enter Hong Kong to 'take up full-time domestic duties' due to the shortage of local full-time live-in domestic helpers and to 'relieve housewives from household chores for taking up employment' (Hong Kong Hansard, June 2005, p.1). The justification for this policy is based on a well-established principle that 'non-local persons are admitted for employment only if the jobs concerned are not readily taken up by local work force' (Labour Department, n.d.). Under current immigration policy, foreign domestic helpers are permitted to work in Hong Kong 'for a specific employer at a specified residence under a standard two-year contract'. Statistics indicate that there were about 323,400 foreign domestic helpers in Hong Kong as at end of January 2014. Among them, over 51 per cent are from the Philippines, about 46 per cent from Indonesia, and the rest from Thailand, India, Sri Lanka, Nepal and Pakistan. In practice, these domestic helpers did play an important role in caring for older people in Hong Kong. As revealed from the *Thematic Household Survey Report No.21*, over 23 per cent (28,600 older persons) received assistance from domestic

helpers/nurses in their daily living (Census and Statistics Department, 2005). As a matter of fact, this percentage and number involved mainly of 'hiring domestic helpers'; employing private nurses as caregiver implies a very huge cost in Hong Kong (refer to Chapter 2).

A mandatory live-in requirement has been incorporated in the Employment Contract for hiring foreign domestic helpers since April 2003, which is claimed to compensate for the shortage of local workers. Under this policy, foreign domestic helpers are required to 'only perform domestic duties at his/her employer's residence and to serve the members of the employer's household as stated in the Contract' (Hong Kong Hansard, June 2005, p.2). Broadly put, they are required to perform domestic duties such as 'household chores, cooking, looking after aged persons in the household, baby-sitting and child-minding'. Upon the completion or premature termination of employment contract, it is the responsibility of employers to provide foreign domestic helpers with free passage (pay cash or air ticket) from Hong Kong to their places of origin. Should they intend to work with a new employer, they have to leave Hong Kong first and submit a new employment visa application to the Immigration Department. Clearly, this policy is operating well to import foreign domestic helpers as caregiver and servant, who are required to do all the domestic tasks, caring for the young as well as disabled family members, and including the care of older people within the household.

Data show that the number and proportion of households employing full-time domestic helpers in Hong Kong has been steadily increasing annually over two decades. In 1990, there were 70,335 households employing foreign domestic

helpers, and the number rose to 312,395 in 2012. The proportion of older person households employing foreign domestic helpers increased from approximately 5 per cent (16,500 households) in 1991 to almost 12 per cent (63,600 households) in 2001 (*Hong Kong Monthly Digest of Statistics*, September 1990 and March 1995). Similar findings are identified in the *Thematic Household Survey Report No.21* (Census and Statistics Department, 2005), showing that 13 per cent of family households with older persons employed full-time domestic helpers. Between 1987 and 2001, households employing full-time domestic helpers rose by 293 per cent. This pattern can be explained by the comparatively low wages of foreign domestic helpers. The rate of change was even more substantial for households of older people; 393 per cent within the ten years. This shows the growing trend of using domestic helpers in looking after the frail or disabled older members at home in Hong Kong.

The median monthly household income of those hiring domestic helpers was HK$40,000. As shown in the *Thematic Household Survey Report No.5*, it is striking to find that over 30 per cent (56,900 households) employ foreign domestic helpers to take care of elderly persons at home (Census and Statistics Department, 2001c). From a policy outcome point of view the government has succeeded in importing a large number of foreign domestic helpers to provide care for older people in the community. The foreign workers are cheaper and have fewer rights than Hong Kong citizens. Foreign domestic helpers cannot become 'permanent residents' even if they have worked in Hong Kong for more than seven years. As cited in the 'South China Morning Post' on 25th March, 2013, the High Court affirmed the government's right to impose immigration control and ruled that FDH

do not have the right to apply for permanent residency in Hong Kong. In terms of rights, for example, if they become pregnant during employment period, they can be asked by the employer to leave Hong Kong and return to their homeland immediately.

Hiring domestic helpers

Although in Hong Kong domestic helpers serve as an important source of care and support for older people, this form of help only applies to individuals or families with better economic resources. In Chinese society, older people are less likely to seek 'friends' or 'neighbours' as their caregiver; representing merely five per cent in the study. Findings from the *Thematic Household Survey Report No.40* (Census and Statistics Department, 2009) reveal that older people requiring others' assistance in daily living and have domestic helpers/nurses as caregiver represent approximately 26 per cent (34,200 older persons). In contrast, over half (147,100 older persons) with this level of need do not report caregivers of any type. That explains why many older people often seek to receive care in private homes (particularly under emergency circumstances) prior to their admission to government-funded care homes. Family care has become less an option for large numbers.

Community care services

The government has also developed aspects of social welfare policy for the older people under the declared principles of 'community care', 'ageing in place', and 'continuum of care'. In the 1970s and 1980s the main focus of community

support services was on home help services. These included meal delivery, personal care, escort to medical consultation, laundry services, and home management services. As clearly written in the *Report of the Working Group on Housing for the Elderly* (June 1989, Item 4.15), the aim is 'to support and strengthen the family, prevent family breakdown, and provide a community care service as a temporary or emergency arrangement to individuals and families to allow those in need to continue to be cared for in the community'.

Initially home help services were operated under two models: a 'central kitchen-based model' in which meals are prepared in a central kitchen and distributed to the service users by home helpers while a 'home-based model' in which home helpers cook and clean up at users' own abode. This operation mode subsequently changed and now is provided on a 'territory-wide basis' by NGOs. Nonetheless, the provision of home help services has been criticised as 'inadequate' in meeting the needs of families who had to care for their frail, old members at home, especially for those who suffer from incontinence and dementia. Recommendations were made in the *Report of the Working Group on Care for the Elderly* (1994), that the government should fill the service gaps in the provisions of home help and day care centres.

Meals services were developed for those 'who suffer from ill health and are physically unable to cook' and those who 'live in an adverse environment and are without suitable cooking facilities' (Hong Kong Government, 1977, p.56). These included canteen services offering 'inexpensive meals' for those without mobility problems as well as 'meals-on-wheels services' for those with health, mobility, or

travelling problems. Publicly funded visiting services are available to isolated older people. Visitors assist in 'letter-writing, escorts to the doctor, or on recreational outings'.

Originally, day care centres were established to assist older people with declining health and 'fair mobility'. As mentioned in the 1977 *Green Paper*, this service provision aimed to render 'attention, meal service, personal care and some recreational activities during the day' (Hong Kong Government, 1977, p.57). The number of day care centres increased sharply from 10 in 1991-92 to 50 in 2005-06 (*Social Welfare Services in Figures 1982 Edition - 2006 Edition*). Likewise, the number of older people utilising day care centres increased substantially from 389 in 1991-92 to 2,052 in 2005-06 (a rise of 428%). However the data only recorded the aggregate total number of head counts about older people using the services, and might not actually reflect the exact number of individuals using the services.

With the fast growth of the older-old population, the objectives of day care centres were later modified to include 'helping the frail and demented elders who are assessed by the Standardised Care Need Assessment Mechanism as suffering from moderate or severe impairment level to maintain their optimal level of functioning, develop their potential, improve their quality of life and to live in their own homes wherever feasible and possible' (Social Welfare Department, August 2007). These centres provide nursing care, rehabilitation exercise, counselling and referral services. In addition, there are respite services that offer 'temporary relief' for family members or relatives who are the main caregivers of older persons requiring a certain degree of personal care whilst living in the community. This

provision is available in all government-funded day care centres for the elderly, but the quota is limited. Subsequently, a carer support service was developed to enhance carers' capacity for care, to reduce their stress in caring, and to prevent elder abuse from occurring. In principle, the provision of these community-based services appeared to be 'comprehensive' in terms of variety. Nevertheless, the supply was inadequate when responding to the continuous growing demand for those living in the community.

The Social Welfare Department stated that subsidies were granted to the NGOs to provide Enhanced Home and Community Care Services (EHCCSTs) in the 18 districts of Hong Kong since April 2001. Integrated services are offered to enable frail elders to receive nursing and care services in their familiar home and community as well as to maintain their maximum level of functioning. As claimed, this provision is in line with the policy principles of 'ageing in place' and 'continuum of care'. Where older people are assessed as at moderate or severe levels of impairment by the Standardised Care Need Assessment Mechanism and requiring 'only personal care, simple nursing care and/or other support services' such as general household duties, escort, meals delivery, Integrated Home Care Services (Ordinary Cases) can be arranged. In 2004-05 there are totally 60 Integrated Home Care Services Teams (IHCSTs), serving 17,902 Ordinary Cases and 1,021 Frail Cases (*Social Welfare Services in Figures: 2003 Edition - 2009 Edition*). As at 2008-09, the number of IHCSTs remained the same, serving 19,764 Ordinary Cases and 1,099 Frail Cases. Clearly, the government did not input additional resources in accordance with the increasing demand from those living in the community. It is

likely a consequence that these services did not allow older people to avoid the need to enter residential care.

Along with the implementation of a 'Lump Sum Grant' policy since 2000, substantial reform on 'Re-engineering Community Support Services for Elders' among the NGOs has taken place since April 2003. All Home Care and Home Help Teams have been rationalised into Integrated Home Care Services Teams (IHCSTs) to 'provide various kinds of care and support services to the frail elders, people with disabilities and other people with special needs' (Social Welfare Department, 2005). These include 'general personal care, escort service, household cleaning'. In 2005-06, there were 60 Integrated Home Care Services Teams (IHCSTs), serving 17,925 Ordinary Cases and 1,093 Frail Cases (*Social Welfare Services in Figures: 2009 Edition*). At the same time, there were 18 Enhanced Home and Community Care Services Teams (EHCCSTs) serving 1,923 cases. Although the number of EHCCSTs increased to 24 in 2008-09, the total number of cases served was very small (being 2,758). In the 41 District Elderly Community Centres (DECCs) and the 114 Neighbourhood Elderly Centres (NECs), there was a total membership of 64,319 and 78,782 respectively in 2005-06 (*Social Welfare Services in Figures: 2005 Edition - 2006 Edition*). Nonetheless, these provisions could not meet the needs of all those left in the community effectively, even with the establishment of various types of community support services.

Evidences show that only limited community-based support services are provided to meet the needs of frail old people in the community (Chow and Mak, 1988; Ngan et al. 1996). Likewise, a study by the Hong Kong Sheung Kung Hui

Welfare Council and City University of Hong Kong (2000) also indicated supply fell well short of demand with the slow development of home- and community-based support services. For instance, the Support Teams for the Elderly began operation only after October 1998, with the number increasing slightly from 35 to 41 units between 2000-01 and 2005-06. Another local study about the profile of elderly applicants waiting for admission to residential care homes shows that over 70 per cent did not receive any forms of community support services (Census and Statistics Department, May 2000). Only about 13 per cent (2259 applicants) of those applying for Care and Attention Homes used home help services. The corresponding percentage and number were even lower for those applying for Nursing Homes; representing only about 6 per cent and 210 applicants.

Clearly, the community-based provision did not keep up with those in genuine care need. According to the *Thematic Household Survey Report No.21* (Census and Statistics Department, 2005), some 45 per cent (101,800 older persons) out of the total 225,100 older persons who needed others' assistance in their daily living did not receive any forms of help. The situation was even worse in 2009. As shown in the *Thematic Household Survey Report No.40,* over 52 per cent (147,100 older persons) did not have any caregivers (Census and Statistics Department, 2009). This posed the question of effectiveness of care in great doubt.

On one hand, the government recognises that its policy requires that more domiciliary care services, day care, respite care, and carer support services need to be provided. On the other hand, its intervention is only minimal and limited. As shown in the *Thematic Household Survey Report No.21*, over 27 per cent (206,300

older persons) of the total 757,400 older persons (aged 65 and above) living in the community required assistance from others in daily living (Census and Statistics Department, 2005). The level of informal care received by older people was classified into five levels (from Level 1 to Level 5) according to the caregivers' employment status and living arrangements. By definition, a higher care level meant less or no informal care was received. It is striking to find more than 11 per cent (86,100 older persons) were at care Level 4. Furthermore, some 10 per cent (78,600 older persons) were at care Level 1. Put in other way, these older people received informal care from a caregiver who was unemployed and co-residing with them, or from a live-in domestic helper. To a certain extent, all these older people were in need of various forms of community care services such as day care and home help to support them to live in the community. However, their care needs were not adequately met with the existing limited provision of community support services. According to the *Hong Kong Annual Digest of Statistics* (Census and Statistics Department, 2001 and 2009), the number of older persons enrolled for day care services was 1,314 in 1998-99, and increased to only 2,135 and 2,257 in 2005-06 and 2008-09 respectively. Likewise, older people enrolling for Enhanced Home and Community Care Services increased slightly from 1,575 in 2003-04 to 1,923 and 2,758 in 2005-06 and 2008-09 respectively. It is clear that the government shows reluctance to assume an active role all through the years. Despite the provision of various types of community care services, its development was far lag behind the great demand from all those in need.

Summing up, the provision of domiciliary care and community support

services has grown in the 2000s in terms of variety and quantity, including home help services, day care centres, and respite services. As stated in the policy documents, these services are meant to perform a crucial role of 'supporting the elderly to live in the community as long as possible' (Hong Kong Government, 1991, p.31). Policy planning for older people has been focused on moving the balance of care away from residential care to greater provision of community care, from being supply-led to needs-led. Government support and public funds have been oriented towards more home- and community-based care, with the emphasis being placed more on the needs and stress of the carers. Again, the importance of family care and support to the older people has been emphasised frequently by the Chief Executive, as reflected in the *Policy Address* (1997, 1998, 2005-06, 2006-07, 2009-10, 2011-12). Throughout the government did little to assist families to care for their senior members at home, regardless of its ideological support for family care. Hence 'community care' connotes merely 'family care' in reality.

The reality behind the public community care policies

Despite announced policies designed to enhance 'community care' for older people, the reality differs from what the government expects. Data shows that the percentage of older people (aged 65 and above) living together with child or children (including with spouse and child) fell from 57 per cent in 2001 to 51 per cent in 2011. The situation is even starker for those aged 80 and above, decreasing sharply from 44 per cent to 30 per cent in the respective period. In the meantime, the institutionalisation rate was comparatively higher than other countries such as the UK, US, Australia, Japan, Singapore, and Taiwan. In 2009, this represents

approximately 7 per cent (58,300 older persons) of the older population aged 65 and above (Chui and Research Team/The University of Hong Kong, 2009). However, this was not in line with the aim of long-term care policies of the HKSAR government. Last but not the least, the limited supply of community care services (though with different types of provision) did not meet the continuous growing demand for older persons living in the community. However, there lacks detailed information on this.

Though with the government's long-term care policy of encouraging adult children to live with and look after their elderly parents and grandparents in the community, the outcome does not always turn out to be favourable. As revealed in the *'Socio-demographic profile, health status and long-term care needs of older persons residing in domestic households'* (Census and Statistics Department, 2005), over 45 per cent of the total respondents cannot get help when needed. Although close to 91 per cent have at least one child living in Hong Kong, it is alarming to find only 20 per cent have children as caregiver, while those with spouse as caregiver is even lower; about 15 per cent. The capacity, willingness and commitment to care of the careproviders are an important influence on the use of long-term care services. If the relationship between the caregiver and an older person is not harmonious, reluctance will exist on the side of caregiver regardless of an ability to provide help.

Informal care provision

Despite development of formal community care services, informal care

remains of paramount importance. Informal care, is essentially basic physical and social support for older people rendered regularly by the family members of the disabled old person, especially for those with declining health conditions, usually unpaid, involving assistance in performing personal care tasks or domestic tasks. In Hong Kong most of the long-term care needs of older adults have always been fulfilled through informal care provision. At any one time, over half (about 55%) of older persons are likely to be receiving informal support from family and social network, including 37 per cent from children and 27 per cent from spouses (Census and Statistics Department, 2005).

Traditionally, informal care has been perceived as 'naturally' offered by the female relatives, namely, the wives, daughters, daughter-in-laws in Hong Kong (Chow and Chi, 1990; Ngan, 1990; Liu, 1999). Similarly in the UK, differential obligations within the British families, often based on gender, have been found to be typical of family life (Finch and Mason, 2001). Family and kinship relationships contain interwoven exchanges in both moral as well as material dimensions. Informal support may also be offered by friends, relatives, neighbours, or domestic helpers. The type of help provided can vary according to family relationship. In Chinese families, there exists an implicit norm for sons to render financial support to older parents while the daughters are expected to take up the daily practical care and assistance at home (Chan and Lee, 1995). Older parents traditionally consult their sons for important decision-making, and their daughters for practical help and personal care (Ngan and Wong, 1995). A rising trend has been observed of elderly parents turning to their daughters for emotional support and care when in times of

trouble and illness (Lee, R.P.L. et al., 1997). In practice, older people often use both informal and formal care at the same time. As observed in the study by Liu (1999), there is a rising trend of receiving both types of care among elderly respondents in Hong Kong over the two-year period under study.

Another local study (Kwok et al., 1996) shows that informal caregivers caring for older persons who needed assistance in activities of daily living such as bathing, dressing, bed transfer, walking and coping with stairs were found to be stressed. Carers' strain was positively related to the depressive symptoms and hospitalisation of the elderly parents at home. Role and time conflicts were commonly experienced by caregivers in performing their own job duties as well as fulfilling caregiving task for their older dependent relatives. Aspects of personal burden upon caregiving included negative consequences over sleep, privacy, leisure time, and physical health of the caregivers. Other sources show that older people with caregivers who express personal burden during the caregiving process were at a higher risk of home admission (McFall and Miller, 1992; Jette et al., 1995). Where there is an absence of support for carers, this can accelerate the demand for residential care placement.

In a local study by Ngan and Cheng (1992), most caregivers reported deprived social lives, undesirable financial effects and health decline during the process of rendering support to the frail, old people. Where caring was beyond the abilities or willingness of the carers, institutional placement can be an alternative (Stone et al., 1987). This is more common where dementia or incontinence at a later stage are extremely demanding and beyond the caring capacities of the carers

(despite their good intentions). Families caring where there is dementia or incontinence are more likely to seek and utilise long-term residential care services.

Female job participation and the impact on social care provision

Influenced by the mix of both Eastern as well as Western culture, the socio-economic status of women in Hong Kong has undergone great change. Historically, there has been an upward trend in women receiving education as well as joining the labour force after the eighties (Lee, M.K., 1995). During the last decade, in almost every age cohort (ranging from 25-29 to 55-59), the employment rates of women have continued to rise steadily. In 1991 their labour force participation rates were 52 per cent, 42 per cent and 28 per cent in the 45-49, 50-54, 55-59 age groups respectively. The corresponding rates move upward to 63 per cent, 53 per cent, and 37 per cent in 2006.

Recent findings of a local survey (Census and Statistics Department, 2007c) indicate a continuous rise in the job participation rates of females (including those married) in 2006 compared with those a decade ago. The remarkable increase of women participating in the job market reflects a strong tendency towards work as well as a reduced availability and supply of informal care for senior members. The probability of informal female care has fallen, particularly amongst those in low income groups. Older adults from these groups would in principle become the potential users of residential care homes. Given that women are the main caregivers to the dependent older people at home, once when they engage in work, the caring tasks may have to be shifted to other persons or even other forms of care. Studies

have shown how in practice the caring function of the family in Hong Kong has been reduced, with the diminishing and limited help available in times of need (Ngan, 1990; Chow, 1993; Chow, 2001; Chow and Lum, 2008).

The emigration of younger generations

Emigration directly influences the availability of informal care and support, and which also adds to the growing demand for residential care places. Around the early 1990s the socio-political climate in the territory influenced the supply of informal care. With the hope of a brighter future, younger generations migrated to other countries like Canada, Australia before the political handover about the sovereignty of Hong Kong to the Republic of China in July 1997. As a consequence, more older people were left alone to live on their own or to be cared by other siblings, if any. One survey found them more likely to be in poor psychological states (Ngan and Hong Kong Christian Service, 1993). These older people experienced feelings of loneliness and abandonment. Some 20 per cent of the sampled 257 respondents described a lack of informal social support or assistance when needed. Some were able to turn to institutional care.

The role of residential care

The view of the Hong Kong Government is that there still remains a relatively small proportion of the older population that requires long-term residential care, regardless of the policy aim to encourage elders to be cared for by family members in their own familiar environment. As stated explicitly in the Green Paper, institutional care is the only alternative for the older people when care in the

community is ‘no longer practical or satisfactory because of increasing frailty’ (Hong Kong Government, 1977, p.29). Residential care is regarded by the government as playing a significant part within the long-term care spectrum, though as a last resort. In formal policy terms, residential care services (including Self-care Hostels and Homes for the Aged, Care and Attention Homes) are provided for older persons who, ‘for health or other reasons’ and who ‘have no relatives or friends to assist when required’ (Hong Kong Government, 1991, p.33). The Ad Hoc Committee of the Elderly Commission (1998, pp.4-6) recommended the government develop residential services to meet the needs of some elderly people. In line with the traditional Chinese cultural values, this long-term residential care policy matches the expectations of most elderly people who prefer to stay and age at own home.

Consolidating residential care

Historically and in terms of cultural thinking, the residential care service originates from Chai-tongs (literally vegetarian halls) which were operated by religious bodies and individuals. As stated in the *Green Paper*, Chai-tongs provide ‘group housing and institutional care’ (Hong Kong Government, 1977, p.21), which offer ‘a measure of security’ to the older and retired persons by ‘providing board, shelter, help and care from co-members in times of illness and infirmity, and assurances of a decent burial’. Living conditions are generally undesirable in these residential settings, but there is a lack of detailed information about the standards of care provision in these chai-tongs.

Along a continuum of long-term care dimension, Hostels for the Aged

provide the lowest levels of care and supervision to the residents. This type of service provision offers communal living for older people who are capable of self-care. Social and recreational activities are organised for the residents, with round the clock staff support in these settings. The effective target group are older people who 'have social and housing need for accommodation' but are able to take care of themselves.

Homes for the Aged belong to another type that offers 'residential facilities and minimal personal care' to older people who are admitted for 'social reasons' such as accommodation problems, poor family relationships, without family members or due to 'declining health' that causes inability to function independently in the community (Hong Kong Government, 1977, p.29). These homes cater for people who are 'reasonably healthy and mobile', and 'relatively independent in daily living activities'. This type of institution gradually changes into Home for the Aged cum Care and Attention Units (*Report of the Working Group on Housing for the Elderly*, June 1989, Item 3.28-3.31). The Home Section provides services such as meals, heavy laundry, daily cleaning, medical consultation escorts, limited assistance in personal care and social and recreational programmes. Meanwhile, the Care and Attention section provides 'general care' for older people who require nursing care not exceeding 2.5 hours per week. Evidence shows that the number of residents using these types of homes was still small. In 2003-04, a total of 6,909 older persons enrolled in the Homes for the Aged (*Hong Kong Annual Digest of Statistics, 2009 Edition*). Along with the phasing out process, the number reduced to 4,755 and 2,911 in 2006-07 and 2008-09 respectively. At the same time, there were

10,635 older persons enrolled in the Care and Attention Homes in 2003-04, and the number rose slightly up to 11,437 and 12,376 in the two corresponding periods.

In reaffirming the importance of 'continuum of care' in residential services, the Ad Hoc Committee of the Elderly Commission (1998) suggested to equipping care homes with 'appropriate facilities and staffing' in order that residents do not need to be transferred to other care homes once their health declines (p.51). In order to recruit extra staffing (including personal care workers, nurses and workmen) to look after the care needs of those very frail residents, the government has paid an 'Infirmary Care Supplement' to Care and Attention Homes since 1996. A 'Dementia Supplement' is also granted to residential homes to strengthen their manpower to 'provide better care and training' to demented residents.

Care and Attention Homes offer general personal care, meals, and limited nursing care to older people who 'suffer from poor health or physical/mild mental disabilities with deficiency in activities of daily living but are mentally suitable for communal living'. Those, aged 65 or above, who can move around with a walking aid or in a wheelchair; who lack family members to offer assistance to them when required, or causing great stress to family members during care provision are eligible to apply. Moreover, those aged between 60 and 64 may apply if there is a proven need for residential care based on health and/or social grounds, subject to their meeting the admission criteria. Nursing Homes provide care to older people with a 'severe impairment level', who are in stable medical condition yet requiring 'regular basic medical and nursing care'; or with chronic disability yet not being totally chairbound, but requiring assistance, with or without a walking aid or

wheelchair, in moving around; and are mentally suitable for communal living and with no persistent tendency to violence, self-destruction/self-injury or disruptive behaviour.

In view of the significant growth of the older population in the nineties, the Elderly Commission (1998) recommended converting Home for the Aged places to a Care and Attention places. This transition is taking some time for all the existing 6,843 places in Homes for the Aged to cater for those with higher frailty levels. Various types of residential care are being consolidated, with the gradual phasing out of Self-care Hostels and Homes for the Aged. Residential care services, as proposed by the Ad Hoc Committee (1998), will focus on older persons 'with genuine need', whereas those with self-care abilities should be 'cared for in the community' (pp.28-29). In the *Policy Address* (2005), the Chief Executive highlighted the aim to 'target the resources' to frail old people with genuine care needs and to enable them 'to lead a quality life in the residential care setting' (p.43). This policy framework requires that more older people capable of self-care are looked after in the community, leaving only those with greater disabilities to receive care in residential homes. As discussed earlier, the development of community based services has not matched the growth in numbers now left in the community in practice. Hence while the policy adds up in principle, in practice it does not work.

Chapter summary

When implementing the long-term care policy in Hong Kong, it is clear that the government adheres consistently to the principle that the state should largely

enable informal care. Strong emphasis has always been placed on the family to shoulder its primary moral obligation of caring for its older members. In line with the policy aims of 'community care', 'ageing in place', and 'continuum of care', concerted efforts have been made by the government to enable family caregivers to continue assuming caring responsibility for dependent older people in the community. The spectrum of policies across fiscal welfare, housing, and employment of foreign domestic helpers have been consistently adjusted to enhance support for family care. Using social welfare policy, the government offers annual subsidies to various NGOs to provide a range of home- and community-based support services including day care centres, respite services, carer support services, enhanced home and community care services. All these are intended to allow older people to age and live in their familiar environments.

Nevertheless, the evidence shows that a significant proportion (more than 45%) of older people do not receive assistance when needed, in spite of the majority having at least one child living in Hong Kong. Furthermore, the number of older people living alone continues to increase remarkably, from 61,001 (nearly 13%) in 1991 to 84,767 (over 11%) in 2001 and 119,376 (nearly 13%) in 2011. A substantial increase is also identified for those living in institutions, with 29,790 in 1991 mounting up to 67,955 in 2001, and further to 80,629 in 2011.

Residential care policy aims to offer personal as well as nursing care to older people with defined levels of impairment. In accordance with the policy aim, a consolidation of residential care has taken place since the early 2000s. Originally, Self-care Hostels and Home for the Aged targeted older people with housing and/or

social needs. These two types of provision have been gradually phased out, leaving only Care and Attention Homes to provide general personal care and limited nursing care to those with more functional disabilities. For those with severe impairment levels, there are in principle Nursing Homes that offer regular medical as well as nursing care.

In practice, reality is somewhat different from what the government's policy intentions. The reality is of growing use of institutional care and of public support for informal community care, but that in both cases the growth does not match demographic change and the growth in need. The likely consequence is that those in institutions have increasingly severe needs and as do many of those defined as only eligible for community-based support. The analysis in this chapter of the content and rationales for public policy changes, and of what evidence is available of outcomes, suggests that the policy makers have not fully allowed for the complexity of interactions between demographic, economic, household and employment changes. Policy making appears to be driven by relatively simplistic and optimistic models of how society works. The object of this thesis is to take just one part of the spectrum of care, publically supported residential homes for older people, and show how a policy framework built on greater selectivity and the efficient allocation of people to relevant services, actually works in practice.

Chapter 4 Residential Care: public provision in the context of a residualist welfare culture

In Hong Kong residential care is not encouraged, and is regarded only as a last resort for older people with more severe impairments. As pointed out earlier, the government of Hong Kong always emphasises the principles of family care and community care in its long-term care policy. However, residential care is seen as an alternative of last resort. This chapter describes residential care and its allocation largely in terms of the concept of the residual model of welfare as proposed by Richard Titmuss. The chapter seeks to identify and explain value assumptions as demonstrated in the attitudes of government officials towards social welfare, and to social cost and the quality of service.

The residual model and value assumptions

As Titmuss (1974) points out, the purpose of model-building is 'to help us to see some order in all the disorder and confusion of facts, systems and choices concerning certain areas of our economic and social life' (pp.30-31). Broadly, three welfare models of social policy are proposed: the Residual Welfare Model, the Industrial Achievement-Performance Model, and the Institutional Redistributive Model. First, the Residual Welfare Model presupposes that the family and the private market are the two 'natural' channels of providing care and insurance, through which the needs of an individual can be properly met. It is only when these systems of provision break down that social welfare institutions will step in and intervene 'temporarily'. Residualists perceive welfare as 'ultimately depending on economic growth prosperity and individual self-help', and that 'egalitarianism discourages initiative and risk-taking', resulting in lower productivity, weaker economic growth and ultimately a reduced quality of life. Within this conception, the state should provide 'a minimum safety net' with strong emphasis being placed on self-help by the individual and family, the voluntary sector, and the private market. The residual role for public welfare is to provide for those who are 'most in need' and least able, protecting those unable to compete in the economic system; effectively welfare

playing the role of an ‘ambulance wagon’.

A second possible form is the Industrial Achievement-Performance Model in which social needs are met ‘on the basis of merit, work performance and productivity’, and benefits such as pensions are gained through participation in the labour force. This perception of welfare is associated with ‘incentives, effort and reward’. Thirdly, Titmuss posits the Institutional Redistributive Model that provides ‘universalist services outside the market on the principle of need’. Institutionalists conceive of welfare as ‘a major integrated institution in society’, with active and maximum state intervention. All three models involve ‘consideration of the work ethic and the institution of the family in modern society’, reflecting the ‘different criteria for making choices’ (Titmuss, 1974, p.32).

Not a welfare state

Under the Residual Welfare Model, the government plays ‘a marginal role’ providing minimal public services to a selected proportion of the population (Titmuss, 1974, p.121). However, there is a redistributive element contained within this model, and this is reflected in the situation of Hong Kong. Since the beginning of the colonial government in the 1950s, Hong Kong has not been a welfare state. For example, during the 1950s, Mr Lo Man Wai (a Legislative Councillor) asserted that it is ‘beyond our resources to set up a Welfare State in the Colony’, and that ‘we lack the administrative staff required for the carrying out of huge schemes of social services’ (Hong Kong Hansard, April 28, 1954). Financial constraints were the main reason for caution. Welfare services were perceived as going ‘hand in hand with steeply progressive personal taxation’ should the ambition be a welfare state (Financial Secretary, Sir John James Cowperthwaite, Hong Kong Hansard, February 28, 1962). Low taxation rates have been a fundamental element of the Hong Kong economic model and so it remains hard to justify the substantial expenditure on welfare services.

In the 1970s, Mr Wilfred S.B. Wong (a Legislative Councillor) reflected established opinion amongst the governing class when he said that the political and

economic structure of Hong Kong was ‘not built on the premise of a welfare state’. Instead, he said, its free economy relies on ‘the principle of harvesting the maximum productivity from incentive associated with such freedom’ and the present tax structure is ‘not designed for a welfare state’. If the tax structure changed to meet rising government expenditure, he expressed a shared concern that ‘the GNP would fall and a lower standard of living would result’ (Hong Kong Hansard, October 6, 1971).

Values and choices exist in all policy-making. However, Titmuss (1974) pointed out that it is ‘not the business of science to say whether people want the right things’ (p.134). Underlying the residual model is the value assumption that state intervention supports economic growth and rising welfare when it is left at a minimal and residual level. A key risk if welfare provision is perceived as moral hazard; specifically that will encourage those who are unwilling or unable to provide for the needs of themselves and their families ‘through the normal mechanisms of the market’ to depend on the state (ibid, p.133). The prevailing view of state provision in Hong Kong was that it was no more than a backstop: ‘a provider for a small minority - in cases of bad risk or bad luck … who were victims of failed private pension schemes’ (Pinker, 1992, p.278).

As a market economy, Hong Kong has been placing high value on competition. Throughout its history there are many instances of colonial governors of various periods affirming explicitly that Hong Kong was not a welfare state. For example during the 1980s, Sir David Clive Wilson (Governor) repeated that ‘[we] do not intend to provide a western-style welfare state. To do so risks encouraging a mentality of dependency that is alien to the Hong Kong way of life’ (Hong Kong Hansard, October 11, 1989). In the early 1990s, Christopher Francis Patten (Governor) reaffirmed that ‘Hong Kong is not a welfare state’, but emphasised that the society ‘cares deeply about the state of welfare’ of its citizens (Hong Kong Hansard, October 7, 1992). Towards the 2000s, Mr Tung Chee Hwa (Chief Executive) assured an audience of ‘not going down the slippery slope towards a welfare state’ during a Business Community Luncheon at the Hong Kong Convention and

Exhibition Centre (October 16, 2000). Likewise, Mr Donald Tsang (Chief Executive) repeated in a press release that the society only accepted an obligation to help 'the disadvantaged members to attain an acceptable standard of living' through their own enterprise (*Big Market, Small Government*, September 18, 2006).

More recently, the Financial Secretary (Mr Henry Tong) stated that Hong Kong cannot compare itself with welfare states as nobody accepts or wants high taxation policy. 'Maintaining the share of public expenditure in GDP at 20 percent or below', in practice, has become an implicit rule or tradition followed by all administrations. This is perceived as striking 'a proper balance between keeping taxation low and enhancing government services. Following the principle of "Big Market, Small Government" helps to maintain our low-tax regime and requires us to spend within our means', and 'best serves the long-term interests of Hong Kong' (*The 2006-07 Budget*). Most recently, Mr John Tsang (Financial Secretary) reminded the HKSAR government not to fall into 'a dire financial crisis' as in other European countries and the US, which face huge debts due to 'the prolonged mismanagement of public finances by their governments and over-expanded welfare measures' (*The 2013-14 Budget*). To conclude, the Hong Kong government has always placed its highest priority on the growth of economy, while the provision of social welfare is not its major concern.

Officials' attitudes towards social welfare

It is clear that government officials share and reflect the attitudes towards social welfare build into the political consensus. When delivering a speech at the Hong Kong Business Community Luncheon on October 16, 2000, Mr Tung Chee Hwa (Chief Executive) emphasised that the HKSAR government 'sometimes gives unconditional benefits, but primarily to the needy, the elderly and the infirm'. The economic philosophy of Hong Kong is the strong emphasis, as in previous decades, on able-bodied welfare recipients becoming 'self-reliant, useful, productive members of the community'. Mr Donald Tsang (Chief Executive) emphasised that a 'dependency culture' is not to be encouraged as it removes the work incentive and

'undermines the productive engine of the economy'. Instead welfare programmes have to be 'designed and developed … to be compatible with self-reliance, self-betterment, self-help and self-esteem' (*Big Market, Small Government*, September 18, 2006).

Underestimating revenue, overestimating expenditure

In Hong Kong, the golden rule of 'underestimation of revenue and overestimation of expenditure' is an established feature of the annual financial budget. As early as the 1950s, Mr Arthur Grenfell Clarke (Financial Secretary) reported with satisfaction that his estimate of revenue had been an underestimate 'somewhat less accurate than it should be … in excess of $300 million'. At the same time he was pleased that expenditure had been less than expected, 'falling short of the revised estimate by 9 per cent' (Hong Kong Hansard, March 4, 1953). In his final budget speech on March 1, 1961, Clarke mentioned that his successors will continue to 'make exactly the same mistake' as he has always made; underestimate revenue.

Interestingly, Sir Charles Philip Haddon-Cave (Financial Secretary) made the golden rule explicit by expressing it in a humourous manner: 'the revised estimates always tend to understate surpluses and overstate deficits. Why this should be, I do not know but it always happens. (laughter).' (Hong Kong Hansard, March 2, 1977). As late as the 1990s, Sir Nataniel William Hamish Macleod (Financial Secretary) said publicly that underestimating surpluses 'has a long history in Hong Kong', and that Financial Secretaries in the past also faced the same familiar problem of 'how to explain a larger than expected surplus', as well as 'a surplus caused largely by underspending' (Hong Kong Hansard, March 1, 1995).

As shown in Table 4.1, the actual revenue in each year is always larger than forecast from 2004 to 2013 (The 2014-15 Budget). The errors of underestimation of revenue were particularly great in the years of 2007, 2010, and 2011. The underestimation of revenue in 2011 gave rise to a surplus of HK$68 billion. Meanwhile there is always overestimation of expenditure in the past years, except in 2008 in which no error is detected. 'Errors' of overestimating expenditure were

pronounced in the years of 2004, 2005, and 2006. An explicit convention of restricting welfare spending remained a key part of the Hong Kong political and executive culture over the period studied in this thesis.

Surplus budgeting

The executives were expected to produce and not to spend savings. During the 1990s, Sir Piers Jacobs (Financial Secretary) reiterated that a 'budget surplus' is not a good reason for 'incurring expenditure beyond our guidelines', especially when Hong Kong has been 'enjoying substantial budget surpluses' (Hong Kong Hansard, March 7, 1990). With the transfer of sovereignty over Hong Kong from the UK to China in 1997, it was explicitly written in the Basic Law (Article 107) that the HKSAR government has to 'follow the principle of keeping the expenditure within the limits of revenues in drawing up its budget, and strive to achieve a fiscal balance, avoid deficits and keep the budget commensurate with the growth rate of its gross domestic product'. Mr John Tsang (Financial Secretary) stressed the importance of maintaining fiscal principles and sustaining the health of public finances (*The 2012-13 Budget*). During the fifty years from 1964 to 2014, Hong Kong experienced only eleven years of budget deficits. All these occurred in times of turmoil and political or economic instability such as the 1967 riot, 1973 oil crisis, 1983-84 Sino-British Joint Declaration, 1989 Tiananmen Square incident, and the post-1997 crisis. The government has always maintained substantial accrued savings.

Reserves

For many years Hong Kong has owned a huge amount of reserves, including foreign exchange reserves. These reserves are for 'meeting balance of payments financing needs, for intervention in exchange markets to regulate the currency exchange rate of that economy, and … maintaining confidence in the currency and the economy, and serving as a basis for foreign borrowing' *(Hong Kong Annual Digest of Statistics, 2013 Edition*, p.96). Reserves 'help reinforce public confidence in the Hong Kong dollar and monetary stability' (*The 2011-12 Budget*).

Evidence shows that this principle has been carried on continuously for decades. Concerning foreign exchange reserve, the amount is HK$944057 million in 1992-93, equating to HK$162754 per capita (Table 4.2). During the 1997-98 period the reserve amount rises sharply to a total of HK$3568835 million, with HK$549957 per capita. Recently in 2012-13, the total reserve goes up to HK$5724529 million, which represents HK$800119 per capita. Likewise, the fiscal reserve also shows a substantial increase annually. During the period of 1992-993 the total sum of reserve is HK$121033 million, representing HK$20866 per capita. In 1997-98, the total fiscal reserve increases enormously up to HK$457543 million, equating to HK$84376 per capita. More so, the fiscal reserve shows an extremely remarkable amount of HK$733914 million in the 2012-13 period, representing HK$102579 per capita.

Recurrent expenditure, recurrent revenue, and total expenditure

Welfare spending has tended to rise none the less. Government data shows that between 1990 and 2013 total social welfare expenditure increased by 970 per cent, the total social security expenditure by 1053 per cent, the total subvention to NGOs by 936 per cent, while the total government recurrent revenue rose by 369 per cent, and the total government expenditure increased by 429 per cent. On the other hand, statistics indicate that the total subvention to NGOs represents less than 3 per cent of total government expenditure, and is less than 5 per cent of the total government recurrent revenue. Total social security spending is less than 11 per cent of the total government expenditure, and is less than 14 per cent of the total government recurrent revenue.

Referring to *The Estimates of the Budget* (1989-2013), the expenditure for services for older people was HK$207 million in 1989-90, and rose to HK$4895 million in 2012-13. This represents a twenty-three fold increase within the 24-year period. Nonetheless, services for older people is only 1.4 per cent of both the total recurrent revenue as well as that of the total government expenditure respectively (Table 4.3).

Recurrent expenditure as % of GDP

Public expenditure on services for older people is a small part of the government's budget, representing about 0.3 per cent of the GDP throughout the 1989-2013 period (Table 4.4). In the early eighties, Sir Charles Philip Haddon-Cave (Financial Secretary) stated that 'as a general rule, when the economy is enjoying strong growth, the relative size of the public sector will tend to fall' (Hong Kong Hansard, February 25, 1981). He expressed worries that for 'the relative size of the public sector to be as high as 20-21% is beyond the capacity of our enlarged and more sophisticated economy'. Recently Mr John Tsang (Financial Secretary) repeated the obligation 'to uphold the principle of keeping expenditure within the limits of revenue', and warned that the government has to 'increase revenue if we want to increase expenditure' (*The 2013-14 Budget*).

The long-cherished free market economic policy turned postwar Hong Kong eventually into a thriving international finance centre. The specific guidelines for using public revenue, first developed by Sir Charles Philip Haddon-Cave, have become 'the golden rules' for all successors to follow. All the concepts - 'Hong Kong is not a welfare state', 'the city enjoys a very low taxation rate and a great fiscal reserve' 'people do not want to pay higher tax' - have been implanted firmly in the mindset of all government officials as well as citizens. Undoubtedly, these underlying values, norms or 'cultures' will not be changed easily but instead to carry on in the territory, affecting each and every day of people's lives.

Social costs

The influx of refugees from mainland China in the 1950s resulted in a surplus of labour, new commercial techniques, as well as new capital seeking employment and security. In a debate on May 23, 1958, Mr Ernest Thornton (a member of the UK Parliament) criticised the hours of work in Hong Kong as 'the worst in Asia' and even 'in the world'. He described the usual work practice in many of the factories as '12 hours per day for seven days per week'. The principle of 'better value for money' or 'more for less' was advocated by Mr Anthony Leung

(Financial Secretary) at the Hong Kong Awards for Services Awards Presentation Gala Dinner on December 10, 2001. However, the social cost that arises subsequently becomes an extremely heavy burden for the society to bear in future.

Statistics show that from 1991 to 2013 the majority of CSSA recipients were older people. In 1991-92, the total number of cases (receiving CSSA due to old age) was 48020, or 66 per cent. The number increased substantially to 153237 by 2012-13, representing 57 per cent. Between 1991 and 2013 the rate of change for these CSSA cases equates to a sharp increase of 219 per cent, which is much faster than that of the total population (an increase of 24%). This sharp increase in CSSA cases (due to old age) is one of the social costs that the government and tax-payers are paying.

A glimpse of the consequences for some people in Hong Kong can be found from the study *'In Times of Great Chaos'*. Here Tisdall (1989) describes vividly the lives of thirty-eight in the care homes of the Helping Hand organisation. Most of these older persons had left China in their early adulthood, and come to Hong Kong for earning a living. They experienced many hardships and turmoil such as losing their close relatives during wartimes and revolutions, enduring and working long hours daily as factory workers, seamen, construction workers, domestic servants, hawkers and coolies. Some were forced to retire due to old age, regardless of good health. Having not much savings to use, nowhere to go, and even nobody to care for them, they end up spending their days in residential care homes. The following lines are extracted from the book, highlighting the difficult lives of eight of these residents:

Lui Man Chi (M/77): Upon arrival to Hong Kong in 1949, he first worked in a spinning factory. Later he opened a small tea-house and ran a roast meat shop for years. Owing to no compensation, he has to depend on Public and Old Age Allowance eventually (Tisdall, pp.10-12).

Peter Chiang (M/68): He studied political economy at the University of Nanking. After getting a teaching permit from the Education Department, he taught in a private secondary school. However, the earnings he got from teaching in private

schools was equated to only about one-third of those teaching at government schools. He got no savings and eventually depended on Public Assistance for daily livelihood (ibid, pp.22-25).

Mak See (F/86): At the age of 20, she was married blindly to a handsome man who was ten years older than her. Four years later her husband died suddenly, leaving her no money. Finally she decided to come to Hong Kong, and worked in a construction site to make a living. Later she changed to work in restaurant kitchens, washing vegetables and slaughtering chickens and ducks for years. Approaching old age, her fingers became too stiff and crooked to do this sort of work. She lived alone in a small cubicle, and was eventually transferred to a care home (ibid, pp.83-86).

Lung Sau Sing (F/78): Through family connections she was given employment at a hospital. She first worked in the children's ward, and later became a private nurse and worked till sixty-six years old. Owing to deteriorating health, she was forced to cease working and to rely on the government and the care home to look after her (ibid, pp.104-105).

Cheng Hei (M/86): He was a seaman with the same company for thirty years, but the Union did not allow him to go to sea at sixty years old. Later he worked as a watchman at a warehouse for about seven years. He was given wages and a place to sleep there. After 'forced' retirement, he sought assistance from the Social Welfare Department, and eventually entered a care home (ibid, p.113).

Chan How Chun (F/76): At sixteen she got a blind marriage, and became a poor widow at twenty-five. In 1945 she came to Hong Kong at the age of thirty-three. First she worked in the factories, and later became a baby amah taking care of many children. 'You never get enough sleep. Employers are fussy and demanding. Food is not all that great'. When working as a maid she saved hard and bought herself some gold teeth and jewellery. With the money she earned, she would send remittance to her siblings in the village in China (ibid, p.114).

Yip Sang (M/82): Before coming to Hong Kong he has an arranged marriage.

He worked hawking vegetables on the streets till the age of 70. Later he opened a tea and coffee stall for workers on building sites nearby. He was hospitalised due to heart disease, and eventually received care in a residential home (ibid, pp.116-118).

Wong Bin Lam (M/70): He finally got a job as a coolie - unloading all sorts of cargo onto the railway trucks, one or two tons to a truck. For thirty years, he worked with a team of other coolies pushing the trucks to the main door of the warehouse, earning about fifteen dollars monthly. Approaching old age, he could not do heavy work and changed to work at a construction site guarding the heavy equipment. He stayed there every night for five years. Later he was hospitalised due to an injured leg, and eventually admitted to a residential care home (ibid, p.123).

Behind the booming economy of Hong Kong lies the reality of the hardships of these many poor older people. For decades, the government has failed to take an active stance and consider the future well-being of citizens. Should they retire one day, a large majority have only little or even no savings of their own. As a consequence, older people have to rely on the support and assistance from the government. Titmuss (1968, p.133) pointed out that social costs and social insecurities are 'the product of a rapidly changing industrial-urban society' and 'part of the price we pay to some people for bearing part of the costs of other people's progress', including redundancies, premature retirements, accidents, diseases and handicaps.

The funding and quality of residual welfare for older people

Despite the adoption of residual welfare approach in Hong Kong, residential care is provided on a non-means tested and non-contributory basis. In principle services are 'available to all who need them' (Hong Kong Government, 1991, p.14). Referring to the website of the Social Welfare Department, the admission criteria for care homes does not take the financial condition of the elderly applicants into consideration. If an older person (aged 65 or above) intends to apply for admission to a Care and Attention Home, he/she has to undergo assessment through the Standardised Care Need Assessment Mechanism (SCNAM); being 'in poor health' or

suffering from ‘functional disabilities’ and requires ‘assistance in personal care and daily living activities’. The lack or inadequacy of family care may be a contributing factor of home admission.

Anyone, rich and poor, who fits into the admission criteria is eligible to apply for long-term residential care. In *‘In Times of Great Chaos’*, Tisdall (1989) reports that many of residents feel grateful and contented to have eventually secured a place to stay in the care home. Some residents find the care provision there to be the best that could ever have. This is reflected from the words of an 84-year-old resident (Chan Lin Tai) who describes her current life as being ‘ten times better than before’, compared with the past chaotic life experiences (ibid, p.28).

Lack of privacy

Embedded in the residual welfare system is a discriminative element, which serves the primary purpose of ‘deterrence’ (Titmuss, 1968, p.134). This explains the existence of a control mechanism - the lack of privacy - within the care homes in Hong Kong. For example, in the Fong Shu Chuen Care and Attention Home of the Tung Wah Group of Hospitals (a government-subsidised home), there are sitting rooms, living rooms, dining rooms, activity rooms, a reminiscence corner, and a multi-sensory room provided for the residents. Six to seven residents live together in each dormitory bedroom, and have to share the washroom and bathroom facilities. Generally, in the local residential care homes such as the Helping Hand, two to eight older people co-reside and share one dormitory bedroom, with each being allocated a drawer for keeping personal belongings. A lack of privacy and personal space is commonly observed in these care institutions. This ‘effective rationing device’ (ibid, p.134), to a large extent, deters many well-off older people from admission to care homes. This basic and minimal type of care service is, therefore, mainly provided for the ‘poor’ older people. The causal links are circular, as Titmuss (1968) warns, the services often continue to be of ‘poor quality’ by becoming discriminatory services for poor people.

A five-tier residential care system

Even in some Nordic countries, older people with fewer resources have increasingly to depend on family care whereas the well-off purchase services in the market, a two tier structure creating a risk of 'a negative self-sustaining cycle of reduced quality where the public sector becomes a last resort' for those who have no option, particularly if more affluent older people are encouraged to leave the publicly provided home care (Vabo and Szebehely, 2012, p.139). Unlike the Nordic countries, the care system in Hong Kong can be characterised as a five-tier system. In terms of the quality of service provision, this can be classified in the order of: private care homes, homes with Bought Place Scheme (BPS) and Enhanced Bought Place Scheme (EBPS), government-subsidised care homes, 'expensive' private homes, and self-financing care homes.

The problems of private provision

Originally, private care homes in Hong Kong accommodated older persons with significant financial resources, providing a 'better' quality of care. However, the reality has changed over time with many poorer older people entering private homes supported by public funding. As at the end of July 1998, eighty per cent of private care home residents are identified to be CSSA recipients (Elderly Commission, 1998, p.41). In many private homes all the residents rely on CSSA for daily living and give all their cash benefits to the care homes as monthly payments. This desperate situation reflects a situation George Orwell (1958, p.9) describes in *The Road to Wigan Pier*, in that the old-age pensioners were 'driven from their homes by the Means Test … handed their weekly ten shillings over to the Brookers' and were given 'a bed in the attic and meals chiefly of bread-and-butter' in return.

Similarly, older people residing in private care homes in Hong Kong hand in all their meagre cash benefits to the superintendent as monthly fees, thereby leaving almost no money for their own use. As at 2013, an abled older person can get a total cash benefits of HK$4070/m (including the CSSA of HK$2935/m and the Normal Old Age Allowance of HK$1135/m), a 50% disabled elder can get HK$5520/m

(HK$4070/m plus the Normal Disability Allowance of HK$1450/m), a 100% disabled elder gets HK$7585/m (HK$3550/m+HK$2900/m+HK$1135/m). Older persons requiring constant attendance can get a total cash benefits of HK$9035/m (HK$5000/m+HK$1135/m+HK$2900/m), which includes CSSA, Higher Old Age Allowance, and Higher Disability Allowance. A recent survey (2013) conducted by the Hong Kong Federation of Trade Unions shows that among the 565 private residential homes, 42 per cent (235 homes) charge 'the minimum home fees' which exceed the monthly cash benefits (including CSSA and other supplements) that an older person receives. Some private care homes charge fees as high as over HK$10000/m. Under such circumstances, 'poor' older people are forced to either move to other care homes which are far away from their current abode or district, or even give up the idea of entering private care homes.

In 2012-13, the cost per bed that the government provides to subvented care homes amounted to HK$12539/m, and that to contract homes being HK$10936/m. On the other hand, the government purchases care places from the private sector through the Enhanced Bought Place Scheme (EBPS) at the lower cost of HK$7561/m per bed. Undoubtedly this causes problems in the funding of privately-run care homes, particularly in having to loan interest for building cost, paying high market rent which is often fluctuating and beyond their control, and making profits. Land in Hong Kong is scarce and valuable, and is always sold at a very high price. Private homes, often situated in commercial or residential buildings, are comparatively less spacious and with considerably high rental cost. In addition, it takes a huge sum of money to carry out regular renovation of the care homes. Hence it is extremely difficult for these profit-making private homes (which are often without full occupancy rates) to meet basic operating costs, not to mention the provision of a decent quality of service. Statistics show that the number of privately-run care institutions fell from 580 to 561 between 2010 and 2013.

With limited income from fees and charges being paid through the CSSA, it is easy to see why many of privately-run homes provide substandard service to older people. As shown from the *Hong Kong Monthly Digest of Statistics* (September

2012), there was a total of 51,265 older people living in residential care homes and receiving CSSA. Not surprisingly, a substantial number of residents currently living in private institutions 'still wish to move to subvented homes' in the long run, as the service quality in the private sector differs substantially and can hardly meet the varied needs of older people (Elderly Commission, 1998, p.27). As reported by the Secretary for Labour and Welfare (Mr Matthew Cheung) on January 8, 2014, there was a total of 25,210 older people (also CSSA recipients) currently staying in non-subsidised residential care places being placed on the Central Waiting List for government-subvented care places as at end of 2009. The number had risen to 26,007 as at end of September 2013.

Summing up, private residential homes in Hong Kong have contributed significantly to supply but not quality by admitting older people unable to continue living at home but who cannot afford to wait for the allocation of public care placements. Most often, these homes accept applicants who are much more frail and/or ill than those in other types of care homes (Leung et al., 2000; Sim and Leung, 2000), and the standards of service provision vary a great deal. As Chow and Mak (1988) suggest, private homes ideally should be developed as a 'viable alternative' part of the whole service network of institutional care for the older persons, and not merely be used as a 'stop-gap measure' to compensate for the inadequate supply of care placements offered by the government-funded Care and Attention homes.

Homes within the Bought Place Scheme/Enhanced Bought Place Scheme

Within the welfare provision system, the second tier consists of care homes within the Bought Place Scheme (BPS) and the Enhanced Bought Place Scheme (EBPS). In October 1989 the government introduced a Bought Place Scheme on a trial basis with Lotteries Fund support. As stated in the policy paper, its aim is 'to encourage the operators to raise their standards [but to] remain cost-effective' (Hong Kong Government, 1991, p.33). It is hoped that 'accommodation and care of an acceptable standard' can be offered through this scheme. Despite government subsidies through purchasing places, these homes face similar difficulties to the

private sector, such as having to make profit, loaning interest for building cost, and paying high market rents. Again, these forces affect the quality of service in these care homes adversely.

Subvented Care Homes

The third tier in the care system consists of government-subsidised care homes, which provide an 'average' service quality to residents. The costs of a care place in these subvented homes are all covered by the government, including land grants, building costs, and subsidised running costs. As stated in the Green Paper, voluntary agencies (especially care and attention homes that are 'more expensive to operate') require 'a greater degree of subvention support, preferably on a unit cost basis, in order to meet improved standards of care' (Hong Kong Government, 1977, p.31).

Care and Attention Homes as operated by the NGOs are able to make a relatively positive contribution, in terms of both quantity as well as quality. As the Elderly Commission (1998, p.8) suggests, subvented agencies or the government provide 'quality basic services for people who cannot afford private services'. In other words, the publicly-funded care homes (though non-means tested) are intended to serve 'poor' people who find difficulty in paying for the more expensive fees in private care homes. Residents of this type of care provision are required to pay a standard rate set by the Social Welfare Department. As at August 2013, the monthly fees amount to HK$2000 (for Homes converted to provide Care-and-Attention Places with Continuum of Care), HK$1813 (for Disability Allowance recipients), and HK$1605 (for Non-Disability Allowance recipients). Compared with the private care institutions, these government-subvented care homes provide a 'better' quality of service because the public funding of core costs allows them to charge lower fees.

Expensive Private Homes

Unlike the first tier in the care system, this type of 'expensive' private care home offers a good standard of service with well-equipped facilities, greater space,

and more staffing. Comparatively, the home fees are highly expensive, charging each resident about HK$20000/m. Most older people cannot afford to pay such a highly expensive fees.

In Hong Kong this type of 'expensive' private home represents only a very small proportion of the overall care sector. Wealthy older people also have other options and may prefer to employ foreign domestic helpers or private nurses and be cared by them in own homes, instead of receiving care in these highly expensive private homes, along with the loss of privacy.

Not for profit, self-financing residential care homes

Among the five tiers, the non-profit-making self-financing care homes render the best quality of service to residents. These homes are operated by NGOs, and without government recurrent subvention. As recommended by the Elderly Commission (1998), NGOs are encouraged to operate self-financing services 'targeted at the middle-income families' (p.37). Home fees are charged depending on the type of room chosen and the requirement for special nursing care. For instance, the Tung Wah Jockey Club Care and Attention Home for the Elderly is a charitable self-financing home which began operation in 1991. It is named after the Hong Kong Jockey Club in recognition of the latter's generous donations. There are altogether 37 bedrooms, with each accommodating one to six residents with self-contained bathroom/toilet. Individual bedside tables, wardrobes, call bells and reading lights are provided. Television sets and night lights are found in each bedroom while a direct telephone line is available in each single and double room. All bedrooms are air-conditioned and well furnished.

A mixed economy of care

'Welfare pluralism' or 'a mixed economy of care' refers to 'a system in which the range and variety of service providers is greater while the statutory authorities of central and local government retain a responsibility for funding' (Pinker, 1990, p.126). The residual model of welfare is, as Pinker (1992) remarks,

‘entirely compatible with a form of welfare pluralism in which the private and voluntary sectors have become the main funders and providers of social services’ (p.278). In this light, the state may ‘only provide for a small minority - cases of bad risk or bad luck’. The Elderly Commission (1998, p.9) recommended the HKSAR government provide an environment ‘conducive to healthy competition to tie in with development of a mixed economy of service provision’. It was suggested that this model would ‘offer more choice’ to the older people and ‘enhance service quality’. In addition, within this model the government will generally minimise its role in direct service operation, and only ‘monitor the service quality’.

According to Gilbert (2000), welfare pluralism usually consists of ‘four sectors - government, voluntary, informal, and commercial - through which social provisions can be delivered to assist citizens in need’ (pp.411-412). These four sectors are ‘imbedded in the public and private domains of the social market of the welfare state, which is separate but overlapping with the economic market of capitalist society’. Hence welfare pluralism is described ‘as using various modes to meet needs’ and ‘as a system for the finance and delivery of social provision that functions outside the market economy’.

Owing to a lot of ‘divergence’ in the nature of social agencies that supply services, Glennerster (2003, pp.7-8) proposes specifically to distinguish between ‘who pays for a service and who provides it’ in relation to welfare pluralism. The finance dimension consists of public and private finance, while the provision dimension includes the public sector, private organisations, and informal and family care. The importance of ‘agency’ or ‘the sense of control’ of one’s own destiny that a service user has in designing social policy is often strongly emphasised in support for this model.

In Hong Kong residential care homes are mainly operated by the NGOs, and the private and self-financing sectors supported by a public policy agenda that emphasises the two principles of ‘ageing in place’ and a ‘continuum of care’. The Social Welfare Department performs the major public funding role. According to the *Annual Reports* (Social Welfare Department, various years), care homes for older

people are mostly operated by the private sector. In 2002, there are totally 62,416 care places: 66 per cent are provided by the wholly private sector, 5 per cent by the self-financing sector, and some 29 per cent by the NGOs. By 2011, the total number of care places had risen to 76,789, with about 69 per cent being run by the private sector, 7 per cent self-financing and 24 per cent NGOs. It is clear that the private sector plays an important role in providing for older people of different levels of frailty across a continuum of care (Leung, 2002).

Initially the Social Welfare Department directly operated a few care homes, but these were closed by 2003-04. *The Estimates of the Budget* (1991-2003) show that the costs of residential care homes operated by the SWD were much higher than those by the NGOs. As recommended by the Elderly Commission (1998), the role of the government has been to change from a 'service provider' to that of a 'service purchaser' (p.3). In terms of their funding care homes in Hong Kong can be categorised broadly into two types: 'government-funded capital cost' and 'government-funded recurrent cost' (see below). Government-funded capital cost refers to the building costs, and/or land, and/or land premiums that are granted by the government. Land premium refers to the cost for use of the land as leasehold paid to the government. Government-funded recurrent cost refers to the sum of money granted as cost per care place. Within this funding framework are the six types of care provision described earlier: supported private care homes, self-financing care homes, a few entirely private care homes, Homes under Bought Place Scheme (BPS) and Enhanced Bought Place Scheme (EBPS), subvented homes, and contract homes.

A typology of care homes

		Government-funded recurrent cost	
		Yes	No
Government-funded capital cost	Yes	Subvented homes	Self-financing care homes (endowed)
		Contract homes	Subsidised private homes (built by developers)
	No	BPS/EBPS in private homes	Private care homes (for profit)

Private care homes

This type of private care provision operates without any direct government subsidy for both capital costs and recurrent costs. As mentioned earlier, the fees charged in this type of care provision vary considerably. The 'poor' residents have to give all the cash benefits they receive from the government (including the CSSA, OAA, and/or DA) in order to get a place. During the 1980s, private homes for the older people flourished, but the service standards varied. According to the *Hong Kong Monthly Digest of Statistics*, the number of older persons living in private care homes grew to 39,400 in 2012, up from 38,300 persons in 2010 (Census and Statistics Department, March 2013). Close to 65 per cent were aged 80 and above.

As shown by the Elderly Commission (1998), most private care homes operate on a 'small scale'. Among them, 72 per cent (306 homes) offer 60 care places or fewer, 14 per cent (60 homes) provide 61 to 100 care places, and 14 per cent (59 homes) provide over 100 care places. The monthly fees vary considerably among these private homes, ranging from HK$6000/m or below to HK$20000/m. It is discussed in the Report that private homes are mainly concerned with making profits and often fail to consider 'the overall interests of society' even though they are 'more flexible in service provision in response to market demand (p.8).

Self-financing care homes

Broadly, self-financing care homes can be classified into two types. One being charitable in nature, and endowed by the parent organisation and other donations. The other main type is funded by residents' fees payment, and operates on a user-pay basis. In the establishment of self-financing care homes, a land grant is offered at a nominal rate to NGOs. Government grants from the Lotteries Fund can be provided to cover some of the capital costs and operating costs of the initial three years.

Self-financing care homes have 'considerable flexibility in deploying resources and fixing fee levels' (Elderly Commission, 1998, p.37). These homes can decide on the amount of fees charged according to the levels of care provided, the types of room, the functional disabilities and financial conditions of the residents. In the case of the Tung Wah Jockey Club Care and Attention Home for the elderly, the fees (in the New Wing) are classified into four levels according to the type of care required - mild, moderate, intensive, and dependent caring levels. Starting from May 1, 2014 onwards, residents are required to pay the fees for a 6-person room ranging from HK$12200/m to HK$18800/m, for a 4-person room fees ranging from HK$12800/m to HK$19600/m, and for a 2-person room fees ranging from HK$17700/m to HK$25700/m. A single room is charged the most highly expensive fees ranging from HK$27100/m to HK$36000/m. The fees (in the Old Wing) of this care home are somewhat cheaper. Although the government provides land and building cost support to these self-financing care homes, some NGOs still face difficulties in actual operation. These include the financial risks involved, market affordability in fees payment, complicated land grant procedures, and shortages of nursing staff.

Privately funded care homes

The government has put in place a scheme to encourage private developers to provide 'quality purpose-built' residential care homes for the elderly (RCHEs) in their new developments (Social Welfare Department, July 2003). Under this scheme,

there is exemption from 'assessment of premium under different types of land transactions including lease modifications, land exchange and private treaty grants'. In return for premium exemption being granted with the support of the Social Welfare Department (SWD), private developers are required to bear the all construction costs.

Once built, these RCHE premises become the properties of the private developers, who have 'the flexibility to lease, sell or operate the premises themselves or through agents as long as the premises remain as RCHEs'. The developers/operators are free to set home fees 'in accordance with the market'. The size of these RCHE premises is subject to 'a maximum limit of a total gross floor area of 5400 sq. m.'. All these private RCHE premises are regulated by the SWD under the existing licensing regime. Despite the premium exemption, many private developers have not entered this market as profits are hard to difficult to achieve.

Homes under the Bought Place Scheme and the Enhanced Bought Place Scheme

This type of care provision does not obtain any financial support from the government in terms of the building cost. Instead, the government subsidises recurrent costs on a per head basis by purchasing places in private care homes. Normal practice is that the SWD purchases 30 per cent to 40 per cent of the places of Bought Place Scheme (BPS) homes. Moreover, the prices of bought place are based on the 'staffing levels and other operational costs of the care homes', which are adjusted with inflation or when necessary (Hong Kong Government, 1991, p.47). Since 1993, the BPS has become a subvented scheme of the Social Welfare Department in which the government purchases residential places from private care homes. The scheme is considered to be the quickest way to increase the provision of subsidised care places within a short time (Elderly Commission, 1998, p.32).

The government will 'monitor the response of the market and the elderly' towards the Enhanced Bought Place Scheme (EBPS). Starting from 2003-04 all BPS places were upgraded to EBPS standards. Under the EBPS, the government offers higher payments and helps private home operators to 'recruit staff at higher wages'.

As part of this initiative, the SWD intends to improve manpower training such as improving the supply of Health Workers and their professionalism (Elderly Commission, 1998, p.11).

Subsidised homes

In this type of care provision, the government provides funding support for both recurrent cost as well as capital cost (including land, and/or land premium, and/or building cost). As indicated in the policy paper (Hong Kong Government, 1991, p.17), subvented agencies currently receive 'some two-thirds of total government expenditure on social welfare services, and employ some 80% of all social welfare personnel, including trained professionals, welfare workers …'. Here its role of 'partnership' with the voluntary agencies in the provision of social welfare is affirmed explicitly by the government, describing it as a 'vigorous and progressive voluntary sector'. In these government-subvented care homes, residents pay a monthly fee that is set at a standard rate by the SWD. Hence after the deduction of these 'comparatively lower' home fees from their cash benefits (including the CSSA, OAA and/or DA), residents still have some money left as their own disposable income.

Contract homes

Along with the implementation of a 'Lump Sum Grant' system since 2000, the subvention mode of the government has undergone significant changes. Competitive bidding was adopted from 2001 onwards as a new mode for selecting service operators for subsidised residential care homes funded by the government. This funding method is open to the NGOs and private sector, and successful bids are granted according to 'quality and volume'. As described in the *Annual Report* (Social Welfare Department, 2002), there is a monitoring mechanism to manage compliance with contract terms. This includes spot checks, regular service reviews, benchmarking of performance standards, complaints investigations and user satisfaction surveys.

Contract homes, established through competitive bidding from 2000, provide care to older people with moderate to severe levels of impairment. In this type of provision, the government subsidises capital cost and recurrent cost. For example, the Tung Wah Group of Hospitals' Willow Lodge (a contract home) began operation in October 2012 after successful bidding. It aims to 'provide quality service in accommodation, personal care and nursing care' to older people who suffer from poor health and have limited self-care ability. The total capacity is 100, including 60 subsidised places and 40 non-subsidised places. Regarding the 40 non-subsidised places, the agency has to sort out ways to fund all the recurrent costs on its own. Each dormitory bedroom accommodates two to eight residents in a shared room with a self-contained washroom and bathroom. Other facilities such as dining rooms, reading corner, resource corner, club rooms and activity rooms, reminiscence corner, sensory training room, and computers are provided for residents' use. Non-subsidised places are provided with television, and some are equipped with independent telephones and refrigerators for residents' personal use. This care home operates on a 'mixed mode' basis. Despite the different fee charges and slight differences in some of the provision of room facilities, the 'better-off' and 'poor' residents live under one roof. Residents, whether belonging to the government-subsidised or non-subsidised section, receive care as rendered by the same group of staff within the same contract home.

The broader context of care for older people in Hong Kong

Data on patterns of need and care within the whole Hong Kong community are scarce. In the case of older people community level data shows the incidence of capacity to perform activities of daily living (ADLs) but not in the context of information of where the care, if any, for these people is coming from. In short, the capacity of the informal care system is assumed but not mapped. What is known is that the number of older people living in residential care homes represents only a small proportion of older people in Hong Kong, as compared with those living in the community. Local statistics provides figures merely on the number of places in different types of residential care homes. There are no exact figures on the number of

older people actually living in private care homes. The Social Welfare Department has only figures on those living in government-subsidised homes and those funded through the Enhanced Bought Place Scheme (EBPS).

According to the *Thematic Household Survey Report No.21*, about 5 per cent of Hong Kong's population of older people were receiving residential care in 2004 (Census and Statistics Department, 2005). Among the total 56,300 elderly residents, close to 24 per cent (being 13,300) lived in Care and Attention homes, 58 per cent (being 32,600) lived in private care homes, and 14 per cent lived in Homes for the Aged. The remaining 4 per cent were living in Nursing Homes and Infirmaries. Clearly, the vast majority of the older people (being 985,700) were living in the community; comprising some 95 per cent. In this household survey, 'older people' were defined as those aged 60 and above. In the 60-69 age cohort, there was merely one per cent (being 3,700) residing in care institutions, while about 99 per cent (being 465,300) was living in the community. The proportion of those aged 70 and above living in care homes rose to 9 per cent (being 52,600) whereas that of those living in the community was 91 per cent (being 524,900). Age was strongly associated with the likelihood of receiving residential care.

In principle, older people living in the community can apply for community care and support services such as day care centres. In practice, the inadequate provision of these services hardly meets the needs of those living in community (refer to the discussion on Chapter 3). As revealed from the *Social Welfare Services in Figures: 2005 Edition*, the head counts of those utilising Day Care Centre Services and Enhanced Home and Community Care Services were only 1,979 and 1,575 respectively in 2003-04 (Social Welfare Department, 2005). At the same time, the number of older people receiving Integrated Home Care Services (ordinary cases) as well as frail cases were to 18,666 and 834 respectively. In short, most older people still living in the community are likely to be receiving informal care from their family members, relatives, friends, neighbours or domestic helpers, and usually without receiving community care and support services. However, there is limited data about how older people living in the community are being specifically cared for

in their daily living.

Concerning the functional ability of older persons in performing activities of daily living (ADLs), this is classified into four levels in the *Thematic Household Survey Report No.21* (Census and Statistics Department, 2005). As indicated, 99 per cent (being 921,000) of older people living in the community versus one per cent (being 14,000) of those living in care homes are without any ADL impairment (Level 1). Older persons who cannot perform 1-2 ADLs independently are at Level 2. This comprises of 73 per cent (being 36,200) living in the community and 27 per cent (being 13,200) living in care homes. Significantly, some 61 per cent (being 10,000) at Level 3 (unable to perform 3-4 ADLs independently) are living in the community while this group has 39 per cent (being 6,400) in care institutions. About 44 per cent (being 17,700) of older people who cannot perform 5-6 ADLs independently (Level 4) are living in the community with 56 per cent (being 22,700) living in care homes. There is a strong association between age and the probability of being assessed as at Level 4: only 3,600 in the 60-69 age cohort were in this total.

Chapter summary

In Hong Kong public policy conceives of residential care only as a last resort for older people with higher levels of impairment. A variety of government policies has produced a complex mixed economy of provision partly subsidised by the state. Some older people with means receive care in government-subsidised homes, whereas many of the poor and frail have to enter entirely private care homes funded only by the state minimum income.

In Hong Kong a five-tier care system produces a very varied quality of service provision. Among the five tiers, the non-profit-making self-financing care homes as operated by the NGOs offer the best quality, while the government-subvented care homes provide average service quality and some privately-run homes are amongst the worst of all. A large majority of private homes render substandard care service to residents whose need for help varies across a wide spectrum. Owing to high recurrent costs and financial problems, many private homes

run into difficulty and eventually close down. A high proportion (about 80%) of residents in private homes rely on CSSA (public basic income support) for daily living. Some do not have high self-care needs but receive institutional care due to their need for accommodation.

Hong Kong is not a welfare state, and this has been declared explicitly in many policy statements made by politicians and government executives since the 1950s. In the early 1990s Sir Nathaniel William Hamish Macleod (Financial Secretary) described Hong Kong's economic philosophy as 'a commitment to enterprise, a commitment to low taxation and a commitment to free markets and free trade'. Entering into the millennium, the concept of 'Big Market, Small Government' is used by the HKSAR government to describe its free market philosophy. In other words, the government promotes economic development within the limits of a small government.

Statistics show that expenditure on services for older people is a very tiny proportion of the total government expenditure, not to mention that of the GDP. It is clear that the government and political leaders do not offer a long-term vision of public welfare and support for citizens. Pension schemes are rare in the territory causing poverty and desperate conditions of many older people after their retirement. These problems are growing more acute as longevity increases. Significant social costs will have to be paid by the society in the long run.

Hong Kong has developed a distinct residual approach to welfare. Residential care homes are supported by a mixed economy of welfare approach, informed by a residual model of public welfare. In the provision and delivery of long-term residential care for older people, the government assumes some of the costs for some of the people. This can be seen in its financial support for the recurrent costs and/or capital costs for the various types of care homes. In the provision of long-term residential care, the government acts mainly as a service purchaser; buying care places from private homes through the Enhanced Bought Place Scheme. The key driver of a growing variety of government subsidies to the residential care market has been the lack of public and private pension schemes.

Many older people have to apply for CSSA to cover their living costs, and there are growing numbers on the Central Waiting List for government-subsidised care home places.

The residual welfare model has been in place since the colonial government, reflecting the underlying values, choices, and 'culture' of the society as a whole, both government and citizens. Essentially, what seems to matter most to the people and the government of Hong Kong is money. 'We live in an age dominated and obstructed by the "money complex"', as Titmuss (2001, p.17) comments, 'ever conscious of the presence of economic problems; … forced more and more to regard money as the only means to security and the possession of material things'. This is core of the Hong Kong situation. For decades, the government has repetitively emphasised that 'Hong Kong is not a welfare state'. More recent claims to be developing a 'mixed economy of welfare' approach, provision and the competitiveness and quality of services are not greatly supported by the evidence within the residential care sector for older people.

Chapter 5 'Gatekeeping' Policies

During the 1990s, despite the government's rhetorical commitment to community care of older people provided largely by the family, demand for residential care places continued to grow, supported in part by substantial increases in the number of people 65 and over, and particularly in the numbers over 85 and with care needs. A new policy initiative, 'the Standardised Care Needs Assessment Mechanism' (SCNAM), was introduced in November 2000 to be used to determine eligibility for places in residential homes supported by public funding. The explicit justification for use of this eligibility test is to improve resource allocation and prioritise those with the greatest need. This chapter will discuss the implementation of this 'gatekeeping' policy as well as what the literature suggests is likely to be its impact on the two residential care homes in Hong Kong that are the main focus of the research conducted by the author.

Expressed need

Bradshaw (1972) proposed 'a taxonomy of social need', namely, expressed need, normative need, felt need, and comparative need. Here the discussion is mainly focused on the first two types of social need. Expressed need refers to 'demand' or 'felt need turned into action'. In the field of social welfare, this is often reflected in waiting lists which are 'a measure of unmet need' (p.3).

In Hong Kong, older people seeking residential care in a publicly-funded care home can make application through various service units of non-governmental organisations (NGOs) or through the Social Welfare Department (SWD). Applications are processed through a Central Waiting List in the SWD, and care places are rationed by the date of application.

With the accelerating ageing of the population from the mid 1990s, the demand for places in Care and Attention Homes rose sharply. The number of applicants in the waiting lists grew substantially from 668 in 1980-81 to 18,121 in 1999-2000 (Table 5.1): more than 27 times within the two decades. As a consequence

of the long waiting lists, it was not uncommon to find many older people submitting early applications to the Social Welfare Department (SWD) for fear of not being offered immediate placements at times of emergency. Before November 2000 the Central Waiting List used by the SWD had long been criticised as 'extremely unreliable' and failing to provide updated information about the numbers waiting for places in residential care facilities (Chow and Mak, 1988; Chan et al., 1993). Consequently waiting lists failed to reflect genuine care needs or real demand for care and attention places. Over half of the respondents on the waiting list could not be reached because of a wrong address, having moved house or death. Entering the new millennium, the situation did not appear to have improved. In this sense the selection process appears not to have been effective even in its own terms, and there remained a need for better service matching and allocation (Leung, 1992).

A significant proportion of older people demonstrated reluctance to enter a residential home upon the offer of a care place. As reported in the Legislative Council Panel on Welfare Services, the rejection rates for the government-subsidised NGO care places as well as those under the Bought Place Scheme/Enhanced Bought Place Scheme reached 36 per cent and 37 per cent respectively by 2002 (Hong Kong Hansard, 12 May 2003). These data pointed to problems of matching people with places and a potential wastage of existing resources due to the allocation process then run by the government. Efficiency in the use of long-term care resources was unlikely within this model of allocation, and the practices used to implement it.

In November 2007, among the total 23981 applicants awaiting different types of subsidised residential care place in the Central Waiting List, about 73 per cent (17414 persons) were applying for admission to Care and Attention homes (Social Welfare Department**,** 2007). The remaining 26 per cent (6294 persons) were listed as waiting for nursing home places, and one per cent (273 persons) had applied for entry to Homes for the Aged. How in principle could this confusion be dealt with? It was vital to identify and effectively apply a measure of need. Instead, as Ter Meulen (2001) has pointed out, it is becoming common for countries to address the problems of scarcity simply through rationing by income and age, and not by fair

criteria of need.

Normative need

Normative need refers to what 'the expert or professional, administrator or social scientist defines as need in any given situation' (Bradshaw, 1972, p.2). A 'desirable' threshold is set by some sort of expert judgement and compared with the current effective threshold. In the case of entry to the local Care and Attention homes, before 2000 the Social Welfare Department had laid down the admission criteria: 'poor health, or suffering from functional disabilities [where] assistance is needed with daily living activities' (Elderly Commission, 1998, p.28). Those who had limited self-care ability or who could not 'be properly cared for' even if co-residing with their families were eligible to apply (ibid, p.8). However the standards set were not precisely specified; for example, how and who defined the terms 'poor health', 'functional disability', and 'cannot be properly cared for'. There was a lack of a standardised measure of social need before 2000, and which could often led to mismatching or wastage of resources in long-term care for older people.

To a certain extent, a waiting list can reflect demand but is 'generally accepted as a poor definition of "real need" - especially for presymptomatic cases' (Bradshaw, 1972, p.3). For example, in a sample survey conducted by the Elderly Commission (1998), only 55 per cent (10600 persons) of the 19300 older people on the waiting list of Care and Attention homes met the current admission criteria (p.20). In other words, about 45 per cent on the waiting list may not have represented genuine current demand for care places. It was reported in the Legislative Council that only about 60 per cent on the Central Waiting List awaiting care and attention places could be identified as having a 'genuine need' for residential care (Hong Kong Hansard, 5 April 2000). This raised fundamental questions about efficiency and fair allocation of resources by the overall care system in Hong Kong.

The pre-admission process before 2000

Older adults or their family relatives could apply for care placements

through the Social Welfare Department or NGOs, and a Central Waiting List was compiled. Applicants might indicate their preferences about the location of residential care homes. Upon the offer of a care placement, elderly applicants would be interviewed and assessed by a variety of professionals (including the referring social workers, medical professionals and service providers) on their eligibility and suitability for services.

Prior to 2000, the selection process for residential home admission was not 'standardised'. Among professionals and agency providers, there was no common assessment tool to decide on the eligibility of older persons for various types of services (Deloitte and Touche Consulting Group, 1997; Gate-Keeping Consultant Team, 2000). The areas of responsibility among agencies were blurred across different forms of residential care provision, with each developing a perception of its own niche and say in selecting the service targets it preferred. Consequently prospective applicants had to deal with an uncoordinated care need assessment mechanism. Should an application be unsuccessful, they would have to restart on the waiting list and undergo the whole pre-admission process once again. This had substantial implications for the waiting time as well as adding to psychological stress for the older people and their families.

In practice, it was often the administrator of the service agency that made the final decision about home admission. With the lack of specific and objective guidelines about the admission criteria, this explained why some residents were admitted to care homes but were found to be not in 'real care need'. It often took more than a month for the completion of a case assessment (Hong Kong Hansard, 8 January 2001). The entire system was criticised as vague and uncoordinated.

Where the health situation of an older person declined quickly, but it was not yet their turn for a placement offer, they had no choice but to seek the government-subsidised bought places in private care homes, under a system of 'priority placement' regardless of their reluctance. According to a local survey conducted by the Hong Kong Council of Social Service (2003), approximately 24 per cent of residents living in the Homes for the Aged were awaiting admission to Care

and Attention homes due to 'ailing health' (Hong Kong Hansard, 24 January, 2007). They were experiencing deteriorating health conditions and were in need of more personal and nursing care of the sort provided in the Care and Attention homes.

Effectively people in greatest care need did not have priority over those with lower care need. The application date was the major factor determining the allocation of service provision under the system before 2000. As Leung and others (1993) showed, the allocation and provision of elderly services tended to be inflexible and fragmented. As a result, mismatching and poor targeting were common.

Growing demand for care places

The demand for institutional care was reflected in waiting lists. As at December 1999, there were 28538 'active applicants' on the Central Waiting List of the Social Welfare Department (Census and Statistics Department, May 2000). Among them, close to 63 per cent (a total of 17824) had applied for Care and Attention homes. Around half of the applicants (mostly females) were between 75 and 84. Frail older people either had to accept admission to private homes with varying service standards for a short-term immediate solutions or they could join the waiting list for the government-funded Care and Attention home placements which might take several years. As a result there was over-registration on waiting lists as a form of insurance. Care places were rationed by time on a waiting list, and people tended to register in advance of needing the service, so increasing waiting times and inefficiency.

The consequences of the economic downturn of the 1990s

During the decade of the 1990s, the economy of Hong Kong was greatly affected by socio-political uncertainties and experienced increased ups and downs. Initially in the early 1990s there was considerable economic development as reflected from the annual Gross Domestic Product (GDP). Economic recession occurred however soon after the 1997 Asian financial crisis. This was clearly indicated by negative economic growth throughout the period of 1998-2003. Per

capita GDP declined continuously for several years, except for a slight growth of 2.9 per cent in 2000 (Table 5.2). In the meantime, government expenditure showed large deficits from 1998 to 2004, except for the 1999-2000 period (Table 5.3). It became apparent that the HKSAR government could no longer sustain relatively lax fiscal policies. Formal measures were seen as necessary in order to gain a better control over government revenue and expenditure.

Rising welfare expenditure

Obviously, the rapid growth of the older population created very demanding financial pressure upon the government. Under the social security scheme in Hong Kong, older persons without means are eligible to apply for Comprehensive Social Security Assistance (CSSA) so as to maintain a basic capacity to live. Throughout the period 1990 to 2007, a high proportion of the expenditure in the Social Welfare Department was spent on social security payments. In 1990-91, close to 62 per cent (HK$3127 million) was used for social security payments (Table 5.4). The amount increased drastically to HK$23161 million (being 71%) in 2006-07, which was a rise of 7.4 times. Comparatively, overall government spending had only risen 4.2 times (HK$2843 million) but the subvention to the non-governmental organisations (NGOs) grew 5.2 times (HK$6449 million) within the 17-year period. This was the wider context in which expenditure on support for older people was framed.

Total government expenditure on services for older people rose sharply from HK$1623.4 million in 1997-98 to HK$3087.2 million in 2006-07 (Table 5.5). This represented a substantial increase of over 90 per cent within a decade. In the meantime, the continuous rise in the government subventions to the NGOs on services for older people grew less quickly: from HK$1364.1 million to HK$2914.2 million within the period, which equated to an increase of almost 114 per cent. The government of Hong Kong was shouldering greater financial responsibilities, and appeared likely to have to continue to provide subsidies to the non-governmental organisations (NGOs) to service an ever-growing frail elderly population in the territory.

In this context, the government of Hong Kong began to initiate reforms in elderly services from the early 2000s. Underpinning this policy change was a paramount intention by the government to achieve better control over resources and to limit social welfare expenditure.

Needs assessment policy after 2000

The Ad Hoc Committee of the Elderly Commission (1998) advised that it was necessary and essential 'to review the admission criteria of residential institutions and to establish a Gate-keeping mechanism for better allocation of elderly services' (p.16). Encouraged as well as recommended by the Deloitte and Touche Consulting Group (1997), the government established a formal 'gatekeeping' policy initiative to strengthen home admission control and to improve appropriate service matching for older persons in need of long-term care. The system, known as 'the Standardised Care Need Assessment Mechanism' (SCNAM), was adopted in the territory from November 2000 onwards. Its intention was to ensure better allocation of resources and the prioritisation of services for the most needy older people (Gate-Keeping Consultant Team, 2000). It was claimed that a standardised assessment tool was 'more objective and efficient' as applicants 'will no longer be subject to repeated assessments by different service providers' (Elderly Commission, 1998, p.31). Instead there would be better coordination and cooperation among social workers, doctors and others seeking help for their clients and, service providers and assessors. It was intended that assessment should become separate from provision and that service providers should 'plan and deliver services according to the assessment results'.

Upon receiving applications for long-term care services, social workers from different service fields such as integrated family service centre, medical setting, elderly service centre will refer applicants to the gatekeepers for assessment of their health conditions, functional abilities and need for care. These 'accredited assessors' or gatekeepers include professionals from various disciplines such as social workers, physiotherapists, occupational therapists and nurses who have undergone structured

training programmes and accreditation on the use of the assessment tool (Social Welfare Department, 2007). Taking into consideration existing resources and the urgency of the applicants' service needs, the gatekeepers submit applications to the relevant agencies to arrange appropriate services for the elderly. Within the basic framework, the gatekeepers assess for any impairment in terms of the abilities of older people in performing activities of daily living (ADLs), continence, cognition, health, mood and behaviour in order to judge their care need for long-term residential care or community support services. Furthermore, 'coping problems' such as the availability of care and psychological support to older people are assessed to match with different service options. Other environmental risk factors are also considered when assessing the care needs. For instance, some older people live in public housing units whereby the elevators cannot reach the specific floor of their abode, thereby having to walk up or down the stairs in daily lives. Such, undoubtedly, causes inconvenience to older people especially to those with mobility problems.

Impairment is classified into four levels under the Standardised Care Need Assessment Mechanism (SCNAM), namely, 'no impairment', 'mild impairment', 'moderate impairment' and 'severe impairment'. Older people being assessed as having care needs (impairment at moderate or severe level) are eligible for applying subsidised long-term institutional care services. These eligible applicants have choices concerning the location preference of care home, its religious background, diet arrangement, and an indication of whether they will accept a subsidised place under the Enhanced Bought Place Scheme (EBPS). If the matched services are not immediately available, they will be put on the waiting list to await their turn for admission. Upon the offer of a care place, they can choose to accept or reject. Case will be closed if applicants reject the offer. A new application and screening process has to be re-started once they intend to apply for residential care service again. While for those being assessed as having no care needs (with no or mild impairment level), they are referred to home- and community-based support services such as day care centre, integrated home care service, District Elderly Community Centre (DECC), Neighbourhood Elderly Centre (NEC). Should there be any disagreement concerning the assessment results and services matched, applicants can seek 'pre-appeal

mediation and appeal channels', and reassessment may be rearranged when necessary. The 'Minimum Data Set - Home Care (MDS-HC) assessment results are valid for twelve months. If there is any significant change or deterioration in the conditions of the older people, including health aspect, coping ability, and living environment, the referring worker will reassess and make different recommendation as to the care needed.

Unlike the former practice, the accredited assessors or 'gatekeepers' (instead of the service providers) are the ones solely responsible for conducting assessments of the impairment level of the applicants (regardless of family income) in relation to their performance in activities of daily living (ADLs), physical functioning, memory, communication, behaviour and emotion, health problems, environmental risk and coping problems. By adopting the standardised tool of the 'Minimum Data Set - Home Care (MDS-HC) test' (an internationally recognised assessment tool), it becomes in principle possible to match needs to services. There was at this point no means-testing. The driving principle of the method was that only those with a clear need for institutional care would be admitted to care homes.

Under the Standardised Care Need Assessment Mechanism (SCNAM), older people assessed as at 'moderate' impairment level are eligible to receive personal care and limited nursing care in Care and Attention homes. This type of care provision offers accommodation and meals for older persons (aged 65 or over). As stated in the Residential Care Homes (Elderly Persons) Regulation (Section 3), these residents 'do not require a high degree of professional medical or nursing care' (Social Welfare Department, October 2005, p.5). Briefly state, applicants have to undergo two tests before admission. First is the test about the impairment level of older people; only those with moderate or higher impairment levels are eligible for entry to residential care homes. Second is the test about the coping capacity of older people. Areas of assessment include whether the physical setting of their living environment is favourable, whether the care and support of family members is available and sufficient, and whether caregiving causes great burden and stress to the carers. The two residential homes in the current study provide this type of care.

However, because once admitted people can develop ‘deteriorating health conditions’ and because of a ‘shortage of medical infirmary beds’, infirmary units were established in some Care and Attention homes (*The Five Year Plan for Social Welfare Development in Hong Kong - Review 1993*, p.39).

Discrepancies between expressed needs and normative needs

There existed a discrepancy between normative needs as defined by the professionals and the expressed needs of the older persons. There was evidence that many in residential homes were not in ‘genuine immediate need for residential care’. It was pointed out by the Elderly Commission (1998, p.19) that these people ‘do not meet the admission criteria at the time of registration’, and may just register ‘to prepare for a rainy day’.

Waiting lists

It was hoped that by setting up a ‘gatekeeping’ policy - ‘the Standardised Care Need Assessment Mechanism’, effective demand could be reduced. The government intended both to increase the supply of care places and to shorten the waiting list and waiting times (Elderly Commission, 1998, p.22). However, Social Welfare Department data show that only initially was the waiting list for Care and Attention homes shortened as anticipated after the implementation of the ‘gatekeeping’ policy. There were 18121 older people waiting for Care and Attention homes places in 1999-2000, and the number reduced slightly to 15323 by 2004-05 (Table 5.1): a decrease of 15 per cent within five years. However, the number rose every year from 2005 onwards, reaching 22293 in 2012, an increase of over 45 per cent between 2004 and 2012.

Waiting times

The government also aimed to reduce the waiting time for government-funded Care and Attention homes. Statistics, however, indicate that this

has not been achieved. In 1982 applicants waited 30 months before admission to Care and Attention homes. The average waiting time for admission to the government-funded Care and Attention homes was greater, being 36 to 48 months, by 1991 (Table 5.6). Following the implementation of the Enhanced Bought Place Scheme (EBPS) by the Social Welfare Department, there was increased supply of subsidised care places and waiting times fell subsequently. It took 10 months in 2007 to enter into private care homes under the Enhanced Bought Place Scheme while the waiting period for other subsidised care places (including government-funded homes and contract homes) was 33 months. However, following the implementation of the 'gatekeeping' policy after 2000, the waiting times still remain more or less the same. The Central Waiting List of the Social Welfare Department has remained long. The policy aims of shortening the waiting list as well as the waiting times have not been achieved as anticipated.

Comparatively, older women have to wait for a longer time before home entry than their male counterparts. In the cases of placement offers for government-subsidised Care and Attention places (those without preference to any region, district, home) as at November 2007, only women who had applied before December 2005 were achieving entry (Social Welfare Department, November 2007). For men, those who had applied before October 2006 were successful. These delays are indicative of the greater number and higher demand for long-term care places from older women, who tend to live longer.

A significant number of older people may die before it is their turn for placement in a government-funded care home. As reported in the Legislative Council, there were some 2500 older persons passing away every year while waiting for admission to residential homes before 2000 (Hong Kong Hansard, 5 April 2000). Among the total 16269 elderly applicants in 2006, around 13 per cent (being 2159) died during the waiting period (Hong Kong Hansard, June 2007). The number of older people dying during the waiting period continues to rise each year, with 2449 in 2007 moving up to 3148 in 2012: an increase of nearly 29 per cent within the 5-year-period. In this context of growing numbers and need it is difficult to show that

the new policy has become more efficient or fairer.

Older people who have children living in Hong Kong

A large majority (75%) of older people have at least one or more children living in Hong Kong, with 46 per cent of them having one or two children (Census and Statistics Department, 2005, p.108). The percentage of those having 5 or more children living in Hong Kong represents approximately 10 per cent, whereas only 25 per cent do not have children in Hong Kong. The government advocates and emphasises the caring obligations of the family in the long-term care policy.

Reality reveals a different scene. Local studies (Chi and Lee, 1989; Ngan, 1990; Hong Kong Sheung Kung Hui Welfare Council and City University of Hong Kong, 2000) detected a considerable number of older persons who are isolated, having almost nobody to turn to in times of need. These people, often very elderly women, were identified as the most vulnerable, and disadvantaged. They were more likely to be living alone and not receiving as much social support or assistance from their family members when needed as their male counterparts (Chi and Boey, 1994). Likewise, in the study by Lee, R.P.L. et al. (1997), about 5 per cent of the 103 respondents said there was nobody to help out when they were sick or in trouble.

There has been a growing number of older respondents indicating a preference to live independently on their own (Lee and Lo, 2005). Some do not wish to become a burden to the family, while others hope to avoid conflicts (Chow and Chi, 1990; Chan et al., 1993). The study, *In Times of Great Chaos* (Tisdall, 1989, p.33), shows how even before the introduction of the new policy, not all older people wished to become dependent on their children. For example, a 77-year-old woman (Yip Sik Hong) explains that it is ‘not easy to be alone in one’s old age. But I don’t want to be a burden to my relatives or children. And here I have the company of all kinds of people’. Furthermore, there is an old Chinese idiom saying of family members: ‘seeing each other is fine, but not living together under one roof’. As described in this book, some residents speak of maintaining occasional contact with their family but ‘at a certain distance’. For example, Lee Man Jun (F/76) tells of her

daughter living very near to the residential care home where she lives, and she 'often' goes to have a cup of soup or 'have a bath' at the daughter's house during cold weather. 'Every Sunday' she goes out for tea with the seven grandchildren and some great grandchildren (ibid, p.15). Similarly, Yip Sang (M/82) meets and keeps in touch with his son and daughter occasionally after they get married (ibid, p.118). Another case is Lai Fook (M/75), who initially lives together with his son, daughter-in-law, and grandchildren on a junk. Without 'compensation in cash' and after housing reallocation, conflicts accelerate and the daughter-in-law bullies and eventually kicks him out (ibid, p.32). The simple existence of family members is not a guarantee of care, even in the cultural context of Hong Kong.

The functional abilities of care home residents

The intended policy outcome was the provision of residential care for older persons with higher impairment levels while those with no or mild impairment are to age and be cared for in the community. Again, the real picture has turned out to be a different one. Even in 2005, some 25 per cent of residents living in care institutions did not have any ADL impairment, but were in 'Level 1' (Census and Statistics Department, 2005, p.122). Moreover, about 24 per cent reported only one or two ADL impairments (Level 2). Evidence shows that a significant proportion of nearly 50% with no or mild impairment was living in residential care homes in 2005, in spite of the fact that the homes would continue to house those who had been admitted under the pre-reform rules. Care home residents with greater functional disability than this comprised 51 per cent; with 11 per cent suffering from three to four ADL impairments (Level 3) and 40 per cent were seriously impaired with five to six ADL impairments (Level 4). Clearly, this does not match with the long-term care policy aims. The explicit policy intention of the government was that only those with more severe impairment levels are to be admitted to residential care homes, leaving others with no or mild impairment to receive informal care or domiciliary services in the community.

Intended consequences

Having identified discrepancies between the long-term care policy aims as set by the government and the outcomes, this research examines the impact of the 'gatekeeping' policy at the level of the two residential care homes run by the Helping Hand organisation. The outcomes within the homes are the main focus of this study. Social policy, as Titmuss (1968) suggests, may bring both intended and unintended consequences (p.22). Here we will first examine if the 'gatekeeping' policy in Hong Kong will give rise to intended outcomes, such as resulting in improved efficiency of residential care for older people. At the same time, the study will evaluate if these intended consequences of purposive action, though being 'relatively desirable to the actor', may be 'axiologically negative to an outside observer' (Merton, 1936, p.895). These 'intended outcomes' may generate negative effects, such as better efficiency may be acquired at the expense of effectiveness of care for older people in the two local residential homes. For example, the 'gatekeeping' policy may result in achieving the government's intended outcome of saving cost, but also affecting adversely the quality of life of residents in the care institutions.

Target efficiency

The intended consequences of the 'gatekeeping' policy in Hong Kong are better targeting and more effective matching of resources to needs. With the inception of the Standardised Care Need Assessment Mechanism (SCNAM) since November 2000, it is intended that older persons admitted to residential care homes are those in greatest need and with higher frailty levels.

Unlike previous practice before November 2000, service providers including agency administrators, and home superintendents do not conduct assessments of the care needs of applicants. Instead the 'accredited assessors' take up this role whereas the service providers are responsible for devising individual care plans tailor-made for each older person upon and after admission, based on the needs-assessment results provided by the 'gatekeepers'. At the individual level, these case managers continue to monitor the health status of older people. If any change is

detected in the residents, reassessment and appropriate services will be arranged. The productivity of any system of care management is 'contingent on users' need-related circumstances and risks' and changes in them (Davies, 2005, cited in Johnson et al., 2005, pp.625-626). The implementation of a case management process in Hong Kong is in principle likely to 'improve the efficiency and effectiveness in the production of welfare for older people' (Ferlie et al., 1989, p.11) by better targeting in a more planned manner.

Target efficiency describes 'the efficiency with which resources are allocated to and among those for whom receipt has been judged the most cost effective method of intervention' (Bebbington and Davies, 1983, p.311). It depends mostly on appropriate case finding and assessment (Davies and Challis, 1986), and equity of access. 'Horizontal target efficiency' refers to the proportion of those in need who get the appropriate service, while 'vertical target efficiency' measures the proportion receiving a service who actually satisfy the target criteria (Glendinning et al., 2004, p.15), that is, have the defined level of 'need'. In this study the principal focus is on the vertical target efficiency achieved within the two homes studied. It is less feasible to assess the horizontal target efficiency of the new policy within Hong Kong as a whole as good data on the needs of older people within the whole population are not available. However, if vertical target efficiency within the homes can be shown to have improved, then it becomes more likely that a higher proportion of those in the wider community with the needs characteristics defined by the policy are receiving appropriate support, and that therefore horizontal target efficiency has at least not been reduced.

This study hypothesised that premature applications for residential placement in Hong Kong needed to be reduced or prevented by operating the Standardised Care Need Assessment Mechanism after November 2000. It was expected that assessments conducted by the 'accredited assessors' were likely to be more objective and efficient. The use of a standardised tool would also help to save time in completing each assessment and reduce duplications. Simply put, it was expected that the formal 'gatekeeping' mechanism tends to add 'vertical target

efficiency' (Bebbington and Davies, 1983) by ensuring those who will benefit most receive support. The policy should target the 'most needy' older people to receive appropriate care in the first place. In the current study, this refers to older people who need of residential care. The research was not able to study directly those who require community or home care services.

According to Robert Walker (2005), effective targeting is concerned with whether the service recipients 'are those intended and the extent to which expenditure is used as anticipated' (pp.179-180). It refers to both people (actual and potential beneficiaries) as well as resources. Within the total population, there are two subsets: the target population and the recipient population. The target population refers to the set of people 'intended to' receive benefits, whereas the recipient population refers to those 'actually receiving' the benefit. The target and recipient populations can intersect to form 'three distinct subsets' named A, B and C. 'A' refers to 'ineligible recipients', 'B' refers to 'eligible recipients', and 'C' refers to 'eligible non-recipients or eligible non-claimants'. Both the claimant and target populations are 'changing continuously as individuals move in and out of eligibility' as well as 'due to changes in their circumstances, and decisions whether to claim benefits or not'. Simply put, better targeting can be achieved if the proportion of ineligible recipients ('A') is reduced while that of 'eligible non-recipients' ('C') is increased.

Good targeting has to consider whether the allocation of resources is matched with 'user variations in risks, needs, likely service effects on the risks and needs, and the relative value of the different benefits' (Davies, 2005, cited in Johnson et al., 2005, p.627). This applies to matching appropriate resources such as various types of residential services with the different and ever-changing needs of older people in Hong Kong. Poor targeting and unmet needs are caused by several factors, including mismatches between the policy intention and the target population, mal-administration and measurement error (Walker, 2005, p.191).

Technical or cost efficiency

Another intended consequence of the new 'gatekeeping' policy is the

implicit intention of the government of Hong Kong to reduce the costs of long-term care. Efficiency is linked to 'the rational use of available resources' (Pruger and Miller, 1991, pp.5-24), either through maximisation or minimisation. It involves a better relationship between means and ends, inputs and outcomes, costs and benefits. Greater efficiency through maximisation is possible if more can be gained with the same amount of resources. At the same time, efficiency through minimisation is acquired if the same outcome can be accomplished with fewer resources. According to Knapp (1984, p.70), efficiency is more about 'the size of the social care "cake"', while equity is concerned with 'its allocation or distribution between individuals'. Efficiency is achieved by 'allocating resources to generate the maximum possible output'. If the outputs are generated at a minimum cost or at a maximised profit, 'technical efficiency' or cost-effectiveness can be added. By 'technical efficiency', is meant 'the extent to which output is maximised within a given service' resource (ibid, p.78), such as by introducing new procedures or technologies to improve output.

The data collected for this study were intended to allow evaluation as to whether the intended consequences of the 'gatekeeping' policy in Hong Kong were achieved after its implementation in late 2000, and whether this involved any financial implication in terms of the costs and efficiency of long-term care.

Unintended consequences

Any purposive act, according to Robert K. Merton (1936), leads to unintended outcomes as well as or instead of the intended ones. These unforeseen outcomes, often difficult to anticipate, may give rise to favourable or negative situations. At the same time, unintended consequences may arise from the complex nature of this world, in which a variety of functional systems interact with one another and respond to changes in each other and the wider environment. Unforeseen consequences 'should not be identified with consequences which are necessarily undesirable (from the standpoint of the actor) …' (p.895). More recently, Perri 6 (2010, p.51) has written that an unanticipated consequence of a policy refers to 'one that transpires, but which was not conceived in advance by the policy-maker'. An

unwelcome consequence is one that 'falls outside the scope of outcomes regarded by policy-makers as desired, or as goals of their original decision'. Furthermore, he constructs a simple typology that categorises eight broad types of consequences of reform based on 'anticipation, intention, and welcome for a policy outcome' (ibid, pp.52-53). These include bad surprises, happy surprises, despairing hopes, unconscious self-destructive intentions, benign side-effects, risks knowingly run, regrets, and successes. As this research will show, at least some of these kinds on unintended consequences did occur after November 2000.

Merton (1936, pp.900-902) classifies the factors may give rise to unanticipated consequences. First is 'ignorance of certain aspects of the situation' due to the human inclination to take things for granted. Human beings often act according to 'opinion and estimate' instead of 'scientific knowledge', and it is almost impossible to foresee and anticipate things from all perspectives. Secondly, people may commit an 'error' in appraising facts which probably involves 'the too-ready assumption' that previous habitual actions leading to the desired outcomes will continue to occur. This includes 'technical error' in making wrong interpretations or analyses as well as 'analytical error' in making incorrect analysis of circumstances and failing to consider the dimensions of time and space. Thirdly, the reason may be related to the 'imperious immediacy of [current] interest'. For example, individuals often fail to consider other possible or further outcomes or risks of the same act. Lastly observers may distort 'the objective situation' and 'the probable future course of events', and thereby leading to unexpected consequences.

The quality of care

While the new policy explicitly sought to achieve better targeting, resource matching as well as shortening the waiting list and waiting times for admission to residential care homes, it seems that the government had not considered other important issues properly: such as the quality of care and the quality of life of residents. In a context of limited resources, it is common to find quality of service being conflated with quantity of service (Titmuss 1963, p.23) and this research

sought to explore whether the greater 'efficiency' of long-term care is being achieved at the cost of the quality of life of residents.

A range of literature suggests that the care relationship between staff and residents in residential homes is of paramount importance. In order to attain and enhance care quality, 'time to care' is essential to developing a positive care relationship (Lewis and West, 2014, p.14). Most strikingly, 'the quality of interpersonal relationships with staff', not other aspects of care, form the basis for most residents' positive as well as negative experiences in the nursing home (Grau, Chandler and Saunders, 1995, p.34). The literature shows that a majority of residents perceive that having a good relationship with staff implies 'a good standard of care'. The most frequently reported 'worst' experiences are also associated with staff, particularly those who provide direct, hands-on care to residents in nursing homes. But due to low wages and benefits, the lack of continuous job training as well as few promotion opportunities based on job performance, it is found that care staff have 'little extrinsic motivation' to render high quality of care (ibid, p.39). Limited continuity in the staff who provide care is also a source of discontent (Lewis and Glennerster, 1996). The literature shows that home visits are often rushed leaving little time for social dialogue (Lewis and West, 2014, p.5). These are some of the main ways in which the research literature has shown that care reforms are likely to encounter problems.

Reciprocity is of crucial importance in all kinds of human relationships, including those between staff and residents. Interestingly, the engagement of staff in caring behaviours 'allow residents to reciprocate', such as sharing past stories and followed by residents' showing concern for the health of nursing assistants (Grasser, 1996, pp.11-13). In that study, over 58 per cent of staff 'often shared' stories or their past with residents. Consequently close to 32 per cent of residents 'often showed' concern for the health of nursing assistants, and approximately 33 per cent 'often showed' concern for their personal life. Similarly, the development of 'personal and responsive relationships' between staff and residents is found to contribute positively to the quality of care. For instance, staff spending time talking with residents about

the ‘small but important details’ such as about pictures in their rooms, sharing personal information about themselves, instead of just focusing on the daily tasks to be completed (Brown Wilson, Davies and Nolan, 2009, pp.1051-1052). These are the consequences of more ‘personalised care’. The literature shows the benefits of staff-resident interactions, receiving support as well as providing support, and being able to reciprocate as being of great importance for older people (Boerner and Reinhardt, 2003).

Quality of life

Relationships between residents also contribute significantly to the quality of life in institutional care. However, the importance is often underappreciated by the policy-makers and administrators. Though material well-being for the individual, group or nation is ‘quantifiable’, ‘the benefits to society of harmonious relations’ are not easily quantified, such as ‘listening and caring’, or ‘how to help people use their loneliness …’ (Abel-Smith and Titmuss, 1974, p.255).

The literature shows that within care homes, generally over half of residents report ‘having a close friend’, with the most being fellow residents and some being staff (Bitzan and Kruzich, 1990). As Kovach and Robinson (1996) remark, an ‘unavoidable’ roommate relationship does offer residents ‘a chance for communication and companionship’ (p.628). But, unfortunately a significant minority of residents has ‘little or no interaction’ with their roommates. Almost half of respondents ‘never’ talk to their roommates’ about family, health, community events, religion, death, television, nursing home, other residents, old age problems. The reasons given centre around physical barriers to communication such as deafness, speech impediments, and mental confusion of roommates (ibid, pp.631-632). It is clear, however, that roommate rapport contributes positively to the life satisfaction of residents, especially for those who talk to their roommates (Park, 2009, p.461).

Talking is observed to be the most common activity among residents who can speak and hear (Gutheil, 1991). There are some popular topics including ‘the weather and the behaviour of other residents’ (Hubbard, Tester and Downs, 2003,

p.104). However, difficulties in vision, hearing, and communication may restrict individuals' capacity to maintain and develop interpersonal relationships, to participate in activities, and to preserve a healthy sense of self and well-being (Resnick, Fries and Verbrugge, 1997). Where a high proportion of residents have high levels of disability, because they have been judged eligible on that basis, the community and relational components of residential care are likely to be reduced.

Research shows that there is close relationship between visual impairment and functional deficits in daily personal care activities among residents (Horowitz, 1994; Sturgess, Rudd and Shilling, 1994). Poor visual functioning is a common disability among old age home residents. It is found to be related to old age, ADL limitations, hearing impairment as well as the prevalence of disruptive behaviours in the study by Horowitz (1997). Moreover, the prevalence of blindness tends to be higher with the rise of advanced age (Tielsch et al., 1995).

Hearing impairment may also reduce daily interaction and communication with other people, and is more commonly found among the very old. It is found to be associated with low social engagement, reducing the ability of a person to establish and maintain relationships as well as to take part in the organised activities (Weinstein and Ventry, 1982; Rudberg et al., 1993). Hearing disability causes obstacles to verbal conversations, and is compounded if hearing aids are not worn or are mislaid by residents (Hubbard, Tester and Downs, 2003, pp.104-105). Nevertheless, with appropriate encouragement some residents with hearing and verbal impairments use non-verbal behavior in meaningful ways to communicate. Humour can be a positive form of 'verbal and non-verbal social interaction' among the residents, such as making light of their own and each other's physical frailties and ageing bodies, reducing worry and concern about accidents (ibid, p.110). But opportunities for all these positive forms of interaction require that skilled staff are aware of their benefits and that the opportunities are facilitated.

Cognitive impairment is found to be closely connected with advanced age and female gender in the local research studies (Liu et al., 1993; Ho et al., 2001). It is well researched in other studies (Gill et al., 1996; Smits, Deeg and Jonker, 1997;

Nikolova, Demers and Beland, 2009) that there is a positive association between cognitive status and functional abilities among older adults in performing ADLs and IADLs. The 'Disablement Process' (Verbrugge and Jette, 1994) posits that a decline in cognitive states of older people will affect their functional limitations and subsequent disabilities in everyday living. On the other hand, cognitive impairment frames the ways in which residents socially interact. Some acts of 'hostility' may occur and direct towards residents who exhibit disturbing behaviours such as 'staying up through the night' (Hubbard, Tester and Downs, 2003, p.110). These behaviours can be negatively interpreted and labelled by other residents. Similarly, physical frailty also affects the social interaction among residents in care homes and people can be particularly disturbed by individual behaviours such as coughing and repeated getting out of a chair (ibid, p.109).

Chapter summary

Long-term institutional care policy in Hong Kong now focuses on targeting and admitting those with higher impairment levels to institutions. Others with few or mild impairments are to receive informal and/or domiciliary care. In policy planning, it becomes apparent that the government has made a 'too-ready assumption' that family will take care of its older members adequately in the community. What data there is available of patterns of informal care suggest things are more complicated. In addition, greater selectivity based on disability has not had the consequences for waiting lists that were expected. As shown by the Census and Statistics Department (2005), 25 per cent (being 14000) of the residents staying in institutions were without any ADL impairment. Although the new policy, 'the Standardised Care Need Assessment Mechanism' has been implemented since November 2000, it is clear that both the waiting lists and the waiting times for Care and Attention homes have not been shortened as anticipated by the government.

In this study the researcher seeks to examine the impact of the 'gatekeeping' policy on the two residential care homes of the Helping Hand in this territory; to see if the intended consequences of better targeting and greater cost efficiency can be

achieved, and to find out who are the ‘winners’ and ‘losers’ from policy shift. At the same time, informed by the literature on unintended consequences the researcher used direct observation and data provided by the homes to explore the ‘efficiency’ and quality consequences of the new policy of selectivity. Targeting efficiency may have been gained at the expense of other crucial aspects such as the quality of care and the quality of life of the residents. Summing up, the outcomes of policy are examined in terms of three aspects - target efficiency, cost efficiency, and effectiveness of care.

Chapter 6 The Research Methodology

In this chapter the methodology (research design, hypotheses, data collection and analysis) is linked to the research aims and questions. This is a cross-sectional study of a defined population which focuses on major changes that occurred between 1990 and 2006 in two residential care homes run by the Helping Hand organisation. As discussed in Chapter 5, the 'Standardised Care Need Assessment Mechanism' (SCNAM) for the targeting of publically supported institutional care of older people was implemented from November 2000 with the primary intention of better allocating resources to those in greatest need. The research intention was to compare and contrast the dependency characteristics of the residents in the two care institutions before and after the introduction of this 'gatekeeping' policy, studying their physical health, functional abilities, cognitive status, and levels of frailty. Initially, a modified version of the Clifton Assessment Procedures for the Elderly (CAPE) instrument had been adopted by a staff team of the Helping Hand in a 1990 study. The same measuring instrument was used by this research in 2006. The fundamental question was to see how the 'gatekeeping' policy, the Standardised Care Need Assessment Mechanism (SCNAM), had achieved in the context of these two care homes its objective of better targeting of long-term care for older people as claimed by the government of Hong Kong. A range of data about the characteristics of the residents of the homes, the staff and the care routines was collected and T-tests and Pearson correlations were used to test the direction and strength of relationships between the variables, and to inform analysis of the findings.

For decades a variety of scales have been used to measure levels of dependency in studies of older people. Functional assessments usually involve three main dimensions, conventionally named, 'activities of daily living' (ADLS), 'instrumental activities of daily living' (IADLs), and mobility (Spector, 1990; Kane and Kane, 2000). These measures seek to be 'the systematic process of identifying or assessing the capabilities and deficiencies of persons at risk as arisen from aging and ill health' (Bernstein, 1992), and have been widely used among frail old people in care homes and those living in the community with chronic health problems (Zimmer, Rothenberg and Andresen, 1997). Measures such as the Clifton Assessment Procedures for the Elderly (CAPE) (Pattie and Gilleard, 1979), the modified Crichton Royal Behavioural Rating Scales (Wilkin and Jolley, 1979) are often used. The Nursing Home Disabilities Instrument (NHDI) has also been identified as a valid and efficient multidimensional instrument for assessing the ability levels of the nursing home residents (Valk et al., 2001).

In the current research, the Clifton Assessment Procedures for the Elderly (CAPE) devised by Pattie and Gilleard (1979), two distinguished clinical psychologists at the Clifton Hospital, is used. The CAPE instrument consists of two main parts: the Cognitive Assessment Scale (CAS) and the Behaviour Rating Scale (BRS), which can be used together or independently depending on the specific purposes. Using this instrument, the cognitive and behavioural abilities of older people can be quickly assessed within a brief period of time. The CAS provides an assessment of mental functioning, and has been shown to be applicable to elderly patients (Pattie and Gilleard, 1975). The BRS is a shortened version of the Stockton

Geriatric Rating Scale used to assess behavioural abilities and disabilities. The CAPE is widely recognised as 'a short, brief, easily administered assessment of deficits' (Mulgrave, 1985, p.180). It can be used for basic screening and deciding 'the most appropriate living arrangements or the degree of support and services necessary for an elderly client'. McPherson and others (1985, p.83) show that the short survey version of the CAPE (Pattie, 1981) is useful in distinguishing older people with different dependency and impairment levels for screening or research purposes, albeit with uncertain 'clinical value with individual patients'. Gibson, Moyes and Kendrick (1980, p.556) suggest the CAPE is most appropriately used 'when an assessment of dependency needs is required, and when management decisions must be taken'. Due to its long and extensive use, the CAPE instrument provides a well-tested benchmark for use with older people in, or being considered for, residential care.

The research design

This study is built on a pioneer project conducted by a staff team in the five residential care homes run by the Helping Hand organisation in Hong Kong: at the Chak On, Lai Yiu, Lok Fu, Kwai Shing, and Tai Wo Hau Care Homes in 1990. Its main objective was to assess the dependency levels and characteristics of residents after admission to these care homes. It enabled continuous assessment of the residents as well as the quality of care provided to them. Using the modified version of CAPE, it had been conducted three times in January, March and July of 1990.

For every older person respondent, there are two sets of questionnaires; one

completed by a nurse, and another by a member of the care staff. Every respondent was interviewed by a nurse and Personal Care Worker (PCW) who conducted interviews separately with the same residents in the three points under study in 1990. Eventually a total of 229 residents from the five care homes were interviewed. The total number of completed questionnaires was 1375. All these data files contain valuable information on the elderly residents, including their physical condition, self-care abilities, cognitive abilities, behavioural problems, sociabilities, relationships with other residents, staff as well as relatives.

The same measuring instrument, the modified version of CAPE, was adopted and replicated in this cross-sectional study in 2006. The objective is to make comparisons of the changes in the local residential homes across the period 1990-2006. Minor modifications were made in the light of known deficiencies of the measuring instrument. Among the five homes in the 1990 survey, two were selected for the current study: the Chak On Care Home and the Lai Yiu Bradbury Care Home. This was mainly due to the constraints of time, person resource, and administrative concerns. Regarding the location of the five care and attention homes, two are situated on the West Kowloon side of Hong Kong, while the other three belong to the western part of the New Territorities. In order to acquire representativeness, this study chose one home from each of the two different regions in Hong Kong for the study in 2006, comprising a total of 152 respondents. The findings are then used to compare with those in the July 1990 survey, which is the ‘only’ one that contains records of the residents’ ages. A total of 122 older respondents (60 from the Chak On Care Home and 62 from the Lai Yiu Bradbury Care Home) were interviewed during

the July 1990 study.

In this quantitative study, the structured questionnaire (Appendix 1) includes an assessment of the older residents' functional abilities, mobility levels, cognitive status, relationships with other residents and staff. Under the Cognitive Assessment Scale, nine questions (Q.15 to Q.22) are asked of the older persons about understandings of their own names, age, present place of residence and time. Aside from that, the elderly respondents were asked to answer Question 23: 'Will you count up from 1 to 10 - as quickly as you can?' to test their cognitive ability. The Behaviour Rating Scale covers four sub-scales of important aspects of behavioural disability amongst older people. Firstly, physical disability includes levels of mobility, incontinence, ability to feed, dress, bathe themselves (Q.6 to Q.9 and Q.24 to Q.32). The second set is about communication ability, which includes expressiveness, comprehension, vision, and hearing (Q.10 to Q.14). The third sub-scale assesses social behaviours such as wandering, accusing others of doing bodily harm or stealing possessions, sleeping patterns (Q.33 to Q.37). The fourth aspect relates to levels of involvement within the residential home, such as engaging in the home's activities, willingness to help others, talking with staff and other residents (Q.38 to Q.46). In addition, information about personal particulars was collected. In order to fulfill the research objectives, six questions (Q.49 to Q.54) were added to this evaluative study. These sought information about the respondents' marital status, educational level, financial situation, prior living arrangements, and date of home admission. Summing up, the dependency levels of the respondents were measured in a comprehensive way through the use of this modified CAPE

instrument.

Inter-rater reliability

Previous studies have tested the reliability and validity of the CAPE instrument. As Pattie and Gilleard (1979) show, long-term test-retest reliability is likely for 'more static populations' in residential facilities, as their cognitive status tends to 'provide a more stable index of level of functioning' (p.20). Despite its simple and brief procedures, the Cognitive Assessment Scale (CAS) has been found to be 'a more sensitive predictor of outcome in the elderly psychiatric patient population' (p.24), compared with, for example, the detailed Wechsler Adult Intelligent Scale (WAIS).

As far as the reliability of the Behaviour Rating Scale (BRS) is affected by use by different observers Pattie and Gilleard (1979) show that the test takes account of a level of agreement between raters, during the same period of observation.

In the previous 1990 study, briefing sessions were held with all the staff involved so as to reduce inconsistencies and to ensure all interviewers used the same yardstick for measurement. For each question, there is a set of criteria with which interviewers were required to be acquainted with prior to conducting interviews. Each elderly respondent was interviewed separately by a nurse and a Personal Care Worker three times in 1990. This produces some variations in the results as indicated in the Pearson Correlation. For variables like 'wanders within the Home without specific purpose' and 'shows willingness to help others', the Pearson correlation coefficients are 0.307 and 0.325 respectively which indicate insignificance (Table

6.1). Nevertheless all items under the Cognitive Assessment Scale, as well as the Behaviour Rating Scale in the questionnaire, are found to be statistically very significant, except for the two variables on ‘accusing’ and ‘sleep pattern’. The level of significance of all other items, including mobility level, communication difficulty, orientation ability, and social disturbance, is $p = 0.000$. In view of this pattern reliability and validity, the modified version of the CAPE instrument was used in this study, and administered in a way as similar as possible to the early studies. Unlike the previous 1990 survey, all the interviews were solely conducted by the researcher in 2006. Information was collected from a proxy if the older person was too frail to respond to the questionnaire. Proxies included nurses, social workers, and personal care workers.

Table 6.1 Inter-rater reliability

Variables	Pearson correlation coefficient	Sig. level
walking aid	0.900	0.000
mobility	0.802	0.000
urine incontinence	0.727	0.000
faeces incontinence	0.651	0.000
expressiveness	0.443	0.000
comprehension	0.395	0.000
vision	0.307	0.000
hearing	0.382	0.000
hearing aid	0.317	0.000
state 'name'	0.492	0.000
state 'age'	0.513	0.000
state 'date of birth'	0.598	0.000
state 'living place'	0.616	0.000
state 'region'	0.639	0.000
state 'day'	0.603	0.000
state 'month'	0.604	0.000
state 'year'	0.587	0.000
counting	0.544	0.000
toileting	0.814	0.000
dressing	0.752	0.000
feeding	0.455	0.000
washing	0.695	0.000
bathing	0.816	0.000
shopping	0.649	0.000
managing money	0.714	0.000
grooming	0.716	0.000
bed making	0.704	0.000
wandering	0.307	0.000
day disturbance	0.361	0.000
night disturbance	0.335	0.000
accusing	0.130	0.066
sleep pattern	0.151	0.033
helping others	0.380	0.000
constructive activities	0.317	0.000
willingness to help	0.325	0.000
talk with residents	0.397	0.000
conflict with residents	0.251	0.000
sociability	0.461	0.000
talk with staff	0.393	0.000
conflicts with staff	0.211	0.000
visit by relative	0.571	0.000

The research aims

Though the Standardised Care Need Assessment Mechanism (SCNAM) for elderly service has been used since November 2000, little has been done to assess the policy outcomes so far. Various aspects of change that have been taken place in the two Care Homes in Hong Kong during the period 1990-2006 are the focus of the present research. These include the demography, daily life and dependency characteristics of the older residents, together with the staffing and financial condition of the two Care Homes. The aim is to compare the dependency and demographic characteristics of the residents at two points of time, particularly whether they are different or remain the same after the introduction of the formal 'gatekeeping' mechanism. Furthermore, this research examines whether service resources have been better allocated and targeted to those older people with the greatest need of care, and whether greater efficiency and effectiveness of long-term residential care are likely to have been achieved by this policy initiative.

Clearly, this study belongs to a form of 'summative evaluative research', as it involves collecting data about a programme intervention 'either during or after its application with the aim of deciding whether it should be continued or repeated' (Netten, 2002, p.176). This summative evaluative research is applied to help reach judgements about the degree of success of a government policy, particularly how far it improved the matching of resources, needs and outcomes of care (Davies et al., 1990), and whether this affects the outcomes of care in a positive manner or not.

Hypotheses

1. Under the Standardised Care Need Assessment Mechanism used since November 2000, only more seriously disabled older individuals will have been admitted to residential homes. In this way, the 'gatekeeping' mechanism is likely to have contributed to a more efficient provision of residential care in Hong Kong.

2. The admission of more disabled older people is likely to have affected the resident case mix in the two Care and Attention homes, and may have adversely impacted on the degree of social participation of older people.

3. With the change in the resident case mix, there may be evidence of an increase in the workload of caring staff in the two residential homes in 2006 when compared to that in 1990.

4. If additional staff numbers and skill have not been added to care for the increasing number of very frail residents in the two care homes, this may have had a negative impact on the outcomes or effectiveness of care.

Research questions

This study investigates the following questions:

1. With the inception of the Standardised Care Need Assessment Mechanism in late 2000, had the two residential homes of the Helping Hand undergone any changes by 2006 when compared with 1990, in terms of the demographic and dependency characteristics of the residents?

2. Has better targeting been achieved following the implementation of the formal

'gatekeeping' policy? Are the two residential homes admitting older persons who are more genuinely in need for care? Are the homes operating in a more efficient manner in 2006 than in 1990, in terms of costs and staffing?

3. Has the selection policy impacted upon the workload of the care staff? In what ways does the resident case mix affect the staff workload in the two care homes under study?

4. Has the selection policy changed the lives of the residents? Are there changes relating to the social participation of the residents in the two care and attention homes across the 16-year time period? What is the interaction between the residents and the staff as well as among the residents themselves at the two points of time? What are the factors contributing to any changes?

5. Are there any positive or negative unintended consequences attributable to the implementation of this 'gatekeeping' policy?

Access to the two homes under study

This research took place in the two institutional settings run by the Helping Hand organisation: the Chak On Care Home and the Lai Yiu Bradbury Care Home. Both care homes admit older persons (aged 65 and above) who are in poor health or suffer from functional disabilities and require assistance in self-care such as toileting, dressing, feeding, bathing. People lacking appropriate care can apply for admission to these institutions. Unlike most of non-governmental organisations (NGOs), the Helping Hand has its own unique funding system. Apart from receiving donations from the Hong Kong Jockey Club Charities Trust, the Community Chest Allocation

and other charity groups, it organises a 'Cookie Campaign' annually and other fundraising events. It does not rely wholly on subvention from the government (namely, the Social Welfare Department) which purchases places under the Bought Place Scheme/Enhanced Bought Place Scheme. In the 1990s, the homes under study also accepted referrals from the Housing Department. Since 2003 all places in the Chak On Care Home became 'bought places' by the Social Welfare Department.

Chak On Care Home

The Chak On Care Home commenced its service operation in January 1989 with a total capacity of 87 older persons, including 28 males and 59 females. Owing to the physical design, residents are allocated to live in three separate blocks within the same housing estate, namely, Lai Chak House, Wing Chak House and Wah Chak House. The General Office is located in the first block - Lai Chak House, where the Superintendent, Nurse-in-charge, social workers, and clerical staff are stationed. The older people are allocated to nine dormitory bedrooms, with each accommodating four to five residents. As at mid-September 2006, the resident population was 43. Next to the General Office is a common room for the residents to dine together, watch television and participate in some activities. The second block, Wing Chak House, consists of four rooms, each with an average capacity of around six persons. The total number of residents can be 25. Likewise, a dining room with television set

is available for the use of older people. Wah Chak House (the third block) has the lowest capacity, serving a total of 19 residents whose impairment levels appear to be more severe. As there is only one kitchen situated at the first block (Lak Chak House) to serve the needs of all the 87 residents, the staff have to walk around and assist in distributing food among the three blocks during the three meal times every day. At night time, there is only one Registered Nurse (RN) on shift duty. This nursing staff member (usually female) has to tour around to oversee the well-being of all the frail old residents scattered across the three separate blocks. This caused inconvenience and sometimes even mess in times of emergency.

Lai Yiu Bradbury Care Home

The Lai Yiu Bradbury Care Home is built as an independent housing block with three storeys, and thereby faces less difficulties than the Chak On Care Home. It began operation from January 1988, providing care places for 76 older people (including 23 male and 53 female residents). The General Office for the Superintendent, Nurse-in-charge, and social worker is situated at the Ground Floor. Within this care and attention home, an elevator is available for the use of visitors, residents and staff. On the first floor, there are eight dormitory bedrooms for residents with higher levels of frailty. Each room accommodates six persons who have to share toilet and bathing facilities with other roommates. There are altogether 52 beds on this floor.

Handrails are installed along the corridor to help the frail old residents walk around independently on their own without staff assistance. At the one end of the first floor, there is a dining room and equipment for doing physiotherapy. On the wall, the date of each day is posted on to orient the residents and keep them aware of the here-and-now. Opposite this dining area is the Nurse Office, where the nursing staff gather for daily duty handover meetings and case discussions. Next to this office is the kitchen which serves meals for the staff and service-users.

A most distinctive feature of the Lai Yiu Bradbury Care Home is its colourful physical design as well as the 'couple rooms' that are not commonly found among other homes within the Helping Hand. Originally the twelve rooms situated at the Second Floor were designed to serve only elderly couples. Owing to some practical constraints, the utilisation of rooms by couples is low. With the adoption of the Standardised Care Need Assessment Mechanism since late 2000, very few couples were jointly eligible for residential homes unless both of them were seriously impaired at the same time. In the end, these 'couple rooms' failed to serve the initial purpose, and came to accommodate twenty-four older persons who are not couples. In between the adjacent rooms, washroom facilities are shared among the four roommates of every two 'couple rooms'. For safety purpose, these facilities are without locks, only with loose curtains. At the one end is the dining room for the residents, who can also stay and watch television during the day. Next to it are the staff quarters for the Home Superintendent. Outside is an open area for the older people to meet their family relatives and friends.

The data collection and interview process

Prior to the field study, the two Superintendents of the Chak On and Lai Yiu Care Homes kept all the staff as well as the residents well-informed about the purposes and time of interviews, the role and identity of the researcher. The information, both verbal and written, was distributed by the Superintendents during the staff daily duty meetings. Before starting the interview, the researcher introduced herself first and explained clearly the purposes of this study. Residents (including those with cognitive or sensory impairments) gave informed consent or by proxy. At the administrative level, every resident had already signed various kinds of consent forms as required by the agency before admission. With the reassurance of the 'confidentiality principle' in this study, the researcher conducted interviews with the elderly respondents on an individual basis. Moreover, the researcher observed and followed strictly the guidelines set out in the 'Code of Practice for Registered Social Workers' issued by the Social Workers Registration Board, a professional and statutory body in Hong Kong. Reference was also made to the 'Guidelines for the Ethical Conduct of Research Involving Human Participants' as adopted by the researcher's employing university. Clear procedures were in place to remove all information that would identify individuals in the data and analysis. For convenience, interviews were usually held after meal times. To ensure privacy, most of the interviews were conducted with the residents at their bedside, especially for those wheel-chair bound or bedfast. Some were held in a corner of the dining room when the elderly respondents were taking breaks after meals.

All the face-to-face interviews were conducted solely by the researcher in

the two residential care homes of the Helping Hand. In order to ensure consistency when making comparisons with the findings in 1990, the previous set of criteria devised for each question were also followed in the present study. The sample consisted of all the 152 residents in the two Care Homes, comprising 80 in Chak On and 72 in Lai Yiu Care Homes. Interviews were carried out during September and October of 2006, with each lasting for an average of approximately 20 minutes, depending on the different ability levels of the residents. Before asking questions such as No.33 to No.42, the researcher illustrated the meaning of 'frequently', 'sometimes', 'rarely or never' to the respondents. When necessary, some daily life examples were given. On the whole, the vast majority of the respondents in the two care and attention homes were willing to respond to the questions. Some residents expressed gratitude for the visits by the researcher and were keen to have further talks with the latter after interviews.

A coincidence occurred when once the researcher went to the Chak On Care Home to conduct interviews and saw a celebration on the Chinese mid-Autumn Festival being held in an afternoon in September 2006. During this recreational activity, the Superintendent and the social worker went around the three separate blocks at the Chak On housing estate, singing old and popular songs and playing games with the older people. On this occasion, the researcher took the chance to observe the ability levels and degree of participation of the residents right on the spot.

Once in an afternoon the researcher grasped another opportunity to observe a social activity ('passing a ball') as organised by the staff of the Lai Yiu Bradbury

Care Home. Most of the older participants lacked physical energy and could hardly move or pass the big ball. Very often, it was only the assistance of care staff that kept the activity going on. Interactions and dialogue among residents as well as between staff and residents were observed to be minimal. A staff member volunteered that this was because the increased disabilities amongst the residents had raised the workload.

Data analysis

The analysis is largely quantitative. The T-test and the Pearson correlation are used to verify the strength as well as the direction of relationships, such as relationship between the residents' dependency characteristics and their degree of social participation, relationships among resident case mix, social participation levels and increased staff workload. The level of significance is the correlation coefficient. The findings in 2006 are collected and compared with those in July of 1990, to see if there has been any change in the demographic and dependency characteristics of the older residents at the two points of time. The data gathered is used to present an overall picture about the residents' dependency characteristics and assess the degree to which the government's policy of appropriate care targeted on the most dependent older people is achieved.

Apart from using the structured questionnaire (the modified CAPE version), the researcher reviewed the *Annual Reports* of the homes (Helping Hand, 1991-2006). This was to examine whether there were changes relating to the staffing levels, home expenditures, costing and subsidies from the government during the

16-year period under study. Furthermore, interviews were conducted with the Superintendents of the two homes to get supplementary information about the daily service operation especially after the policy implementation of the Standardised Care Need Assessment Mechanism since 2000. The researcher also recorded observational data collected during visits, particularly on the 'special occasions' and this has been used where appropriate to add to the more systematic data collection.

Limitations

Changes in the dependency characteristics of the residents in the two residential care settings are important in showing how the 'gatekeeping' policy is working. Nevertheless, this is only one way of looking at the evidence. Other aspects are important such as the quality of life of residents and the quality of care provided by care staff. Secondly, the researcher was sometimes faced with obstacles when approaching the older residents with severe functional disabilities or impairment levels such as those who were profoundly deaf, inarticulate, or confused. Sometime more explanation had to be given to respondents who had difficulty in comprehending the questions. Supplementary information was on occasion collected from staff, including nurses, social workers. Personal care workers helped to translate to respondents on the spot or refer to the written records. To ensure more reliability and validity, the researcher took further steps to double cross-check with the staff after the completion of interviews where there were doubts about information provided by the elderly respondents themselves, such as the source of referral, date of birth, and financial status.

Throughout the whole process of the field study, the majority of the residents showed cooperativeness in answering the questions. Despite the prior notice from staff and explanations about the purpose of interview, two of the respondents asked if the researcher was a government official who came to investigate their real life situations. To a certain degree, this sort of perception may have affected genuine responses during the face-to-face interviews. Lastly, a few residents expressed difficulties in responding to the question of 'prior living arrangement before admission to care home'. Despite further explanation, some still expressed doubts in answering this question, which might be a sign of poor memory.

Chapter summary

This chapter describes the research design, methodology, aims, hypotheses, and questions addressed in this cross-sectional study. The modified version of the CAPE instrument used in 1990 project is replicated for use in 2006. Among the five care homes in the previous survey, two used for the current study: the Chak On Care Home and the Lai Yiu Bradbury Care Home. Altogether 152 older residents from these two homes were assessed in this research. Through the period of field study from September to October 2006, the researcher held face-to-face interviews with all the older residents in the two homes, and administered the structured questionnaire independently by herself. Each interview took around 15 to 30 minutes, depending on the different ability levels of individual older persons. For those unable to answer the questions due to cognitive and/or physical factors, the assistance of a staff such as a nurse, social worker or personal care worker (PCW) was sought.

Using T-tests and Pearson correlations, the data collected was statistically analysed to test the research hypotheses. These aim to measure the degree of success of government policies of 'community care', particularly the introduction of the formal 'gatekeeping' policy, the Standardised Care Need Assessment Mechanism. By assessing change in the degree of frailty of the older people living in the two homes, it is possible to draw broad conclusions as to whether institutional provision supported by government funding has become more targeted on those with higher levels of disability and so also means that those with lesser levels of disability are more likely to be living, probably with support, in the community. Above all, this study seeks to evaluate whether better targeting of care, within the terms defined by government policy, had been achieved after late 2000, and whether this has had any impact on the outcomes of care in the two old people's homes of the Helping Hand across 16-year time period.

Chapter 7 Changes in the Resident Case Mix: 1990 to 2006

This chapter examines data collected on the demography, dependency characteristics and ability levels of older people living in the two Care Homes of the Helping Hand in 2006. Furthermore, it investigates whether any changes occurred from 1990 to 2006, particularly with the introduction of 'the Standardised Care Need Assessment Mechanism' (SCNAM) from November 2000. All the older people in residence in the two Care Homes had been there less than three years as at 1990. This was due to the commencement of service operation at Chak On and Lai Yiu in 1989 and 1988 respectively. At the time of writing, very few residents in the two Care Homes had been admitted prior to 1998. In order to minimise the effects arising from the length of stay, this study has selected to focus principally on those with three or fewer years of residence. The use of a 3-year cut-off coincidently divides the total number of respondents in the 2006 survey into two halves, and provides a way of comparing long and lesser-stay residents. Though somewhat arbitrary, the choice of three years as a cut-off point is practical.

Two forms of analysis are presented. Firstly, the two cohorts - residents of more than 3 years and those of 3 years or less - are set side by side to reveal the changing characteristics of the older residents (if any) at the two Care Homes in the 2006 survey. Those with more than 3 years of residence will have received institutional care before the new policy (SCNAM), whereas those with 3 years or less were admitted after this 'gatekeeping' policy in late 2000. It is hypothesised that those admitted after the start of the new policy will have higher degrees of frailty. It is also likely that residents become more functionally impaired and older, the longer

their stay. However, it is to be expected that the introduction of gatekeeping will have reduced the differences in age and dependency between the longer and shorter-stay groups.

Secondly, comparisons are made between the findings in 1990 and 2006 to examine whether there were any significant changes between the two cohorts of residents with 3 years or less periods of stay at the two specific points of time. As hypothesised, the shorter-stayers in 2006 should be more disabled and older than their comparator group from 1990. Based on foundations of the 1990 data, this analysis explores changes in the resident case mix between 1990 and 2006.

Along with the inception of the formal 'gatekeeping' policy in late 2000, the present study places its focal interest upon whether admission policies have become more targetted. Those with higher levels of frailty and functional disabilities should have been given greater priority in admission to institutional care. Consequently new home residents are likely to be more frail, old and functionally impaired in 2006 than in 1990. Put in the other way, if these two Care Homes admit only those who are in most need of long-term care greater vertical target efficiency (the proportion receiving a service who actually satisfy the target criteria) in access and care are a more likely consequence.

Two cohorts of home residents in 2006

Comparisons are made between two cohorts, namely, those resident for more than 3 years versus those with 3 years or less of stay in the 2006 survey. In the first place, a T-test is used to compare the difference between the mean scores of the

two cohorts of residents in the two Care Homes at Chak On and Lai Yiu as at 2006.

Referring to Table 7.1, no significant differences ($p > 0.05$) are identified among many items across these two cohorts of home residents in 2006. Those resident for 3 years or less do not differ significantly from those with over 3 years of stay. However, there is some evidence of declining ability levels. This is well reflected from the higher mean scores in: 'walking aid' (3.11 versus 2.60), 'urine incontinence' (1.31 versus 1.08), 'faeces incontinence' (1.00 versus .74), 'vision' (.88 versus .74), and 'bed making' (1.69 versus 1.59).

On the other hand, the statistical significance is particularly prominent in the two variables of 'age' and 'hearing'. Concerning 'age', respondents with 3 years or longer period of stay appear to be distinctly older. The mean is 87.78, compared with that of 84.39 in the shorter-stay cohort (Table 7.1). As revealed by the T-test, the two cohorts differ significantly as at 2006 ($p = 0.007$; t-value = -2.742). In both residential facilities, more than 51 per cent of the respondents (3 years or less period of stay) belong to the age range of 80-89 (Table 7.2). Interestingly, over a quarter (26%) are of aged 90 and above. Hence in this shorter-stay cohort, about 77 per cent are classified as very old (aged 80 and above). Meanwhile, for those longer-stay respondents (having over 3 years of residence), the vast majority (approximately 87%) fall within the age range of 80 and above.

As far as the 'hearing' is concerned, residents experiencing 'no hearing difficulties' score '0', '1' for having 'some hearing problems' and '2' for 'totally deaf' respectively in the questionnaire (Q.13). Again a higher mean of .75 is identified among the longer-stay cohort in 2006, compared with that of .42 in 1990

(Table 7.1). T-test indicates a high significance level ($p = 0.003$; t-value = -2.992). Over half of the senior respondents with longer period of residence appear to experience severe hearing difficulties, comprising 18 per cent being classified as 'deaf' (Table 7.3). On top of that, around 39 per cent suffer from 'some difficulties'. While for those with 3 years or less of stay, the proportions are smaller, 5 per cent and 33 per cent respectively.

However, broadly speaking, those newly admitted (with 3 years or less of stay) appear to be almost as frail as those who have lived in the residential homes for over 3 years. This is some evidence that the use of 'the Standardised Care Need Assessment Mechanism' meant people with greater functional need were admitted to residential facilities.

Residents' conditions across the two Care Homes as at 2006

As there are no major differences between the two cohorts in 2006, the analysis explores if there exists any disparity across the two Care Homes of the Helping Hand. Again a T-test is used to measure the differences between the mean scores for those with 3 years or less residence period in the two local homes under study.

Among items such as 'mobility', 'incontinence', 'age', 'toileting', 'bathing', no significant differences ($p > 0.05$) are detected between the two care and attention homes (Table 7.4). Only in the two items of 'expressiveness' and 'bed making' do the older residents differ significantly at both institutional facilities. In the Chak On Care Home, the mean of 'expressiveness' equates to .76, higher than that of .28 in

Lai Yiu. Referring back to the questionnaire (Q.10), respondents 'being well enough to make oneself easily understood at all times' get '0', '1' for those who 'can be understood sometimes or with some difficulty', and '2' for those who 'can rarely or never be understood for whatever reason'. In this sense, the higher the score, the less their ability to express themselves. By comparison, older adults living at Chak On tend to be weaker in expressing themselves. As indicated from the T-test, the statistical significance is obvious ($p = 0.002$; t-value = 3.143).

While for 'bed making', residents at Lai Yiu get a higher mean of 1.82 when compared with that of 1.37 at Chak On (Table 7.4). Referring back to the questionnaire (Q.32), those requiring 'maximum assistance' attain the highest score of '2', whereas '1' and '0' for those requiring 'some assistance' and 'no assistance' respectively. Put in the other way, residents with 3 years or less residence in the Lai Yiu Bradbury Care Home tend to rely more on others' assistance in 'bed making'. The high statistical significance is reflected in the T-test ($p = 0.005$; t-value = -2.865).

Aside from the above instances, there were no big differences between the resident groups with over 3 years of stay in the two Care Homes under investigation. As clearly indicated in Table 7.5, most of the items show an insignificant statistical difference ($p > 0.05$). Only few items; 'mobility' (.018), 'managing money' (.037), and 'sleep pattern' (.020) differ significantly across the two Care Homes.

Residents at Lai Yiu were more dependent in terms of 'bed making', with the higher mean of 1.97 as compared to that of 1.46 in Chak On (Table 7.5). Concerning the orientation ability, those staying at Lai Yiu are assessed as more

disorientated towards the current region they live in. Its mean stands at 1.39, much higher than that of .77 at Chak On. Using the T-test, the two aspects of 'bed making' ($p = 0.001$; t-value = -3.620) and 'state "region"' ($p = 0.005$; t-value = -2.932) reflect a high statistical significance. However, briefly stated, the demographics and dependency characteristics of the residents appear to be very similar across the two homes under consideration.

Chak On Care Home

Referring to the 2006 survey, no significant differences ($p > 0.05$) are found in the Chak On Care Home relating to all items when comparing the two cohorts - older persons living there for 3 years or less compared with those with over 3 years of residence period. The only exceptions lie in the two items of 'age' and 'state "region"'. As revealed in the T-test, the levels of significance are high ($p = 0.021$; t-value = -2.347) and ($p = 0.026$; t-value = 2.265) respectively (Table 7.6). The longer-stay cohort (over 3 years of residence) tends to be much older, having a mean age of 87.51. For the shorter-stay cohort, this stands for 83.32. Meanwhile, the latter group is inclined towards stating the current 'region' wrongly. Its mean equates to 1.24, compared with the lower mean of .77 for those having over 3 years of stay. Referring to the questionnaire (Q.19), respondents who state their current region wrongly get the highest score of '2', and '0' for those answering in a 'correct' form.

Generally stated, older people with a more lengthy residence period appear to be declining in various aspects. This can be evidenced by the higher mean in items like 'walking aid' (2.90), 'mobility' (1.38), 'urine incontinence' (1.44), 'faeces

incontinence' (.92), and 'toileting' (.79) (Table 7.6). On the other hand, amongst those receiving long-term residential care after the 'gatekeeping' system (those with 3 years or less residence period), the mean scores of the items 'feeding' (.44), 'washing' (.51), 'bathing' (1.44), 'shopping' (1.51), 'managing money' (1.20), and 'grooming' (.54) are higher. Nonetheless, the significance levels of all these items are not statistically prominent ($p > 0.05$) in the T-test.

Precisely put, older residents in the Chak On Care Home appear to be very much alike in terms of dependency characteristics, regardless of whether the home admission occurred before or after the inception of the new policy: SCNAM. In this light, the newly admitted applicants are as frail as the longer-stayers. The two cohorts in residence at Chak On do not differ significantly ($p > 0.05$) in 2006.

Lai Yiu Bradbury Care Home

The same applies to the situation in the Lai Yiu Bradbury Care Home. Most items reveal no statistical significance ($p > 0.05$) when comparing the two cohorts of residents (Table 7.7). Only across few areas; 'mobility' (.033), 'expressiveness' (.020), and 'wandering' (.028) show some differences. Older persons with residence of over 3 years report comparatively higher mean in some items. For instance, the longer-stay cohort faces greater 'hearing' difficulty, with a higher mean of .88 (versus .38). Statistically, it differs significantly from those shorter-stayers at $p = 0.002$; t-value = -3.153.

Similarly the mean in 'counting' equates to .94 (versus .33), reflecting a comparatively lower cognitive ability for the longer-stay cohort (Table 7.7). Seeing

from the questionnaire (Q.23), older adults managing to count up from 1 to 10 in a 'correct' way get the lowest score of '0', and '2' for those providing 'wrong' answer. As revealed from the T-test, the two cohorts at Lai Yiu differ significantly ($p = 0.001$; t-value = -3.367).

Summing up, there is little statistical significance between the two cohorts of residents (those with over 3 years of home stay versus those with 3 years or less residence) across both homes at Chak On and Lai Yiu in the current research. Similar results are also detected within each individual residential facility. Residents who are newly admitted appear to be as frail and impaired as those who having been living in the institutions for a more lengthy periods of time. To a certain extent, this provides evidence to support the hypothesis that the new policy (SCNAM) as implemented since November 2000 has fulfilled its essential function of screening and admitting more frail applicants into long-term residential care.

The 1990 and 2006 scenarios: Residents' characteristics across the two Care Homes

To further evaluate the outcome of the new policy, the 'Standardised Care Need Assessment Mechanism' (SCNAM), since November 2000, the researcher examined if there were any differences in the dependency characteristics of the home residents at the two specific points of time in 1990 and 2006. For this comparison those sampled in both cases have more or less the same length of stay (that is, 3 years or less residence period) in the two Care Homes under study. Various items such as age, mobility, level of continence, ability levels, and mental status of the older residents are investigated across the 16-year gap.

The data indicate that older people with 3 years or less of stay in 2006 are much older, more frail and functionally disabled than those in 1990. This is clearly reflected in the comparatively higher mean of most items in 2006, such as 'urine incontinence' (1.08 versus .39), 'bathing' (1.34 versus .92), 'managing money' (1.36 versus .81) (Table 7.8). Referring back to the questionnaire (Q.8), older adults suffering from 'persistent' urine incontinence score '3', whereas those 'never' have such difficulty score '0'. Similarly, those requiring 'maximum assistance' in 'bathing' (Q.28) and 'managing money' (Q.30) get the highest score of '2', while '0' is given to those needing 'no assistance'.

Using a T-test, significant differences are detected in many items such as 'age', 'comprehension', 'toileting', 'feeding', 'bathing', 'bed making'. All of these items show significance levels of $p < 0.05$ (Table 7.8). Furthermore, many other items show significance levels equating to 0.000, which are commonly recognised as highly statistical significant. These include items like 'urine incontinence', 'faeces incontinence', 'shopping', and 'managing money'. Thus the findings coincide with the anticipated outcome arising from the policy of 'Standardised Care Need Assessment Mechanism' in Hong Kong, accepting and placing the senior applicants with greater need for care under institutional facilities.

Age

The residents with 3 years or less of stay in 1990 and 2006 differ considerably in terms of 'age'. In 2006, the mean age of respondents is 84.39, much higher than that of 80.39 in 1990 (Table 7.8). Using the T-test, the level of

significance is shown (p = 0.001; t-value = -3.482). In this sense, older people admitted for care after the 'gatekeeping' policy in the two residential homes of the Helping Hand are of more advanced age.

Similarly, over 51 per cent of the respondents (with 3 years or less residence period) in 2006 fall within the age range of 80-89, and over 26 per cent belong to that of aged 90 or above (Table 7.9). In other words, more than 77 per cent of the 80 respondents in 2006 fall into the oldest-old stratum (aged 80 and above). While in the 1990 scene, the corresponding rates for the two highly advanced age groups are lower, occupying some 40 per cent and 13 per cent respectively. As evidenced in previous studies (OECD, 2005; Wittenberg et al., 2006), the oldest-olds are more likely to have high levels of dependency and frailty and hence a need for long-term care.

Among the elderly respondents in 2006, a lower proportion is found in the younger-old age groups, representing 5 per cent and approximately 18 per cent in the age cohorts of 60-69 and 70-79 respectively (Table 7.9). On the contrary, nearly half (approximately 47%) of the 122 respondents belong to the younger-olds in the 1990 survey. From this perspective, the 'gatekeeping' mechanism appears to have functioned in a more efficient way in screening older applicants into residential settings.

Mobility

Concerning the mobility level of older persons, the mean (1.30) in 2006 is higher than that of 1.10 in 1990 (Table 7.8). This implies that older residents in 2006

tend to experience greater problems with mobility. Turning to the questionnaire (Q.7), those facing the most difficulty in mobility and who 'cannot walk' get the highest score of '3', whereas those capable of walking independently without aid score '0'. Results from the T-test indicate a high significance level in the 'use of walking aid' ($p = 0.006$; t-value = -2.773).

As a matter of fact, a large proportion of oldest respondents in the 2006 study was found to be wheelchair or chair-bound. Close to half (around 49%) of the total resident population were in the above two categories, compared with only 13 per cent in 1990 (Table 7.10). On the other hand, there was a lower proportion (nearly 19%) being capable of walking independently without any aid in 2006, compared with the approximate 21 per cent in the 1990 situation. In essence, in 2006 the resident population is distinctly more frail and functionally dependent than in 1990. It is very likely that this rise in resident dependency implies greater demands and challenges for the caring professionals in their daily work.

Continence levels

Again, the severity of incontinence level and frailty is reflected in the higher mean in 2006. By comparison, the mean of 'urine incontinence' equates to 1.08 in 2006, much higher than that of .39 in 1990 (Table 7.8). Similarly, the mean of 'faeces incontinence' represents .74 in 2006, whereas it is lower in 1990 (.24). Referring to the questionnaire (Q.8 and Q.9), respondents suffering from urine and faeces incontinence 'persistently' attain the highest score of '3', whereas those 'never' have such difficulties get the lowest score of '0'. Viewing from the T-tests,

both items of ‘urine incontinence’ and ‘faeces incontinence’ reach a high statistical significance of p = 0.000, with the corresponding t-values of -4.674 and -3.990.

Meanwhile, there was a smaller proportion of older people identified as free from ‘urine incontinence’ and ‘faeces incontinence’ in 2006. The proportion of those having no ‘urine incontinence’ reduced considerably from some 75 per cent to 54 per cent between 1990 and 2006 respectively (Table 7.11). The rate of those having no ‘faeces incontinence’ also dropped from 80 per cent to 70 per cent across the two time frames (Table 7.12).

Furthermore, there was a significant increase in older adults suffering from ‘persistent’ urine as well as faeces incontinence in 2006. For instance, the proportion of those having ‘persistent’ urine incontinence was raised from 5 per cent to 28 per cent across the period (Table 7.11). In the case of ‘persistent’ faeces incontinence, the increase (over 21%) is substantial compared with no cases in 1990 (Table 7.12).

Ability levels

To examine the functional abilities of older persons, the researcher collected data on capabilities in carrying out activities of daily living (ADLs) and instrumental activities of daily living (IADLs). By 2006 there is a decline in the proportion of older persons having the capacity to perform ADLs independently without any assistance. For instance, the two items of ‘toileting’ and ‘bathing’ show a higher mean in 2006, being .74 and 1.34 respectively (Table 7.8). As indicated in the questionnaire (Q.24 and Q.28), residents requiring ‘maximum assistance’ in ‘toileting’ and ‘bathing’ get the highest score of ‘2’ and the lowest score of ‘0’ for

those having ‘no assistance’. Through the use of T-test, a high statistical significance is clearly shown in both items of ‘toileting’ (p = 0.002; t-value = -3.109) and ‘bathing’ (p = 0.001; t-value = -3.377).

Among older respondents who find ‘difficulty’ and require comprehensive help in ‘toileting’, the proportion rises considerably from 29 per cent in 1990 to over 47 per cent in 2006 (Table 7.13). However, close to 53 per cent in 2006 manage ‘toileting’ without help. This occupies a larger proportion in 1990, being 70 per cent. Regarding the aspect of ‘bathing’, an overwhelming majority (almost 63%) require maximum assistance in 2006. This was merely 31 per cent in 1990 (Table 7.14). All these demonstrate the increased resident dependency as at 2006.

Concerning the ability to perform instrumental activities of daily living (IADLs), respondents in the 2006 study also demonstrate a much lower ability level. Again the frailty of the older residents is reflected in the higher mean in each item of IADLs. For instance, the mean of ‘shopping’ stands for 1.60 in 2006, compared with that of 1.15 in 1990 (Table 7.8). For the item about ‘managing money’, the mean is 1.36 in 2006, higher than that of .81 in 1990. By referring to the questionnaire (Q.29 and Q.30), those requiring ‘maximum assistance’ in ‘shopping’ and ‘managing money’ attain the highest score of ‘2’ while ‘0’ goes to those having ‘no assistance’. Using the T-test, older people differ significantly (p = 0.000) relating to these two aspects as at 1990 and 2006, with the respective t-values of -3.779 and -4.559.

Cognitive status

Moreover, there is an upward trend in the measure of ‘confused mental

condition' in 2006. This can be demonstrated by various items; 'wandering behaviour', 'orientation ability', and 'comprehension'. As far as 'wandering behaviour' is concerned, the mean rises up from .24 in 1990 to .26 in 2006 (Table 7.8). Back to the questionnaire (Q.33), those who wander 'frequently' within the homes without specific purpose get the highest score of '2', and '0' for those 'rarely or never'. Across the two residential homes in 2006, a larger proportion of respondents was found to exhibit 'wandering' behavioural disturbance. No statistical significance is identified concerning this aspect in the T-test ($p > 0.05$; t-value = .296).

Regarding the aspect of 'orientation ability', older people show a greater decline in 2006 compared with that in 1990. Nine questions on cognitive ability broadly summarise a degree of mental frailty. Overall these produce a T-test significant difference: $p = 0.000$; t-value = -5.358.

Measures of 'comprehension' have changed by 2006. This is well-evidenced from the higher mean of .55 in 2006 versus that of .30 in 1990 (Table 7.8). By referring to the questionnaire (Q.11), respondents who 'understand almost nothing of what others communicate' attain the highest score of '2', whereas '0' goes to those who 'understand almost everything others communicate'. Again a statistical significance ($p = 0.003$; t-value = -3.013) is observed through the T-test. Compared with the 1990 situation, residents in 2006 demonstrate higher levels of impairment and functional dependence.

The two Care Homes in 1990

Having explored the conditions of residents (with 3 years or less period of stay) as at the two specific periods, 1990 and 2006, the researcher also analysed how far there were any differences between residents in the two care and attention homes, Chak On and Lai Yiu, in 1990. Using the T-test, most of the items do not show statistical significance ($p > 0.05$). In this light, the residents living in Chak On and Lai Yiu did not differ significantly in 1990.

Referring to Table 7.15, only items about 'mobility' (.026) and 'night disturbance' (.001) show significance levels with $p < 0.05$. Older persons staying at the Lai Yiu Bradbury Care Home experienced greater mobility difficulties than those at Chak On, as evidenced from the higher mean of 1.29 versus that of .90. Meanwhile older persons living in the Chak On Care Home tended to exhibit more disturbed behaviour at night, comprising a higher mean of .43 (versus .10 in Lai Yiu Care Home).

Residents' characteristics in each Care Home as at 1990 and 2006

On the other hand, there are much greater differences appear when comparing the characteristics of the residents (with 3 years or less period of stay) at the two residential facilities in 1990 with 2006. Within the Chak On Care Home, the mean scores of most items such as 'walking aid' (2.44 versus 1.78), 'expressiveness' (.76 versus .33), 'toileting' (.71 versus .33), 'shopping' (1.51 versus 1.13), and 'managing money' (1.20 versus .83) are generally higher in 2006 compared to those in 1990 (Table 7.16). By adopting the T-test, high statistical significance levels ($p <$

0.05) are identified among sixteen items. For several items such as 'urine incontinence', 'comprehension', and 'state "date of birth"', the significance levels are greatest (p = 0.000). Therefore, the characteristics of the residents at Chak On are significantly different at the two points of time, 1990 and 2006. In 2006 (that is, admitted after the introduction of the 'gatekeeping' system) there are lower levels of functional ability and greater dependency.

The same is true of in the Lai Yiu Bradbury Care Home. Many items are comparatively higher as at 2006. For instance, the mean age of residents is 85.51 in 2006, much higher than that of 80.11 in 1990. Among the thirteen items generating $p < 0.05$, more than half reach high statistical significance levels at p = 0.000 in the T-test (Table 7.17). These include the cognitive abilities of elderly respondents to tell their own 'age', 'date of birth', 'living place', 'region' as well as their abilities in 'managing money'. Again, there are no big differences relating to the conditions of the older residents in each of the two Care Homes at each of the specific time periods. This suggests the improved vertical target efficiency of the 'Standardised Care Need Assessment Mechanism' (SCNAM) in selecting and targeting elderly applicants with more serious disabilities and frailty levels for entry into institutional care.

Prior living arrangements

According to the *Annual Reports* (Helping Hand, 1991-2006), there was a higher percentage of elderly persons living with immediate family prior to their admission to Care Home during the nineties. Owing to the changing family

structures in Hong Kong, this proportion declines from some 33 per cent in 1992 to nearly 25 per cent in 2006 (Table 7.18). On top of that, the proportion of those residing with relatives also drops considerably from 10 per cent to less than 1 per cent across the two specific periods. In the absence of whole good whole population data, it is difficult to be sure what these changes demonstrate. As mentioned earlier, the sources of social supportive networks for older adults appear to have weakened in Hong Kong over this period. These data echo to former studies (Ngan, 1990; Chow, 1993; Chou and Chi, 2001). On the other hand, the data could suggest that as well as greater vertical target efficiency from 2006, there was also greater horizontal target efficiency, in other words, a higher proportion of those with both ability and social care access needs were being admitted after 2006. But paradoxically the data also reveals that the proportion of those living alone before admission fell from 27 per cent to 19 per cent within the two respective periods under study (Table 7.18). It might have been hypothesised that the proportion living on their own would have increased. However, the literature shows that those living on their own are a fitter group, a survivor group, and so this may account for an assessment system that focuses on functional ability leading to fewer of those living own their own being admitted to the homes.

At the same time, the data shows a rising trend of older people living in other kinds of residential facilities prior to entry to the two Care Homes after 2000. As shown in the *Annual Reports* of the two homes (Helping Hand, 1991-2006), this increase is substantial; rising from 30 per cent in 1992 to approximately 56 per cent in 2006 (Table 7.18). This suggests a growing phenomenon of deteriorating health

conditions, or social isolation, amongst the older people that caused them to have already accessed other forms of long-term residential care, and especially for those in lack of social or family support. This is consistent with the previous research findings by Lee and Lo (2005). Owing to the urgent need for residential care, yet a long Central Waiting List of the Social Welfare Department, many older people sought care places in private homes first before subsequent admission to government-subsidised homes. During the face-to-face interviews in 2006, some of the respondents expressed a felt need for transition from sheltered homes or other private institutions to the Care Homes of the Helping Hand due to their declining health or functional disabilities, and of course because to the lower costs that would be incurred. Therefore in the early 2000s, older people (including those living alone as well as those living in various types of care institutions prior to home admission) with greater physical need for care tended to be placed within these two residential homes. Thus, in the context of a selection system that focussed primarily on need measured in terms of ADLs, because of the patterns of choice in Hong Kong available to people without informal sources of care, broader need characteristics were being captured by the selection system.

Financial status

Regarding the financial circumstances of older persons living in the care and attention homes, the overwhelming majority are found to be reliant on Comprehensive Social Security Assistance (CSSA) for daily living. As revealed from the *Annual Reports* (Helping Hand, 1991-2006), around 87 per cent of the residents encountered financial hardship and had to depend upon CSSA in 1992

(Table 7.19). Furthermore, the proportion rose to over 91 per cent in 1999 and then remained stably for subsequent years to 2003. As at 2006, more than 86 per cent of home residents were CSSA recipients. There were approximately 13 per cent who obtained monetary support from their families or relatives. Overall, there appears little disparity in the financial circumstances of residents over the two time frames of 1990 and 2006. Most residents are without means, and have to depend on financial assistance from the government or to a lesser extent support from their family relatives. As detailed in Chapter 5, the SCNAM measures, first and foremost, functional ability (ADLs) of older people. Following this, it takes into consideration other factors such as the availability of informal care and support, and whether caregiving causes stress or burden to the caregivers. Financial resource, however, is not a factor at all when assessing the real need for institutional care. Hence older people, no matter rich or poor, can apply for publicly-funded care homes in Hong Kong.

Apart from above, most of the respondents do not have any retirement assets. Less than one per cent had independent pensions in 2006 (Table 7.19). Despite the fact that the SCNAM does not include financial resources when assessing the care need of applicants, financial resources play a role indirectly, through self-selection processes. Those with money or relatives willing to help or pay are unlikely to apply for government-subsidised residential care homes in the first place. As discussed in Chapter 4, there is a general lack of privacy and personal space in publicly-funded care homes in Hong Kong; three to eight persons often live together in one dormitory bedroom, thereby having to share the bathroom and

washroom facilities. Those with alternative are unlikely to choose to enter publicly-funded care homes. Though a relatively crude selection system the SCNAM may effectively target the more socially and financially needy as well as the most disabled. Viewed from this perspective, a degree of 'horizontal equity' (Davies and Knapp, 1981) in the allocation of care has been achieved by the formal 'gatekeeping' policy reform. The population of those entering these two homes is a subset of older people who have care needs and are additionally dependent on the state for income.

Sources of referral

Since its establishment, the Helping Hand organisation in Hong Kong has received referrals from a variety of sources. These include the Social Welfare Department (SWD), the Housing Department (HD), some cases of independent application and internal transfer, as well as other non-governmental organisations (NGOs). Around 13 per cent of the cases in 1991 were referred by the Housing Department (Table 7.20). Since 2003 this has fallen to 4 per cent. By 2006, the organisation had ceased to take in direct referrals from the HD. This implies greater vertical and horizontal target efficiency in access to this form of residential care as all applications have to be made through the centralised system of the SWD.

Some referrals come from the Social Welfare Department. In 1991 this proportion was close to 45 per cent, and had increased drastically to approximately 92 per cent by 2003 (Table 7.20). By 2006, all of the cases come from the only one source - the SWD. This recruitment process that relies solely on a basis of SWD

referrals is more equitable. There is no longer any discretion for the agency itself along with the government policy of 'the Standardised Care Need Assessment Mechanism' for elderly services. Greater target efficiency, certainly vertical but also, to a degree, horizontal efficiency is likely with the system selecting the most disabled and those with lower incomes. While for those equally disabled but not with meagre income, they have wider choices in selecting care places and are unlikely to apply for government-funded homes in the first place. This explains why a vast majority of the residents in the two Care Homes under study have been those receiving financial assistance from the government, namely, the Comprehensive Social Security Allowance *(Annual Reports of the Helping Hand, 1991-2006).*

The efficiency of care

Greater efficiency in the use of resources for the care of older people may have been achieved within the two Care Homes. The homes have put in place a version of greater 'target efficiency' (Bebbington and Davies, 1983). With the introduction of the individualised, needs-led assessment scheme, the 'gatekeeping' policy in late 2000, the residential facilities are selecting and accommodating older individuals with more severe levels of functional disabilities and of highly advanced age as at 2006, and with very low incomes. The following section investigates how the two Care Homes had changed their selection procedures and processes as at 2006, and considers the consequences. It also attempts to examine the nature and significance of changes at the two Care Homes within the 1990-2006 period. Questions are raised as to about the changes within each individual home during the 16-year time frame.

Overview of residents' characteristics in 1990 and 2006

Across the period from 1990 to 2006, both Care Homes at Chak On and Lai Yiu show significant change ($p < 0.05$) in most items measuring the residents' characteristics (Table 7.21). These consist of mobility, level of continence, communication ability, capability to perform ADLs and IADLs. A T-test has been used to test the difference between the mean scores in 1990 and 2006. Many items are detected to have high statistical significance levels ($p = 0.000$). These include 'age', 'walking aid', 'urine incontinence', 'faeces incontinence', 'comprehension', 'hearing', abilities to perform ADLs like 'toileting' and 'bathing', as well as IADLs like 'shopping', 'managing money' and 'bed making'.

Referring to Table 7.21, the ability levels of older people in 2006 are clearly reduced. This is reflected in the higher mean in 2006 for 'urine incontinence' (1.18 versus .39) and 'faeces incontinence' (.86 versus .24). Concerning the aspects of 'toileting' and 'bathing', the mean scores equate to .79 and 1.31 respectively in 2006, whereas these stand for .40 and .92 in 1990. Hence by 2006, the residential homes had admitted people with significantly great functional limitations and higher dependency, requiring much assistance in carrying out activities of daily living (ADLs).

Age

The findings show that the two Care Homes changed significantly in terms of the age of residents at entry. Using the T-test, the mean age of respondents equates to 85.99 in 2006, much higher than that of 80.39 in 1990 (Table 7.21). A

high statistical significance (p = 0.000; t-value = -5.824) is revealed. By 2006 the overwhelming majority (more than 82%) of older persons living in these facilities belong to the age cohort of 80 and above, comprising some 34 per cent being over aged 90 (Table 7.22).

While for the 1990 scenario, it is somewhat different. The corresponding proportion of the very old is much lower. About 53 per cent were aged 80 and above, of which 13 per cent were 90 and above (Table 7.22). Across the period, the proportion of those belonging to the younger age cohorts of 60-69 and 70-79 dropped drastically from around 47 per cent to almost 18 per cent within the 16-year period. This shows that a key consequence of the selection process was to admit distinctly older people. Since the younger cohorts admitted before the introduction of the selection process were likely to have been less representative of the need distribution in the whole population, it is possible that the homes are by 2006 being used more efficiently relative to whole population need.

Mobility levels

Turning to the physical functioning of the residents, including mobility, the level of continence, and communication ability, by 2006, there is a growing proportion facing mobility difficulties and dependent on assistance from others. This can be seen in the higher mean scores for ‘walking aid’ and ‘mobility’ in 2006, being 2.84 and 1.43 respectively (Table 7.21). The statistical significance is shown as p = 0.000; t-value = -4.526 and p = 0.002; t-value = -3.114 in the above-mentioned items respectively.

Furthermore, the proportion of those being 'wheelchair-bound' rose from approximately 7 per cent to 51 per cent within the 16-year time frame (Table 7.23). The rate for those 'bed-ridden' also increased up to 2 per cent in 2006, whereas none occurred in 1990. Moreover, only half (48%) of the elderly residents were able to walk with personal help, and over 5 per cent cannot walk at all (Table 7.24). Retrospectively looking at the 1990 scenario, the corresponding rate for those 'walk with personal help' was only 8 per cent. While those unable to walk independently on their own represented nearly 15 per cent in 1990. Viewing from the statistical figures, the two homes had accepted and placed a much higher proportion of older persons with mobility restrictions by 2006.

Referring to the *Annual Reports* (Helping Hand, 1991-2006), the proportion of 'fully ambulant' older residents had decreased sharply from approximately 34 per cent in 1991 to 24 per cent in 2000 and even further to 16 per cent in 2006 (Table 7.25). On the contrary, the proportion of those being 'wheel-chair or chair-bound' increased considerably from nearly 12 per cent to 33 per cent within the respective period.

Apart from above, an additional increase of almost 2 per cent is identified as 'completely bed-bound' (Table 7.25). These data are likely to indicate greater 'target efficiency' in the use of public and charitable funding to support frail older people (Bebbington and Davies, 1983; Davies and Challis, 1986) achieved by the two residential homes of the Helping Hand amidst the care provision for older persons in Hong Kong. How far this contributed to greater equity in access to care amongst the older population of Hong Kong is less clear.

Continence levels

Another aspect being closely linked with the functional ability of a person is the level of continence. Previous findings (Ouslander et al., 1982; Brandeis et al., 1997) reveal that urinary incontinence is strongly associated with impairments in older people, giving rise to great distress in their daily lives. A higher mean of 1.18 in 2006 is detected, compared with that of .39 in 1990 (Table 7.21). The statistical level of significance is very high with p = 0.000 and t-value = -5.881.

By comparison, the proportion of older respondents having no incontinence decreased sharply from 75 per cent to 49 per cent in 1990 and 2006 respectively (Table 7.26). On the other hand, the rate for those suffering from urinary incontinence 'persistently' rose from 5 per cent to 31 per cent within the specific period of sixteen years.

Concerning faecal incontinence, there is a positive relationship with 'female gender, advancing age' and 'physical disability' in particular, causing 'social isolation' among older people (Nelson et al., 1998). The higher mean of .86 in 2006 represents .24 in 1990 (Table 7.21). Again, the level of significance is high (p = 0.000; t-value = -5.095).

Likewise, the proportion of home residents suffering from faeces incontinence 'persistently' rose from 0 per cent in 1990 to 24 per cent in 2006 (Table 7.27). In the meantime, the proportions facing no problem of incontinence fell considerably from 80 per cent to 64 per cent. In the 2006 survey, respondents were more likely to have double incontinence.

Communication ability

Despite the two above-mentioned aspects of physical functioning, subjective dependency is often less when older people can express themselves clearly (through gestures, verbal and written means) as well as make themselves being understood by others. Otherwise, this will cause limitations to their participation in social activities (Resnick et al., 1997). Communication abilities include the capabilities to express oneself, the levels of comprehension, and aspects of vision and hearing.

Communication difficulties were significantly higher in the 2006 cohorts: a higher mean of .62 in 2006 when compared with that of .43 in 1990 (Table 7.21). Again, the statistical significance ($p = .020$; t-value = -2.345) is high. Similarly, the proportion having 'some problems' in expressiveness increased from approximately 28 per cent to 36 per cent in 1990 and 2006 respectively (Table 7.28). While for those 'being inarticulate', the proportion also rose steeply from 7 per cent to 13 per cent across the two corresponding periods. Nevertheless, this is not statistically significant with $p = 0.064$.

Regarding the ability to comprehend, the residents differed significantly at the two specific points of time. A higher mean of .61 in 2006 is identified, compared with that of .30 in 1990 (Table 7.21). The high statistical significance is clearly shown ($p = 0.000$; t-value = -4.094).

Comparatively, more older people in the 1990 survey have better comprehension skills (Table 7.29). In the meantime, those 'unable to comprehend

others' messages' rose from 3 per cent to 12 per cent in 1990 and 2006 respectively.

Vision

Another aspect which is strongly associated with a decline in functional independence is vision impairment or loss. Many studies (LaForge, Spector, and Sternberg, 1992; Horowitz, 1994) evidence that vision impairment restricts the mobility levels and capabilities of older adults in undertaking self-care tasks. It also affects their participation in the daily social activities in an adverse manner (Thompson, Gibson, and Jagger, 1989).

The mean scores for 'vision' turn out to be the same across the two time frames of 1990 and 2006, being .80 (Table 7.21). No statistically significant change is identified ($p = .995$; t-value = .006). However, those with 'normal' vision in 1990 outnumber those as at 2006, being 54 per cent and 41 per cent respectively (Table 7.30). In contrast, those with poorer eyesight and need to 'wear spectacles' increased from 13 per cent to 43 per cent. This rising proportion was probably due to the growing number of older people suffering from cataracts in the two residential homes, and who received better care and treatment by the public hospitals (being operated under the Hospital Authority) after the late nineties. For those 'partially blind', the proportion fell from 31 per cent (being 38) to approximately 11 per cent (being 16) across the two corresponding periods. This might be because of the provision of residential care places for blind elders after the late nineties. With more 'blind' older people having been admitted to the Aged Blind Home, the proportion of 'blind' residents in the two Care Homes under study reduced significantly in

2006.

Hearing

As well as vision problems, hearing impairment is found to be associated with low social engagement, reducing people's ability to establish and maintain relationships as well as to take part in the organised activities (Weinstein and Ventry, 1982; Rudberg et al., 1993).

The mean of those with hearing problems is .58 in 2006, much higher than that of .26 in 1990 (Table 7.21). Back to the questionnaire (Q.13), respondents who are 'totally deaf' attain the highest score of '2' whereas those with 'no hearing difficulties' score '0'. Obviously the high statistical significance is shown ($p = 0.000$; t-value = -4.370).

Eleven per cent of the sample in 2006 were classified as 'deaf' compared with the merely one per cent in 1990 (Table 7.31). About half (53%) of the respondents in 2006 experienced no hearing difficulty, being classified as 'normal'. While in 1990 the corresponding rate was higher, representing some 75 per cent.

As far as the use of 'hearing aid' is concerned, the mean (.28) in 2006 was higher than that of .16 in 1990 (Table 7.21). Nevertheless the level of statistical significance is not high ($p = .076$; t-value = -1.780). The percentage using a hearing aid does not rise steeply in a proportionate manner despite the fast growing rate of 'deaf' residents, because for the profoundly deaf hearing aids are of no help.

Activities of daily living (ADLs)

Functional abilities are measured by the capabilities of individuals to carry out activities of daily living (ADLs). These measures are often regarded as 'the cornerstone of nursing home resident classification' (Fries, 1990). Using this questionnaire (Q.24 - Q.28), older adults requiring 'maximum assistance' in ADLs (namely, toileting, dressing, feeding, washing hands and face, and bathing) get the highest score of '2'. Those managing to perform ADLs independently and requiring 'no assistance' score '0'. Compared with the 1990 situation, the mean scores for all items (except 'washing') in 2006 are much higher. For instance, the mean for 'toileting' represents .79 in 2006, whereas this stands at .40 in 1990 (Table 7.21). Likewise, the mean for 'bathing' (1.31) is higher in 2006, compared with .92 in 1990. All items (except 'washing') reveal the high statistical significance level with $p < 0.05$. Aside from that, both items of 'toileting' and 'bathing' indicate an obvious difference in the mean ($p = 0.000$). The corresponding t-values equate to -4.006 and -3.683.

As shown in Table 7.32, close to 61 per cent of older residents required maximum assistance in 'bathing', compared with only about 31 per cent in 1990. The need for help in 'dressing' and 'toileting' were 33 per cent and 30 per cent respectively in 2006 but much lower in 1990, being approximately 16 per cent and 11 per cent.

Clearly by 2006 the two homes were looking after people with far lower ADLs capacities and much higher levels of disability. This is likely to indicate a more efficient use of the resource.

Cognitive status

In this research, the cognitive states of older people in the two residential homes at Chak On and Lai Yiu were found to be more disabled in 2006. All items relating to cognitive orientation show a higher mean in 2006. As indicated in Table 7.21, respondents tend to be more disorientated towards telling their own 'age' (1.16 versus .54), 'date of birth' (1.74 versus .53), 'year' (1.54 versus 1.14). Furthermore, a high statistical level of significance ($p = 0.000$) is identified in these three items, with the corresponding t-values representing -6.250, -13.914 and -3.743. The older respondents differed significantly ($p < 0.05$) in all aspects concerning cognitive orientation between 1990 and 2006.

During the face-to-face interviews, close to 85 per cent of the home residents in 2006 managed to state their 'name' correctly (Table 7.33). While in 1990, the corresponding proportion was higher (96%). On the other hand, over 7 per cent failed to tell their 'name', compared with some 3 per cent in 1990. The vast majority (73%) in 2006 named the 'year' wrongly, whereas this was 55 per cent in 1990.

Meanwhile, only 19 per cent of elderly respondents in 2006 were able to name the 'year' (Table 7.33). This was much lower than that in 1990, being 41 per cent. Interestingly, over 41 per cent of the respondents in this study failed to provide accurate information about their own 'age', while this was 23 per cent in 1990.

Looking at thinking capacities, a more comprehensive picture can be revealed. Each respondent was asked to answer a total of nine questions (Q.15 to

Q.23) relating to the present situation such as their name, age, date of birth, current place of living. For each question, the marks attained equate to '0' (answer correctly), '1' (partly correct) and '2' (completely wrong). The proportion and number of those capable of providing correct answers to the nine questions (scoring '0' mark) dropped sharply; to over 3 per cent (5 respondents) in 2006, as compared to nearly 25 per cent (30 respondents) in 1990 (Table 7.34).

In addition, more older people in 2006 provided wrong answers to all the questions (attaining '18' marks); 6 per cent compared with the only 3 per cent in 1990 (Table 7.34). This reaffirms the hypothesis that the care and attention homes accepted older adults with higher frailty for long-term residential care from the mid-2000s. They may have been providing care efficiently shortly before the inception of the new policy (SCNAM).

Instrumental activities of daily living (IADLs)

The dependency characteristics of older persons were measured by their abilities to perform instrumental activities of daily living (IADLs). The means for most items such as 'shopping' (1.58 versus 1.15), 'managing money' (1.28 versus .81), and 'bed making' (1.64 versus 1.16) in 2006 are greater than those in 1990 (Table 7.21).

Interestingly, it is noteworthy to find around 76 per cent and 72 per cent of older respondents in 2006 require substantial help in 'bed making and 'shopping' respectively, compared with rates of 50 per cent and 49 per cent in 1990 (Table 7.35). Over half (53%) needed substantial assistance in 'managing money', whereas this

was 30 per cent in 1990.

Amongst those managing to carry out IADLs independently without any assistance, the proportions were comparatively lower in 2006. These were approximately 14 per cent, 24 per cent, and 13 per cent in 'shopping', 'managing money', and 'bed making' respectively (Table 7.35). Only in the item of 'grooming' was the proportion of those with 'no assistance' higher, over 68 per cent, in 2006 (versus 49 per cent in 1990). Clearly, the 'Standardised Care Need Assessment Mechanism' had successfully screened for persons with higher levels of dependency in performing IADLs by 2006.

Behavioural disturbance

Another aspect relating to the characteristics of the home residents relates to behavioural disturbance. Most items do not differ significantly ($p > 0.05$). For example, the significance levels for 'wandering', 'accusing', and 'sleep pattern' represent .683, .614 and .587 respectively (Table 7.21). In 1990 and 2006, the proportions of older persons exhibiting 'frequent wandering' behaviour remain similar at approximately 7 per cent and 6 per cent respectively (Table 7.36). Likewise, for those who 'rarely wander', the proportions were almost 83 per cent and 85 per cent in the two corresponding periods. As for those with undisturbed 'sleep patterns', the proportions also stay near at around 39 per cent and 41 per cent at the two points of time. To a certain extent, this shows the new policy (SCNAM) was selecting applicants with higher functional disabilities instead of those exhibiting behavioural disturbance.

On the other hand, the two items of behavioural disturbance at both day and night show statistical significance of .048 and .017 respectively ($p < 0.05$) (Table 7.21). Surprisingly, the older the respondents, the less their behaviour is measured as disturbed at both day and night. During the 1990-2006 period, the proportion with 'frequent' day disturbance falls from 10 per cent to 4 per cent, while that with 'frequent' night disturbance decreases from 7 per cent to some 3 per cent (Table 7.36).

Summing up, these findings reveal the significant changes in residents' characteristics that had taken place in the two Care Homes of the Helping Hand between 1990 and 2006. Compared with the 1990 situation, both homes were caring for older adults with more serious functional impairments and greater age by 2006. It is likely that selection was a consequence of targeting of those with highest needs.

Differences between the two Care Homes in 1990 and 2006

In 2006 the mean scores between Chak On and Lai Yiu did not vary greatly (Table 7.37). This is evidenced, for example, in items of 'vision' (.78 versus .83), 'hearing' (.55 versus .61), 'toileting' (.75 versus .83), 'dressing' (.75 versus .83), 'feeding' (.42 versus .49), 'wandering' (.21 versus .21). No statistical significance can be identified across the two Care Homes. Among different aspects like 'walking aid', 'toileting', 'dressing', 'feeding', 'bathing', and 'wandering', the levels of significance are not outstanding either ($p > 0.05$). In 2006 the characteristics of older residents staying at the residential homes of both Chak On and Lai Yiu appear to be similar.

However in the case of cognitive impairment, the two residential homes did differ significantly ($p < 0.05$) at both periods - 1990 and 2006 (Table 7.38). In this study, older respondents were asked of their own name, age, date of birth, living place, region, the present date to check their cognitive orientation ability. Most items like 'age', 'date of birth', 'living place', 'region', and 'year' at Lai Yiu reach a very significant statistical level ($p = 0.000$) in the T-test. In other words, the Lai Yiu Bradbury Care Home had accepted people with more serious impairments by 2006. On the other hand, the situation is less obvious in the Chak On Care Home. All items except 'name', 'age', and 'date of birth' do not increase to a degree that is statistically significant, with $p > 0.05$. This would possibly be due to the comparatively faster cognitive deterioration of residents at Lai Yiu after their admission. Again, it reflects the major selection criterion for home entry being the functional ability of older people rather than their cognitive states.

In terms of behavioural disturbance, the Chak On Care Home accommodated older persons who exhibit high levels of disturbed behaviour by 2006. This can be reflected from behaviour that occurred at daytime and night time, as well as the sleep patterns, whereby $p = 0.003$, 0.002, and 0.018 respectively (Table 7.38). Again, this change was statistically significant ($p < 0.05$). While in the Lai Yiu Bradbury Care Home, increases in behavioural disturbance were less obvious and not statistically significant at all ($p > 0.05$). Dependency levels tended to have risen less in Lai Yiu than Chak On in this dimension.

Nevertheless the two Care Homes have selected people with greater functional disabilities in various aspects such as 'walking aid', 'mobility', 'urine

incontinence', 'faeces incontinence', 'toileting', and 'bed making' after the new policy (SCNAM). The mean scores for all these items are higher in both homes in 2006.

Upon comparison between the two institutional facilities, residents staying at Chak On require more assistance from others in carrying out activities of daily living (ADLs), such as 'toileting' and 'bathing', with $p < 0.05$ (Table 7.39). In Chak On too, difficulty in communication, as shown from the high statistical significance level of $p = 0.000$ in 'expressiveness' and 'comprehension'. This is not applicable to the situation in Lai Yiu ($p > 0.05$). While at Lai Yiu, residents appear to be more disorientated, with a high significance level ($p = 0.000$) in items like 'age', 'date of birth', 'living place', 'region', and 'year' (Table 7.40). They are more dependent to perform the instrumental activities of daily living (IADLs) such as 'shopping', 'managing money', and 'bed making'. Despite the 'Standardised Care Need Assessment Mechanism' (SCNAM) for elderly services, it is possible to find varying degrees of decline in different dimensions such as functional competence, cognitive level, and communication ability that occurred to individual residents after home entry, subsequently causing some differences between the two Care Homes.

A picture of the general health of the people staying in the residential facilities can be constructed by referring to the *Annual Reports* (Helping Hand, 1991-2006). Information about whether their health status has improved or deteriorated throughout various years can also be detected. In the Chak On Care Home, residents experience a higher percentage in the prevalence of different types of diseases such as diabetes, heart disease, and hypertension in 2006 when compared

to those in 1991, with the exceptions in Parkinson's disease and respiratory tract disorder. For example, over one-third (38%) of the residents suffer from dementia in 2006 as compared to merely 15% in 1991 (Table 7.41). Likewise, 35 per cent suffer from stroke in 2006, whereas the proportion remains smaller at 29 per cent in 1991.

Turning to the Lai Yiu Bradbury Care Home, a trend of declining health of older persons can also be traced by 2006, except for those suffering from hip fracture, Parkinson's disease, respiratory tract disorder, and stroke. Over 27 per cent of older residents in 2006 suffered from dementia, whereas the corresponding rate was around 17 per cent in 1991 (Table 7.42). A rising proportion of those with cataracts is apparent, being close to 27 per cent and 48 per cent in 1991 and 2006 respectively. In the case of diabetes, the increased prevalence is more apparent, with approximately 6 per cent and 18 per cent at the two corresponding periods.

On the other hand, it is interesting to note a falling proportion of stroke patients staying at Lai Yiu, dropping from 42 per cent in 1991 to nearly 29 per cent in 2006 (Table 7.42). Again, this can be accounted for by the selection criterion of the 'gatekeeping' system, which measures mainly the functional disability of older people, instead of the diseases they suffered such as arthritis, hypertension, and stroke. Overall, the two Care Homes selected older individuals with worse health conditions and greater functional disabilities by the mid-2000s. Most probably, this can be mainly explained by the inception of the new policy (SCNAM), resulting in greater selectivity in terms of functional and financial criteria.

Chapter summary

In this research, the findings provide strong evidence to support the hypothesis that older people newly admitted to these two residential facilities were much more functionally impaired and of greater age with the policy implementation of 'the Standardised Care Need Assessment Mechanism' (SCNAM). Greater targeting (Davies and Challis, 1986) appears to have been applied after the mid-2000s. It is likely that a higher proportion of the most needy in the community were being selected, not only by these two homes, but by others in the 'public system', leading to a more efficient use of public money. At each point of time sampled, 1990 and 2006, the population in the two homes were similar in terms of mobility, ability levels, and cognitive status.

Apart from above, the research shows that residents of 3 years or less as at 2006 were much more frail than those in 1990 (assuming both groups have taken residence for a similar period of time in the two Care Homes). The mean age of residents in the two homes was higher in 2006. Additionally, the cognitive states of older residents as well as their capabilities to perform ADLs and IADLs were comparatively more severe as at 2006. Again, this finding is equally applicable to the two institutional facilities at Chak On and Lai Yiu.

Prior to the admission into the two residential homes, there is a marked increase of elderly respondents being placed in other institutional care of various kinds, including private nursing homes and sheltered homes. This is consistent with growing resident dependency across the past decade or so. A decreasing proportion is identified as living with their families or relatives before entry. Among the

respondents in the current study, the overwhelming majority were poor and had to rely on Comprehensive Social Security Assistance (CSSA) for their daily livelihood. Last but not least, the Helping Hand had surrendered all quotas to the Social Welfare Department. There was no agency discretion after 2003. The data shows that the people who are admitted to care within the two institutional facilities are the most frail, old and marginalised. Specifically, the resident population is largely made up of poor, particularly old, widows who were living alone prior to entry to a care home. In this sense, greater efficiency, and possibly equity, in access to the two Care Homes is likely.

Chapter 8 Changes in Costs and Staffing: 1990 to 2006

Increases in the population of older people and in longevity have led to more years of disability. This has generated greater need for health and social care services. In the previous chapter, we noted the increasing age and levels of impairment of the resident populations of the two care homes. In this sense, the 'gatekeeping' policy has led to better 'target efficiency' in the use of this resource. Whether this has produced greater 'equity' of response to need in the whole population is less clear. This chapter assesses the impact on costs in the two care homes and whether greater cost efficiency of care is achieved in relation to income, expenditure, and staffing arrangements. The data are explored to determine whether there is any change among the three areas between 1990 and 2006, and what the consequences for the residents have been.

Different sources of income

The total income of the two residential homes of the Helping Hand is derived from various sources. These include fees payment from older residents, an annual subsidy from the HKSAR government (namely, the Social Welfare Department), and donations from some charity organisations such as the Community Chest of Hong Kong. On top of the above, a portion of the total home income comes from charitable funds raised by the organisation itself.

Regarding the total income, the two Care Homes show a substantial increase between 1991 and 2006. At the Chak On Care Home, the total income was HK$2436059 in 1991 (Table 8.1). The sum rose to HK$10541571 in 2006,

comprising a remarkable growth of 333 per cent. By 2002, the total income reached its peak, going up to HK$11774726. There was much less growth from 1999 through 2006. In terms of income per head, the peak is also detected in the year 2002, being HK$141864. Yet from 2002 onwards, the income per capita drops every year and with the amount lowering to HK$122576 in 2006.

Likewise, at the Lai Yiu Bradbury Care Home, there is a significant increase of 319 per cent within the 1991-2006 period (Table 8.1). In 2001, the total income reached HK$9738061. Again there is less change and fluctuation between 2001 and 2006. Total income reaches its peak in 2006, equating to HK$9950139. Similar phenomenon occurs when looking into the income per capita. The amount of HK$129841 in 2001 shows a peak, but then fluctuates and reaches another peak in 2006 (being HK$136303). To a large extent, the ups and downs in the total income of the two Care Homes reflect the general economic climate in Hong Kong, affecting the sum of money as derived from various sources every year.

Home fees payment: rental income, meals, and other charges

Every older individual admitted for long-term residential care is required to pay home fees every month. These include payment of rent, for meals and other charges. In Hong Kong, residential home fees are charged according to the maximum limit of the Comprehensive Social Security Assistance (CSSA) that the 'eligible' senior adults obtained from the Social Welfare Department. Under most circumstances, the CSSA recipients have no money left (excluding the Old Age Allowance and Disability Allowance) for their own use after paying the home fees.

In this sense, the fees reflect payments available rather than costs.

As far as income in the form of rent is concerned, the total amount appears to show no significant change in both homes from 1998 onwards. At the Chak On Care Home, the rental subscription reaches HK$1406337 in 2006 (Table 8.2), which is close to the level in 1998 (being HK$1446247). Similarly at the Lai Yiu Bradbury Care Home, the total sum was HK$1216587 in 2006. Again, this is close to that of HK$1190440 in 1998. Upon comparison, the rental income has increased significantly at Chak On, with a growth rate of 220 per cent between 1991 and 2006 (Table 8.3); the highest year is 2003, amounting to HK$1642750. At the Lai Yiu Bradbury Care Home, the rate of increase is 198 per cent during the same period with the peak amount in 1999, amounting to HK$1375443. However there is only slight variation in rental income across the two Care Homes throughout the years from 1998 to 2006. This is mainly due to the slight adjustment of annual home fees by the Helping Hand in the period, and which is related to the amount of CSSA each year.

The picture turns out to be clearer when referring to the income per capita. Again, the peak rental received per capita (being HK$19102) at Chak On is found in 2003, and drops to that of HK$16353 in 2006 (Table 8.2). At Lai Yiu, the highest amount per capita income occurs in 1999, at HK$19934. Fluctuating amounts are found in the subsequent years, reducing to HK$16666 per capita in 2006. To recall, the real property market of Hong Kong fell sharply in 1997, and housing rents decreased drastically. In accordance with this economic turmoil, the Social Welfare Department also reduced the amount of rental subsidy considerably to the CSSA

recipients. The two Care Homes do have limited control over the fees they can charge. Again, the unstable economic state within the territory greatly affected the total income of these residential homes.

Regarding charges for meals and other items, rising rates are detected from 1991 to 2006, occupying 207 per cent and 172 per cent at the two Care Homes respectively (Table 8.3). At Chak On, the peak amount (being HK$1898390) is also found in the year 2003, with the highest charge per capita being HK$22074 (Table 8.4). While for the Lai Yiu Bradbury Care Home, the amount shows a substantial increase after 2001, reaching HK$1523340 in 2002 and then fluctuates in the following years. Only slight differences are identified in the total amount between 2002 and 2006. Again, such is clearly reflected in the charge per capita with the amount going up to HK$20044 in 2002 and reaching HK$21169 in 2006.

Government subsidy

Apart from receiving payment fees from older residents, the two Care Homes under study obtain an annual subsidy from the government, namely, the Social Welfare Department (SWD). This source is one of the major income sources across the two residential homes. As a usual practice, the SWD purchases places from the care and attention homes in the non-governmental organisations (NGOs). For every place or bed bought, the SWD pays an amount that is defined as “the market price” and the NGOs, such as the Helping Hand, have very little say in this matter. The ‘Enhanced Bought Place Scheme’ (EBPS) was implemented since 1998. As claimed by the Social Welfare Department, the scheme aims to upgrade the

service standard of the elderly homes through 'enhanced service requirements in terms of staffing and space standard' (Social Welfare Department). A higher public fee tends to raise the supply of subsidised places at the care and attention homes and so helps reduce waiting times for subsidised care-and-attention places.

Referring to Table 8.5, the two Care Homes received the largest sum of money through the government-subsidised bought place scheme in 2004. At Chak On, the amount of subsidy was HK$6140653, and that of Lai Yiu was HK$5614418. Regarding the payment per capita, the peak amount of subsidy also occurs in the same year, being HK$72243 and HK$76910 in the respective homes. As observed, the subsidy from the Social Welfare Department shows a slight fluctuation at the Chak On Care Home from 1999 to 2006 and at the Lai Yiu Bradbury Care Home during the period of 2001-2006. The growth in the subsidy was 345 per cent and 356 per cent in the two corresponding Care Homes between 1991 and 2006 (Table 8.3). The government subsidy remains an essential source of financial support in the two Care Homes under study, constituting about 50 per cent of the total income throughout the 1991-2006 period (Table 8.6 and Table 8.7).

Community Chest donations

Another source of income that the two Care Homes receive is derived from an independent, non-profit making organisation - the Community Chest of Hong Kong. This charity organisation is governed by a Board of business and community leaders who contribute their time voluntarily. Throughout it has been heavily engaged in a wide range of fund-raising activities within the territory.

In the year 1994, the two residential homes received the largest donation from the Community Chest of Hong Kong. As indicated in Table 8.8, the amount was HK$1268004 at Chak On, and HK$1028004 at Lai Yiu. Coincidently, donation per capita is also the highest in the same year, being HK$15464 and HK$15118 respectively. However the sum donated by this local charity organisation fluctuates and reduces substantially after 1994. All through the years from 1994 to 2006, the rate of change represents a decrease of some 82 per cent and 78 per cent in the two respective homes. Social service providers such as the Helping Hand do not have any control over the sum of money donated by charity organisations such as the Community Chest. To a large extent, this exerts high pressure over the aggregate total income of the Care Homes under study.

Self-generated income

Aside from the above-mentioned sources of income, the Helping Hand generates donations through holding a Cookies Campaign annually since the mid-1980s. The sum of money generated by the agency itself increased significantly from 1997 onwards. As shown in Table 8.9, the total amount at Chak On reached its peak of HK$2174716 in 2000. While for Lai Yiu, the largest sum is identified in the year 2001, being HK$1562659. Similarly, the donations per capita corresponds to the highest sum of HK$25287 and HK$20836 respectively in the two Care Homes.

At the Chak On Care Home, the self-generated income amounted to HK$129001 in 1991 (Table 8.9). The sum rises drastically to HK$1362567 in 2006, which is a nine-fold increase. Likewise at the Lai Yiu Bradbury Care Home, the sum

of HK$1357856 in 2006 represents more than five times that (being HK$249901) in 1991. Interesting to note, in terms of income per capita, the amount of self-generated donations at Chak On in 2006 (being HK$15844) is comparable to that of HK$15664 in 1998. At Lai Yiu, the sum of HK$18601 in 2006 is nearest to that in 2000 (being HK$17782). Across both residential homes, there is little fluctuation in the annual donated sum generated by the agency. The pattern is probably associated with the poor economic climate around 1997.

Structural change in income sources

To conclude, changes can be seen in the structure of the total income of the two Care Homes between 1991 and 2006. Throughout these years, a major and significant source of the total home income comes from the Social Welfare Department. As observed from Table 8.6 and Table 8.7, government subsidy accounts for about half of the total income across both Care Homes under study. Another important source of income derives from the home fees paid by older residents, including rental payment, meals, and other charges. Nevertheless, the significance of this item falls slightly over the period. For rental income, the proportion at Chak On reduces from 18 per cent to 13 per cent in 1991 and 2006 respectively (Table 8.6). While for Lai Yiu, it decreases from 17 per cent to 12 per cent within the corresponding period (Table 8.7). Relating to the fees for other items across the two Care Homes, the rate moves downward from 24 per cent in 1991 to about 17 per cent in 2006.

Donations from the Community Chest of Hong Kong become less

significant from the late 1990s. At the Chak On Care Home, the proportion decreases drastically from 20 per cent in 1993 to merely 2 per cent in 2006 (Table 8.6). Likewise, a significant reduction of 17 per cent is detected at the Lai Yiu Bradbury Care Home during this time period (Table 8.7).

In a context of the general economic recession around the mid-1990s and substantial decreases in donations from charity organisations such as the Community Chest of Hong Kong, the Helping Hand generated more of its own income annually through a range of activities. This has gradually become increasingly important, with the rate of increase being most obvious from 1997 to 2006. At Chak On, the proportion rises considerably from 1 per cent in 1993 to 13 per cent in 2006 (Table 8.6). A similar phenomenon occurs at Lai Yiu, with a considerable increase from 1 per cent to 14 per cent at the two respective periods (Table 8.7). Interestingly, a significant rate of 11 per cent is detected in the self-generated income at Lai Yiu in 1991. This was a very exceptional year and the reason is not clear. On the other side, the Chak On Care Home generates only 5 per cent in the same year (Table 8.6).

In short, the Helping Hand continuously endeavours to improve its total income, especially in the economic downturn in Hong Kong after the mid-1990s. From the early 2000s, the self-generated donations to the agency increasingly became a vital source of income.

Expenditure items

To examine the costs of care and to decide whether cost-saving has taken place in the two care and attention homes between 1990 and 2006, the researcher

has investigated both the total income as well as the total expenditure. Concerning the total home expenditure, items such as rent and rates, water and electricity, food, staff salary and the provident fund are included. Broadly, the total running costs of the two Care Homes show some increase after 1991. Coincidently the peak amount in both Care Homes is identified in the year 2001, in which the sum equates to HK$11984826 at Chak On, and HK$10049859 at Lai Yiu (Table 8.10).

Regarding the expenditure per capita, the amount in 1991 is HK$60163 at Chak On and mounts up to more than double after a decade, being HK$140998 (Table 8.10). Likewise, at the Lai Yiu Bradbury Care Home, the costs per capita also increase remarkably from HK$60962 to HK$133998 within the corresponding time frame. However, a decrease of around 16 per cent is detected between 2001 and 2006 across both residential homes. By 2006, the expenditure per capita was fallen to HK$117856 at Chak On and HK$112262 at Lai Yiu. To a certain extent, this is related to the substantial decrease in staff salaries across the two Care Homes in the same period. As revealed in the *Annual Reports* (Helping Hand, 1991-2006), per capita expenditure on staff salaries at Chak On falls after 2001, and Lai Yiu after 1999 (except for the year 2003-04). At Chak On the amount per capita falls from HK$109912 in 2001 to 87010 in 2006; a decrease of nearly 21 per cent (Table 8.11). Likewise, the amount per capita at Lai Yiu falls from HK$95235 to HK$76725 in the corresponding period, constituting a decrease of over 19 per cent.

Throughout the period from 1991 to 2006, the rate of change represents an increase of 113 per cent and 110 per cent money costs in two respective Care Homes (Table 8.3). As indicated in Table 8.10, the total running cost at Chak On was

HK$10135574 in 2006. This is close in money terms to that in 1997, being HK$10030644. A similar phenomenon occurs at Lai Yiu. In 2006, the total expenditure (being HK$8195127) is even lower than that of HK$8483594 in 1997. To a large extent, this is due to tight budget control by the HKSAR government after 1997, leading to falling income and a corresponding fall in expenditure by the homes.

Rent and rates

As far as the expenditure on rent and rates across the two Care Homes are concerned, the peak amount (being HK$578700) at Chak On is in 1998 (Table 8.12). The expenditure fluctuates slightly from 1997 to 2006, with the amount in 2006 being exactly the same as that in 1998 (having the same inflation rate of 4.7% in both years). Turning to the expenditure per capita, the amount in 1992 equates to HK$4248 and rises up to HK$6889 in 1998. Compared with the inflation rate of 4.7 per cent in 1998, the rental increase at Chak On is high; being 6.5 per cent in total expenditure and 5.2 per cent per capita costs. On the other hand, no rental increase (being HK$578700) is observed regardless of inflation in 2006. The amount per capita slides slightly down to HK$6729 in 2006, representing a reduction in the rate of over one per cent.

At the Lai Yiu Bradbury Care Home, the peak amount relating to rent and rates expenditure is in 2001, being HK$768420 (Table 8.12). Similarly, the greater fluctuation is also identified at Lai Yiu across the years from 1999 to 2006. The total expenditure of HK$760020 in 2006 is quite close to that of HK$757890 in 1999.

These reductions are common to other sectors in Hong Kong. In terms of the expenditure per capita, the amount was HK$4631 in 1992 and reaches its peak at HK$10984 in 1999. Despite the deflation rate of 5.1 per cent in 1999, Lai Yiu still shows a very high rental increase of nearly 30 per cent in both total expenditure (HK$757890) and per capita costs (HK$10984). Likewise, the expenditure per capita falls to HK$10411 (an increase of 1.5%) in spite of the inflation rate of 4.7 per cent in 2006.

Overall, the expenditure per capita on rent and rates at Lai Yiu is much higher than that at Chak On, especially after 1998. As the Lai Yiu Bradbury Care Home is built within a commercial complex under the management of the Commercial and Business Development Branch (CBDB) of the Hong Kong Housing Authority (HKHA), it needs to follow strictly and pay the rental costs according to the scale set by the HKHA instead of commercial rents. As stated in the 1999-2000 Corporate Plan, the CBDB aims 'to recover capital cost in the provision of welfare and community facilities' and 'to contain the vacancy rate below 5.5% and rent arrears below 4%' (Hong Kong Housing Authority, 2001). That explains why rental charges at Lai Yiu are lower than market prices but higher than those in public housing estates.

Throughout the period from 1991 to 2006, the rate of change in rent and rates represents an increase of 81 per cent and 119 per cent at Chak On and Lai Yiu respectively (Table 8.3). On comparison, the CCPI for housing comprises an increase of only 54 per cent in the corresponding period (Table 8.13). This includes rents, rates, government rent, maintenance costs, and other housing charges (Census

and Statistics Department, 2002). A Composite Consumer Price Index (CCPI) is compiled by the local Census and Statistics Department based on the overall expenditure pattern of all the households taken together to reflect the impact of consumer price changes on the household sector as a whole. However, for the homes rent is charged by the Hong Kong Housing Authority and rates are charged by the government of Hong Kong. Social service agencies such as the Helping Hand often do not have any say or bargaining power over these costs. Furthermore, there are practical difficulties for residential homes which cannot move to new accommodation even when the costs of rent and rates rise considerably. The real increases in building costs for the Care Homes under study were much higher than the increases in rent. This is why the homes had to accept the increases in the rents they paid.

Water and electricity

Another item on home expenditure relates to water and electricity. At the Chak On Care Home, the amount in 2006 (being HK$284534) rose from HK$294287 in 2000, and which also represents the peak amount (Table 8.14). In terms of per capita cost, the amount was HK$1593 in 1991 doubling to HK$3422 in 2000. It moved slightly downward to HK$3309 in 2006. Compared with the CCPI of 3.6 per cent in 2000, the increase at Chak On is greater; constituting 11.7 per cent in total expenditure and 9.1 per cent per capita costs.

At the Lai Yiu Bradbury Care Home, the total expenditure on water and electricity was HK$298529 in 2006 (Table 8.14). Such represents a rise of nearly 6

per cent, which is higher than that of the CCPI (2.1%). This then fell to the level close to that in 1998 (being HK$288645), and with slight increase from 1999 to 2004. The peak amount was in 2003, HK$395133. The per capita cost was HK$2137 in 1991 and increased to HK$4089 in 2006. Coincidently, per capita cost in 2003 (being HK$5199) was also the highest along the fifteen years' time. Compared with the CCPI of 1.4 per cent in 2003, there is an increase of 2.3 per cent in both total expenditure and per capita costs. This is mainly due to the outbreak of severe acute respiratory syndrome (SARS) in Hong Kong in 2003, when individuals were advised to wash hands frequently and to raise personal and public hygiene.

Across the years from 1991 to 2006, the rate of change relating to water and electricity comprises an increase of some 126 per cent and 118 per cent at Chak On and Lai Yiu respectively (Table 8.3). On comparison, the growth rate of its Composite Consumer Price Index is much lower, occupying merely 59 per cent in the corresponding period (Table 8.13). Despite the efforts of the two Care Homes to control the total expenditure, the rate of increase is still higher than the CCPI. Most probably, this was due to the greater number and proportion of frail residents admitted after the 2000s, in that the need for consumption on water and electricity is greater. For example, more disabled persons may require more heat during winter. For those suffering from urine and faeces incontinence, much more electricity and water are required for washing clothes. Another thing to note, the comparatively higher per capita cost at Lai Yiu is mainly due to the 24-hour service operation of the escalator for the use of staff, residents, and visitors. While at the Chak On Care Home, there is no such provision of lift service and hence a comparatively lower

cost per capita.

Food

Unlike the above-mentioned items, the total expenditure on food shows a decrease since 1998. At Chak On, the peak amount (being HK$546858) is found in 1998 (Table 8.15). Starting from this year onwards, the total expenditure on food falls except for the years of 2001 and 2002. In 2006, the sum reaches HK$404009, which is lower than that of HK$409438 in 1994. Compared with the CCPI for food (1.7%) in 2006, a decrease of 7.9 per cent in total expenditure and 9 per cent in per capita costs at Chak On is identified. When considering per capita cost, the amount of HK$6157 in 1991 falls substantially to HK$4698 in 2006. Likewise, the highest per capita cost is identified in 1998, equating to HK$6510.

At the Lai Yiu Bradbury Care Home, the largest sum of food expenditure is identified in 2001, equating to HK$536165 (Table 8.15). Since then, there is continuous reduction in the total expenditure, except in the years of 2003-04 and 2004-05. The total sum in 2006 is HK$440352, which is lowered to a level close to that in 1995 (being HK$429178). Referring to the CCPI for food (1.7%) in 2006, a decrease of 14.8% in total expenditure and 13.6% in per capita costs at Lai Yiu is observed. Unlike the Chak On Care Home, the per capita cost of food shows a slight increase, moving up from HK$5639 in 1991 to HK$6032 in 2006. Interesting to note, the highest per capita cost (being HK$7382) is identified in the year 1999 instead. Per capita cost at Lai Yiu is nearly 30 per cent higher than that at Chak On in 2006, and the reason is not clear as each Care Home has its own autonomy to

decide on the expenditure and choice of food.

Concerning the rate of change for food between 1991 and 2006, Chak On experiences an increase of 17 per cent and that of 22 per cent at Lai Yiu (Table 8.3). Compared with its Composite Consumer Price Index of being 45 per cent (Table 8.13), the rates of increase appear to be lower across the two Care Homes. Perhaps associated with the drastic growth in the number of functionally disabled older people in 2006, who may be likely to consume much less food in daily lives. Previous studies focus more on food consumption and nutritional care, but seldom assess whether food costs for older and more frail people are less, and which requires further research efforts.

Staff salaries

Among the different items on total home expenditure, staff salaries represents a major aspect across the two residential homes under study. At the Chak On Care Home, there is a continuous rise in expenditure on staff salaries within a decade, going up from HK$3381135 to HK$9342504 in 1991 and 2001 respectively (Table 8.11). The peak is in the same year, with the cost of HK$109912 per capita in 2001. However, the amount falls to HK$9116094 in 2002 and continues to drop in every subsequent year. In 2006, the total expenditure on staff salaries had fallen to HK$7482866, which is almost back to the level in 1997 (being HK$7641254).

Likewise at the Lai Yiu Bradbury Care Home, a continuous increase in expenditure on staff salaries is clearly revealed between 1991 and 1999. The corresponding sum is HK$2708495 in 1991, and mounts up remarkably to

HK$7309266 in 1999, comprising a remarkable increase of approximately 170 per cent (Table 8.11). Referring to the cost per capita, the highest amount is also detected in 1999, equating to HK$105931. Nonetheless, starting from 2000 onwards, the amount decreases gradually each year till 2006 (except in the year of 2004). In 2006 the total expenditure on staff salaries moves downward to HK$5600928, reducing to a level close to that of HK$5564579 in 1996. However, less difference is identified when referring to the per capita cost. In 2006 the amount per capita was HK$76725, which is closest to that of HK$74786 in 1995. Between 1991 and 2006, the rate of change in staff salaries showed an increase of 121 per cent and 107 per cent at Chak On and Lai Yiu respectively (Table 8.3).

In the context of the stringent budget cuts from the HKSAR government around the late nineties, most of the NGOs in the social welfare sector faced a major challenge. The implementation of a 'Lump Sum Grant' policy in 2000-01 (Social Welfare Department, 2000) has had a great impact upon the social service agencies. Under this 'new' subvention system, the Social Welfare Department allocates a lump sum to the NGOs and each has its autonomy to allocate this subsidy as it wishes. In order to cope with the tight financial constraints, many NGOs changed their usual employment strategies. Instead of hiring 'permanent' staff as in the former decades, the Senior Management Level began to recruit 'contract' staff. Underlying this new employment strategy was cost-saving, as only 'permanent' staff are entitled to all kinds of fringe benefits such as annual leave, medical welfare, and a provident fund. In the long run this adds heavy costs for the employing organisations. On the other hand, 'contract' staff enjoy much less of these benefits, and earn much lower pay.

They are bound less generous constraints and their posts can be terminated within a very short notice. It became a common practice among service agencies from 2000 not to renew the employment contracts of 'contract' staff after termination dates. This reduces obligations in relation to provident funds. This means greater flexibility as well as a further reduction in the total operation costs from the perspective of the agencies.

Under the new employment system, a 'contract' member of staff will fill a vacancy once when a 'permanent' member of staff resigns or leaves the agency. Following this, the Master Pay Scale (MPS) did not apply to the newly recruited staff member in the two residential homes under study. New staff were employed at lower wages and less favourable terms. In the field of social welfare, this saves much of the financial costs of care by adopting a new system of employing 'contract' staff. For example, when employing an Enrolled Nurse (EN), according to the Master Pay Scale (Table 8.16), an EN received a monthly salary of HK$7850 in 1991 (MPS Point 9). Whereas the EN continued to work in a service agency till 2005, this pay would have risen to HK$25340 (MPS Point 21). Within the 14-year period, the increasing rate would have been some 223 per cent in money terms.

In the case of recruiting a Personal Care Worker (PCW), a monthly stipend of HK$5370 (MPS Point 3) would have been paid in 1991 (Table 8.17). If a PCW had continued to work in the same welfare agency till 2005, a stipend of HK$13515/m according to the Master Pay Scale (MPS Point 9) would have been paid. The rate of increase represents around 152 per cent across the years from 1991 to 2005. Nevertheless in reality, the actual total expenditure on staff salaries within

this specific time frame was much less. To a large extent, this was mainly due to the use of new employment strategies by most social welfare organisations towards the 2000s. Many NGOs adopted such new employment strategies, in which recruiting 'contract' staff became a popular practice in Hong Kong. That provides a sound explanation of why the Helping Hand managed to produce a surplus in its annual balance after 2002 (Table 8.18).

Upon comparison, the Lai Yiu Bradbury Care Home managed to produce more surplus, with the amount of HK$999029 in 2002 mounting up to HK$1755012 in 2006 (Table 8.18). While at the Chak On Care Home, the corresponding sum was HK$46719 and HK$405997 in the respective periods. Referring to the *Annual Reports* (Helping Hand, 2002-06), the two Care Homes under study succeeded in reducing their overall expenditure substantially, especially with respect to staff salaries. As a result overall, cost-savings in wages were achieved across the two Care Homes by 2006. However, this may have had profound implications for the quality of care for older people.

Provident funds

The strategy of employing more 'contract' staff among the NGOs in the 2000s, has had long-term implications for expenditure from the provident fund. In Hong Kong, 'permanent' staff receive a comparatively higher salary, and are entitled to better fringe benefits including a provident fund. On the other hand, this is not applicable to the situation of 'contract' staff who often get lower pay and fewer

fringe benefits. Under the 'old system', 'permanent' staff used to enjoy the provident fund payment of 5 per cent, 10 per cent or 15 per cent of salary after retirement or resignation. Owing to financial constraints, most of the welfare agencies revised policy in relation to staff recruitment around the mid-2000s. Under the 'new system', 'permanent' staff in the Helping Hand are entitled to receive provident fund payment of a maximum up to 10 per cent, whereas 'contract staff' get merely 5 per cent or with a ceiling of HK$1000 monthly from the provident fund.

As clearly revealed in Table 8.19, the Lai Yiu Bradbury Care Home managed to reduce expenditure on the provident fund from 2001 (except in 2003-04). In 2006, the amount equates to HK$431148 which stays near to the level of HK$420839 in 2000. Since 2001, the amount shows a reduction, except for the years of 2003-04 and 2005-06. This pattern is well explained by the adoption of new employment strategy to recruit 'contract' staff to replace those 'permanent' staff who leave the agency. Consequently costs per capita fluctuated every year, rising from HK$1553 in 1991 to the peak amount of HK$6135 in 2001. The subsequent years show some decrease and the amount further drops to HK$5906 in 2006. On the other hand, cost-savings are not so obvious at Chak On, with the expenditure increasing every year (except 2001-02). Expenditure increased annually in terms of costs per capita, moving upward from HK$1757 in 1991 and reached HK$8436 in 2006. This was probably due to the greater number of 'permanent' staff at Chak On whose provident fund payments are comparatively much higher.

Although the two Care Homes managed to control the total expenditure on staff salaries, this only applies to the situation of 'contract staff'. Staff joining the

social service agencies before the 'Lump Sum Grant Subvention System' (LSGSS), launched in 2000-01, still enjoy relatively higher salaries as well as more fringe benefits. Prior to this social welfare subvention system, the government of Hong Kong used to reimburse the NGOs for the actual costs incurred in the provision of social services. As stated by the Social Welfare Department, the NGOs are supposed to redeploy human resources and other expenditure items 'to meet evolving priorities and changing community needs' (Social Welfare Department, 2000) in a more 'flexible' and 'cost-effective' manner under the Lump Sum Grant funding arrangement.

Payments into the provident fund are difficult to reduce in agencies employing a considerable number of 'permanent' staff. For example, in the case of a long-serving Personal Care Worker (PCW) who earned a monthly income of HK$13515 in 2005 (Table 8.17), the Care Home had to contribute at least HK$1352/m (about 10%) on behalf of this 'permanent' staff member to the provident fund. On the other hand, in the case of a 'contract' personal care staff whose wages equate to about HK$7000/m, the residential home contributed only 5 per cent (being HK$350/m) or a ceiling of HK$1000/m. It is clear, therefore, that the recruitment of 'contract' staff to replace 'permanent' ones in the two Care Homes at Chak On and Lai Yiu has served a significant purpose: reducing the total running costs substantially.

Structural changes in expenditure

As far as the total expenditure of the two residential homes is concerned, all

items including rent and rates, water and electricity, and food show an increasing rate of change within the period of 1991-2006. For instance, total expenditure at Chak On and Lai Yiu show a rise of 113 per cent and 110 per cent respectively (Table 8.3). The fastest growth was the expenditure on the provident fund, representing 423 per cent and 334 per cent across the two Care Homes. This is accounted for by the large sum of money allocated to the 'permanent' staff in the provident fund, in spite of the adoption of a new employment strategy after the early 2000s. As a matter of fact, there remain a considerable number of 'permanent' staff of different ranks and positions in both residential facilities at Chak On and Lai Yiu, and who have worked for the agency for a number of years. From the perspective of the employing agency, the Helping Hand, this implies a heavy financial burden in the long run. While for other expenditure items such as water and electricity, rent and rates, food, staff salaries, the rate of increase appears to be relatively lower.

Staffing arrangements and care provision

The data show that the case-mix characteristics across the two local Care Homes shift to the substantially more disabled and dependent by 2006, with the policy implementation of the 'Standardised Care Need Assessment Mechanism' in late 2000. Greater disability disrupts the normal or 'traditional ordering' of a home, whether it be a private home or an institution (Twigg, 1999, p.388). Generally, the ability levels of older residents in performing ADLs and IADLs show a pattern of decline in the current study. Many more required intensive help from staff in daily living. The growing dependency of residents creates additional demand and harder work for the personal care staff, and particularly with the more or less same staffing

levels.

Amidst the daily routine within residential facilities, the care staff (including the Personal Care Workers) are mainly responsible for carrying out all the hands-on tasks, sometimes called 'short interval needs' (Ferlie et al., 1989). For example, they have to change bed sheets, assist the frail elderly people in different aspects of feeding, bathing, and toileting. As mentioned in the previous chapter, six out of the 122 senior respondents (approximately 5%) in 1990 suffered from 'persistent' urine incontinence (Table 7.26). However, the number and proportion had risen rapidly by 2006, with 47 among the 152 respondents (around 31%) being persistently urine incontinent. Similarly, the proportion of older people facing problem of faeces incontinence 'persistently' was over 24 per cent (37 out of 152 respondents) in 2006 (Table 7.27). In contrast, none of the elderly respondents in 1990 suffered from 'persistent' faeces incontinence. Therefore, the tasks involved in handling the rising number of individual frail older residents were far more demanding upon care staff by 2006.

Furthermore, there were greater numbers and proportions of frail older people requiring 'maximum assistance' in carrying out activities of daily living (ADLs) by 2006. For example, a total of fifty residents (almost 33%) across the two Care Homes required help in 'dressing' every day (Table 7.32). On the other hand, the corresponding number in 1990 was merely nineteen, representing only 16 per cent. Another aspect relates to 'washing'. In 1990, eighteen older people (nearly 15%) need 'maximum assistance'. The figure increased to thirty-five by 2006, or 23 per cent.

In the case of 'toileting', over 30 per cent of the respondents in 2006 needed help (Table 7.32). In terms of number, this involved forty-six older residents requiring 'maximum assistance'. The figure was comparatively smaller in 1990, consisting of only thirteen residents. Suppose an average of ten minutes is needed for helping each disabled older person with toileting in the residential facilities, the estimated time exceeded seven and a half hours a day in 2006. On the other hand, this only takes two hours for the personal care staff to implement in 1990.

In the case of 'feeding', there were twenty-three respondents (15%) across the two Care Homes requiring 'maximum assistance' in 2006 (Table 7.32). While in 1990 only four respondents (3%) needed significant help. If it consumes fifteen minutes for a care worker to feed a seriously impaired resident, it takes an hour to complete all the feeding tasks for the four frail old people at one meal in 1990. On the contrary, the time required for feeding all the twenty-three functionally disabled persons in 2006 was much longer, taking almost six person-hours.

Most strikingly, 92 out of the 152 respondents (over 60%) in 2006 required 'maximum assistance' to help with bathing (Table 7.32). The corresponding figure in 1990 was merely 38, comprising around 31 per cent. Suppose a Personal Care Worker (PCW) uses fifteen minutes to move and bathe for a functionally disabled service-user, it consumes nine and a half hours to finish bathing all the thirty-eight older residents in 1990. In the case of bathing for the total ninety-two residents in 2006, this required a much longer time of twenty-three hours. Viewing from this perspective, the additional as well as heavier workload of care staff in 2006 is clearly reflected. Bathing at home permits individuals to gain some sense of control

over their daily lives, and 'without fear of observation or rebuke' (Twigg, 1997, p.228). However for older people living in institutional settings, this is associated with loss of 'identity, a material expression of the self and of memories', especially when they are placed under professional care coupled with a very tight daily schedule and routine. This will be further discussed in the following chapters.

Aside from the ability levels in performing activities of daily living (ADLs), change can also be demonstrated in terms of cognitive ability between the two cohorts of respondents in 1990 and 2006. Referring to the questionnaire in this current study (Question No.15-23), older residents were asked to state their name, age, birth date, current living place, region, present date, month, year, counting from one to ten. If they were able to answer all these nine questions 'correctly', they scored '0'. For those giving a 'partly correct' answer, the score is '1' in each question. Those providing a 'wrong' answer score '2' marks in each question. Hence the higher the total scores, the more disorientated the respondents are.

In this study, there were altogether nine older people providing 'wrong' answers to all the nine questions, scoring a total of '18' marks (Table 7.34). This represents a higher proportion of almost 6 per cent, when compared with the 3 per cent in 1990 (being four older persons). For those who are able to answer correctly in four questions and with the other five questions being 'partly correct' or 'wrong', they attain a total score between '10' and '14'. In 1990, the figure is thirty-two respondents (about 26%). On the other hand, the corresponding number was sixty in 2006, representing approximately 40 per cent. Not surprisingly, there was a greater number and proportion of older people in 1990 demonstrating higher cognitive

ability levels. Among the 122 respondents, thirty (about a quarter) were able to provide 'correct' answers to all the nine questions, scoring '0' mark. Comparatively only five residents (around 3%) in 2006 managed to answer all the nine questions correctly.

To a great extent, the dependency levels and the physical and mental conditions of older residents directly affect the workload of staff. The more severe the levels of impairment, the heavier the workload on the care staff. This study shows that compared with 1990, the Personal Care Workers (PCWs) in the residential homes at both Chak On and Lai Yiu had to deal with a more demanding and heavier workload by 2006. However, at the two specific time periods, the provision of staff at the two Care Homes appears to be similar. There seems to have been no additional staff to deal with the additional hands-on tasks for older people. Briefly put, the same levels of staffing and care workers in 2006 had to cope with a more diverse set of long-term care needs of a larger number with higher proportion of very frail disabled residents in the two Care Homes. There remains the crucial question of whether the quality of care in these homes may have been affected because of reduction in costs and spending. In a local study of the fourteen residential care homes, a 'low staffing level' was associated with cases of 'malnutrition' among residents (Woo et al., 2005). It is suggested that 'inadequate staffing levels' in most of the residential homes in Hong Kong imply negative impacts upon the quality of care and life of older people (Woo and Chau, 2009, p.484). Crucially and specifically, the policy-makers and administrators need to understand that care staff are 'a central part of the care environment' (Mozley et al.,

2004, p.193), and the need to provide adequate staffing levels and skills training opportunities in order that they can manage the diverse and complex tasks competently.

Chapter summary

Between 1991 and 2006, the total income of the two residential homes of the Helping Hand showed a significant increase. As indicated in Table 8.3, the rate of change represents an increase of 333 per cent and 319 per cent at Chak On and Lai Yiu respectively. Among the various sources, subsidy from the government (the Social Welfare Department) remains important, occupying about 50 per cent of the total income in the two Care Homes (Table 8.6 and Table 8.7). Owing to the unfavourable economic situation in the territory as well as the constrained resources of the HKSAR government in the early 2000s, many NGOs in the welfare sector had to search for alternative sources of funding support to continue operating. This is true of the two care and attention homes in this study, for which the subsidised amount from the SWD and other charity organisations dropped considerably and fluctuated between 2000 and 2006.

By 2006, the two Care Homes no longer relied solely on government subsidy or other funding bodies such as the Community Chest of Hong Kong. Instead the residential homes organised fund-raising activities to generate and supplement additional income. Self-generated donations to the agency become more prominent. From 1991 to 2006, the rate of change represents an increase of 956 per

cent and 443 per cent across the Care Homes at Chak On and Lai Yiu respectively (Table 8.3). On the other hand, the rate of change in donations from the Community Chest of Hong Kong was only 80 per cent and 75 per cent in the two respective homes over the period.

Concerning the total expenditure of the two Care Homes, all items (except the provident fund) increased marginally between 1991 and 2006. Referring to Table 8.3, the rate of change in total expenditure were 113 per cent and 110 per cent at Chak On and Lai Yiu respectively. No significant rate of change is identified in the recurrent costs of food items, rent and rates, water and electricity. As for the expenditure on staff salaries, reductions had taken place at Chak On since 2001. Likewise, this also happened at Lai Yiu from 2000, both in terms of the total amount as well as per capita costs (Table 8.11). By adopting a new employment strategy around the early 2000s, staff were recruited on 'contract' basis instead of as 'permanent' staff. To a large extent, this accounted for reductions in total expenditure by the two Care Homes.

It is likely that the volume of care work carried out by the staff, and the services provided by the two homes, have increased significantly more than funding. In this sense in the two Care Homes in the current study, there is evidence of greater cost efficiency since 2002 (Table 8.18). In the Helping Hand homes, the salary cost of staff has remained the same or fell for some years after 2003 in response to the generally unfavourable economic climate in Hong Kong (Table 8.11). However, if output is seen in terms of volume and quality, then the likely decline in the quality of care in the two homes makes the case that there has been greater cost-efficiency less

likely.

Total staff numbers remained largely ‘unchanged’ across the two residential homes throughout the sixteen years. The same dollar in 2006 has to do much more work than that in 1990. In restricted sense, the care and attention homes at both Chak On and Lai Yiu appear to have increased efficiency in terms of money costs. Because of the changing resident case-mix across the two Care Homes after the implementation of the ‘gatekeeping policy’ in 2000, those living in them in 2006 are more seriously impaired than those in 1990. The staff had to cope with the more demanding daily tasks that come with the care needs of a greater number of very frail elderly people by 2006. Given a broadly similar level of staffing, the workload of the frontline personal care workers had increased substantially by 2006. The data show that shouldering all those hands-on tasks of ‘feeding’, ‘bathing’, ‘washing’, ‘dressing’, and ‘toileting’ for the greater number of very frail older people by 2006 was extremely time-consuming, particularly when compared with 1990. This generated a more demanding and heavier workload for each personal care worker. As documented in previous literature, there is strong association between cost and dependency or client characteristics (an indicator of case-mix) (Davies and Knapp, 1981; Knapp, 1984). It is likely that the cost savings seen in the two homes over the period studied, largely driven by reductions in payments for staff facing a substantially more needy population, did result in lower quality of care for at least some residents.

Chapter 9 Changes in Social Participation amongst the Residents of the Homes: 1990 to 2006

As the previous chapter shows, staffing levels remained more or less the same in the two homes in 2006 compared with the 1990 situation. With a striking increase in the proportion and number of very frail old people living in the two institutions, a similar number of personal care staff was having to meet the challenge of coping with the much greater volume of care needs amongst residents selected largely because of their levels of physical dependency. Hence the researcher investigated whether this had any consequences for levels of social activity amongst the residents as well as on their social interaction both within and outside the homes.

In the case of social participation, three main areas of concern are addressed here. First is the residents' engagement in different kinds of social activities as organised by the two local Care Homes under study. Secondly, it relates to the nature and quality of social relationships within the institutional facilities. In other words, the interactions of older people with fellow residents as well as with staff in the residential settings are explored. Thirdly, it involves the social contacts of residents with the 'outside' world, such as keeping in touch through visits from family, relatives or friends. Hence this chapter aims to unveil the social life of residents, including their involvement in home activities. Furthermore, it depicts the relationships and interactions of older people with fellow residents as well as with staff across the two Care Homes in 2006, and observes whether friendship or conflict occur among them in daily living. The focal interest is comparing patterns of behaviour at the two specific points of time; that is, to examine if there are any

changes in levels of social participation as well as interpersonal relationships between 1990 and 2006, and to identify the associated factors. Another major concern is to explore whether social ties are maintained after the older people's admission to the two residential homes. The literature shows that social interaction with others is a prime determinant of felt well-being. So despite the fact that it is difficult to measure these matters with any precision, this chapter seeks to understand changes in the quality of social life in the two homes across the research period.

Social participation in activities in the homes

In the field of gerontology, a variety of theories have been used to explain the behaviour of older adults entering into the late stage of life. Among them, one of the most commonly cited is the Activity Theory, which proposes that senior adults who continue taking part in social functions tend to acquire a positive personal sense of identity and adjustment well to old age (Havighurst, 1968). On the contrary, the Disengagement Theory argues that older people may withdraw from social participation or other activities where this is 'functional' to both the individual and society; implying a more negative connection between social engagement and psychological well-being (Cumming and Henry, 1961). Meanwhile, the Model of Selective Optimisation and Compensation takes a neutral position, asserting that older adults willingly reduce social activity with the decline of health (Baltes and Baltes, 1990). Atchley's Continuity Theory (1997) postulates that individuals make adjustments in volume and type of activity when facing changing life circumstances.

The literature presents evidence that for older people involvement in activities and maintaining social ties and relations has positive impacts on mental health. Engagement in social activities is found to have an association with life satisfaction (Ho et al., 1995), successful ageing (Horgas et al., 1998; Rowe and Kahn, 1997), and quality of life in care homes (Mozley et al., 2004). A recent study in Hong Kong suggests Tai Chi as a 'promising exercise option' in nursing homes which helps to improve the health-related quality of life of residents (Lee, L.Y.K. et al., 2009, p.42). To a certain extent, these data support Erikson's (1963) concept of ego integrity in later life, in that people experience a sense of integrity through active social participation. Where this is absent there is evidence they may fall into a state of depression or despair at this advanced old stage (Mozley et al., 2004; Victor et al., 2005).

Social participation can sustain vital functions. Thus it is importanty there is 'an ability to take advantage of opportunities for social interaction, limited as they may be in many facilities' (Mor et al., 1995, p.2). Many studies indicate the positive association between older people's engagement in home activities and resident outcomes such as higher morale, increased survival, slow down of functional decline and higher life satisfaction (Spector and Takada, 1991; Ho et al., 1995; Mitchell and Kemp, 2000; Tomaka et al., 2006). In a small-scale study by Keller-Cohen et al., (2006, p.590), an experimental sample of 20 respondents in residential settings were set a 'roster of daily activities' to expose them to more opportunities for social engagement. The results showed the residents demonstrated 'better linguistic performance' subsequently. Summing up, research findings indicate that residents

who get involved in a variety of activities tend to age more successfully.

Clearly, functional disability and dependency, increasing frailty and decline may hinder involvement in activities (Moos et al., 1984; Choi and Wodarski, 1996). The more seriously impaired are less likely to participate in the functions organised by residential homes. For instance, residents with dementia as well as those with functional disability are found to have less involvement in social activities and tend to be more 'socially withdrawn' (Zimmerman et al., 2003, p.14). Those with better functioning in activities of daily living (ADLs) appear to have the highest degree of involvement, though with varied levels of engagement across the five countries (Schroll et al., 1997). This raises questions about the direction of causality.

The findings in this study corroborate much previous work. Residents were asked if they were occupied with constructive activities in the two Care Homes. As indicated in the Question No.39, the respective scores of '0', '1', and '2' are allocated to those having social activity participation 'frequently', 'sometimes', and 'rarely'. It is worthwhile to note that over 45 per cent of respondents in 2006 'rarely' take part in some kind of constructive home activity, and only around 12 per cent 'frequently' do so (Table 9.1). In the 1990 situation, many of the residents were more functionally capable. Unsurprisingly there was a higher proportion of 18 per cent that 'frequently' took part in activities, with merely 26 per cent 'rarely' doing so. From the cross-tabulation, the year of survey differs significantly with the variable of social activity engagement (Chi-square = 10.868, Sig. = .004).

Most measured variables are found to have modest correlation with the social activity participation of older people. As observed from Table 9.2, the two

variables concerning ‘cognitive ability’ (r = .396) and ‘expressiveness’ (r = .304) stand out as having moderate association with social activity engagement. Moreover, slight association is identified between activity participation and several other variables such as ‘mobility’ (r = .277), ‘urine incontinence’ (r = .269), and ‘faeces incontinence’ (r = .262). All of them reach the significance levels of .000. While for other variables such as ‘sex’ (r = .102), ‘vision’ (r = .116), and ‘hearing’ (r = .185), the correlation is rather weak, with significance levels being less than .05.

Separated from ability levels, age is strongly associated with social participation. In a study of 516 long-term care respondents, those in institutional settings as well as the oldest-old age cohort were found to have ‘lower levels of activity engagement’ in various kinds of instrumental tasks (that are related to IADLs) and leisure activities (Horgas et al., 1998, pp.564-566). Residents reaching highly advanced ages spent more time resting and much less time in performing instrumental tasks and other activities. However, it is difficult to separate out the causal pathways: Mozley and others (2004, p.195) find residents in most homes predominantly ‘inactive’ and ‘rarely seen to interact’. Over half of the respondents were observed to be just ‘sitting in complete inactivity, either awake or dozing in their chairs’. Likewise, Victor and others (2005) suggest that those lacking engagement in meaningful social activities were more likely to acquire poor psychological well-being. This echoes the findings in an observational study by Clark and Bowling (1989), in that the lack of social activities in nursing homes had a negative impact on the quality of life of residents. ‘Inactive’ residents were more likely to suffer from depression.

In the case of Hong Kong, there is a general dearth of literature about the social participation of older people in the community, and even less for those living in institutions. A study by Chou and others (2004) focussed on various types of leisure activities such as watching television, listening to radio, playing mahjong or cards, and found that the participation levels of the sample of older people still living in the community were correlated with their gender, education, economic status, self-rated health, and functional impairment. In general the poorer and more disabled people were the more constrained were their interactions with others. A more recent study (Woo and Chau, 2009, p.478) which looked at elderly residents in both subsidised and private homes detected a general lack of 'programs of activities and rehabilitation' in these institutions. Over half of the sampled 1820 residents (67%) spent most of their time watching television, and merely 23 per cent took part in exercise. Those living in subsidised homes were found to have more engagement in activities. This was mainly due to the higher frailty level of residents in the private care homes in Hong Kong, which is an obstacle to their social participation.

The two local Care Homes in this study provided a variety of activities or programmes for the residents. As documented in the *Annual Reports* (Helping Hand, 1991-2006), various types of social, recreational, rehabilitative, educational as well as developmental activities were organised. 'Social' activities included birthday parties, festival celebrations, regular visits from students, service agencies, and business firms. 'Recreational' activities involved films, operas, dramas, dances, carnivals, field trips, eating out, and interest groups. 'Rehabilitative' activities mainly referred to morning exercises, reality orientation training, and reminiscence

classes. ‘Educational’ activities included nutrition and health talks, medical and dental consultations, newspaper reading, and religious programmes. Lastly, ‘developmental’ activities included gardening, calligraphy, painting, handicraft classes, volunteering services in the home and the community. Generally older persons made their own choices as whether to get involved in these home activities or functions, though sometimes with the encouragement of staff.

In the current study, respondents were asked if they were ‘frequently’, ‘sometimes’, or ‘rarely’ occupied with some kind of constructive activities. Looking at the Question No.39, the corresponding scores attained equate to ‘0’, ‘1’, and ‘2’. As indicated in Table 9.3, rehabilitative activities stand out to be most frequently organised by the two care and attention homes all through the years from 1992 to 2006 (except in the year of 2005), in terms of both proportion and number. In 1992, the proportion involving rehabilitative functions represents over 68 per cent (being 4534) of the total frequency of activities (being 6624), and remains stable at around 50 per cent for some years. It is from 2001 onwards (except 2004 and 2006) that the proportion and volume of rehabilitative activities show a considerable fall. By 2006 rehabilitative programmes comprise merely 35 per cent (being 2189) of the total frequency of activities (being 6298). On the other hand, educational activities appear to increase throughout the years, rising from 12 per cent (being 804) to 28 per cent (being 1780) in 1992 and 2006 respectively. Other types of activities (including social, recreational, and developmental) also show an increase in the total volume between 1990 and 2006. To some extent, this can be explained by the deteriorating health status or ability level of the residents. Another vital factor is the significant

change in the objectives and focal concern of the residential homes in Hong Kong. Greater emphasis was placed upon the provision of nursing care in institutional facilities from the mid-2000s, in accordance with the growing frailty of older residents. The classification of different types of activities may not reveal the full picture of social interaction in the care homes, and so the data need to be interpreted in a careful manner.

Helping others

As far as social engagement of older people is concerned, the researcher also explored whether they help fellow residents within the care homes. As stated in the Question No.38, those who 'frequently' help others get a score of '0', while those who do so 'sometimes' or 'rarely' score '1' or '2'. The results reveal that the overwhelming majority of home residents (over 76%) 'rarely' help others during residential living (Table 9.4). On the other hand, the corresponding proportion comprises of only 34 per cent in 1990. This echoes the study by Horgas and others (1998), in which frail older people tended towards performing less tasks or instrumental activities of daily living (IADLs). Residents spent most of the leisure time watching television and resting, rather than involvement with 'helping' activities such as caring for others. There is a lower proportion of respondents (approximately 6%) in 2006 helping others 'frequently' within the residential facilities, whereas a higher proportion (being 14%) is identified in 1990. As reflected from the cross-tabulation, there is a high correlation between the year of survey and the variable 'helping others' (Chi-square = 48.820, Sig. = .000). Briefly put, the residents in 2006 were much more frail and therefore unlikely to help fellow

residents in the Care Homes, compared to the 1990 situation.

Regarding the associated factors with the variable of 'helping others' in the two care institutions, the Pearson correlations are moderately strong in several variables (Table 9.5). These include 'cognitive ability' (r = .481), 'urine incontinence' (r = .362) as well as 'mobility' (r = .315), and all reach the significance levels of .000. In other words, residents with cognitive impairment and functional disability are less likely to help others. Two variables, 'hearing' (r = .172) and 'age' (r = .140) show a very weak correlation with 'helping others', with significance levels less than .05. Therefore whether older people help others or not within the two local Care Homes is linked to their ability levels, including both physical and mental aspects.

Concerning the willingness of older individuals to help fellow residents in institutional facilities, the results at the two specific points of time turn out to be the same as hypothesised. As indicated in the Question No.40, those showing willingness to help others 'frequently', 'sometimes', or 'rarely' get the scores of '0', '1', or '2' respectively. Fewer older people show a 'willingness to help others' across the two Care Homes in 2006, with the majority of over 70 per cent in 2006 'rarely' doing so (Table 9.6). On the contrary, the corresponding proportion in 1990 was 17 per cent. Only 9 per cent of respondents in 2006 show willingness to help others 'frequently', which is comparatively less than the 14 per cent in 1990. Again, the year of survey affects substantially the residents' willingness to help others (Chi-square = 80.174, Sig. = .000).

When exploring the factors associated with the variable concerning

'willingness to help others', the Pearson correlations of the two items 'cognitive ability' and 'urine incontinence' are found to be moderately strong at .514 and .410 respectively (Table 9.7). Both reach the significance levels of .000. Viewed in this light, the willingness of older people to help fellow residents within the Care Homes is again closely associated with their ability levels, coupled with the two specific periods of survey that also impact on the scores.

In summary, capacity for social engagement is greatly affected by the impairment level of nursing home residents, no matter whether physical or cognitive. This outcome is supported by evidence in the study by Kolanowski and Litaker (2004, p.599), in that both 'cognitive and physical functioning' (instead of 'personality' factors) are the major predictors of activity engagement of older people. Social and recreational programs should therefore be designed according to the functional level of residents, in order to offer them 'meaningful involvement in their environment'. Mozley and others (2004) support this conclusion, stating that it is desirable for care homes to initiate and provide opportunities for interaction and activity among residents. Likewise, Park (2009, p.476) emphasises the importance of residential care homes helping older adults 'to develop meaningful relationships within the facility' as well as to design sociable mealtimes that enhance psychological well-being.

Interactions with fellow residents

Apart from engaging in different kinds of activities organised by the care and attention homes, older people can spend time interacting and talking among

themselves as well as with staff in their everyday lives. Does this happen in the actual situation of residents in the two local Care Homes under study? Do they sustain contacts with fellow residents and staff, and how frequently? How much does friendship or conflict occur during their daily residential living?

Social interaction or bonding remains an essential issue for people throughout various stages of human life. According to Attachment Theory (Bowlby, 1984), human beings are born with a biological propensity to be close to others and seek to maintain some intimate relationships across their life spans. A study by Cicirelli (2010, p.191) gives support to this. As shown in the attachment relationships of 80 married and widowed older people, they are connected with a substantial 'variety of attachment figures' in spite of the 'smaller attachment networks'. These facilitate and enhance adaptation of older people in later life. Furthermore, the strength and quality of social relationships contribute considerably to the physical and mental well-being as human beings move towards advanced age (Walters and Bartlett, 2009). In their study about a group of 51 respondents who relocated to a new home after retirement, some kind of new social companionship or affective bonding is usually established. This so-called 're-ordering' of social networks is needed and essential for older adults when facing significant life changes. Building a strong proximal 'non-kin' social relationship is deemed to be an important source of affective support in old age (Litwin, 2001; Fiori et al., 2006). This applies to elders living both in the community as well as in the residential facilities. Hence when older people move to take residence in institutional facilities, will they also have to re-order and develop social bonding? Is there any obstacle to

this kind of relationship-building for older people living in the two local Care Homes under study?

In this current study, the residents were asked if social conversation with fellow residents takes place ‘frequently’, ‘sometimes’, or ‘rarely. Referring to the Question No.41, the corresponding scores equate to ‘0’, ‘1’, or ‘2’. Using cross-tabulation (Table 9.8), the year of survey differs significantly in the variable of ‘conversation with residents’ (Chi-square = 26.038, Sig. = .000). As revealed, around 13 per cent of the respondents in 2006 ‘frequently’ talk with fellow residents. This proportion is comparatively lower than that in 1990, which involves some 20 per cent. In the meantime, there is a striking proportion of older people who ‘rarely’ talk with fellow residents. This comprises of more than half of the total respondents in 2006, being close to 56 per cent. On the other hand, the situation in 1990 is more positive, with about 25 per cent who ‘rarely’ talk with others. For those who ‘sometimes’ talk with others, a decrease is also indicated, falling from around 55 per cent to 31 per cent in 1990 and 2006 respectively. Social interactions among residents are observed to be on the decline within the two Care Homes by 2006.

Among the different variables, ‘cognitive ability’ (r = .476) and ‘expressiveness’ (r = .409) stand out as closely correlated with ‘conversation with residents’, arriving at the significance levels of .000 (Table 9.9). Other variables such as ‘urine incontinence’ (r = .346), ‘faeces incontinence’ (r = .324), ‘hearing’ (r = .269), ‘mobility’ (r = .263), and ‘sex’ (r = .216) show only modest association, and approach a significance of .000. Again, those with higher ability levels are more likely to be engaged in social dialogues with their fellow residents. On the other

hand, those who are very frail and disabled may encounter difficulty in establishing social connections or relating with others (including staff and fellow residents). That accounts for their infrequent contacts. As shown by Park (2009), this may cause negative impacts upon the physical health and psychological well-being of older people.

Likewise, there exists a remarkable difference in the variable 'conflict with residents' at the two specific periods of 1990 and 2006. In Question No.42, older adults were asked whether they have conflicts with other residents. The scores given to those involving in conflict with residents 'rarely', 'sometimes', or 'frequently' equate to '0', '1', or '2' respectively. Using the cross-tabulation, over 66 per cent of the respondents in 1990 engage in 'frequent' conflicts with fellow residents in daily living, and with only 4 per cent 'rarely' do so (Table 9.10). On the contrary, the vast majority of respondents (nearly 82%) in 2006 'rarely' have conflicts with others, and merely around 3 per cent frequently do so. Again, the year of survey differs significantly in relation to the variable of 'conflict with residents' (Chi-square = 1.787, Sig. = .000). To sum up, even 'conflict' demonstrates social interaction or communication, and so may actually be a positive feature; better for health than passivity. However, the data shows that residents were engaged in fewer conflicts or interactions with staff in 2006, and which may be a negative sign.

The variable 'cognitive ability' appears to have a stronger association with 'conflict with residents', arriving at the Pearson correlation r = .349 and the significance level of .000 (Table 9.11). Several variables such as 'urine incontinence' (r = .299), 'faeces incontinence' (r = .259), 'age' (r = .235), and 'hearing' (r = .226)

demonstrate more modest correlations. As for other variables such as ‘mobility’ (r = .143) and ‘expressiveness’ (r = .105), the correlation is very weak, the significance levels being less than .05. Clearly the cognitive functioning of older people plays an influential role in the volume of daily interactions and conflicts among residents.

Sociability levels

The literature offers evidence that the lucidity, vision, and speech of older people are crucial determinants of their sociability within institutional lives (Retsinas and Garrity, 1985). The number of friends made and social isolation are directly affected by confusion as well as the ability to see and speak of individual residents. Likewise, Resnick and others (1997) find that sensory impairments such as visual, hearing and communication disabilities tend to impact upon levels of participation of older residents in home activities.

In this present study, the researcher enquired into whether older people are able to establish friendships during their residence at the two Care Homes. Referring to the Question No.43, respondents claiming to have ‘good’, ‘average’, or ‘no’ friends within the institutions acquire the respective scores of ‘0’, ‘1’, or ‘2’. Compared with former studies, some different results are generated here regarding the sociability level. In 2006 only about 7 per cent of them mention having developed ‘good’ relationships with fellow residents, while around 43 per cent claim to have ‘average’ relationships with others (Table 9.12). Worse, it is alarming to find almost half of the respondents fail to establish any friendships within the Care Homes. On the contrary, over half of the respondents (nearly 53%) in 1990 mention

having ‘average’ relationships with fellow residents. In the meantime, there is a higher proportion of about 20 per cent being able to establish ‘good’ friendships, and an approximate 28 per cent state they have ‘no’ friends in the residential facilities. Hence the year of survey affects significantly the sociability levels of residents in the two Care Homes under study (Chi-square = 17.203, Sig. = .000).

Apart from above, the variable ‘cognitive ability’ (r = .556) demonstrates a strong correlation with the sociability level of older people, reaching the significance level of .000 (Table 9.13). Other variables such as ‘urine incontinence’ (r = .398), ‘expressiveness’ (r = .372), ‘faeces incontinence’ (r = .350), and ‘mobility’ (r = .319) show modest associations with the sociability level, and at the significance levels of .000. On the other hand, the two variables of ‘hearing’ (r = .138) and ‘sex’ (r = .117) are found to have weak correlations with the sociability level, at the significance levels of less than .05. Therefore, functional ability (including physical and cognitive aspects) of older people is closely linked with their sociability level. Precisely put, social interaction among residents by 2006 had become very minimal, and even avoided. The older people were rather socially isolated in daily living within the two Care Homes of the Helping Hand in Hong Kong.

Relations with staff

Besides interacting with fellow residents, there are also opportunities for older people to relate with staff such as social workers, nurses, and personal care workers in their day-to-day residence. According to Mitchell and Kemp (2000), the care environment serves as an essential influence on the mental health of older

people. This includes support from the home staff as well as from fellow residents, and the engagement in social activities. Similarly, the research by Mozley and others (2004, p.193) echoes this, emphasising the importance of interactions with care staff. Findings suggest that when staff, as 'a central part of the care environment', and residents have less involvement and interaction with each other within daily institutional living, the residents' quality of life will be adversely affected and depression may occur.

A process of 'sequestration' has been detected in some care homes, separating the 'fit' from the 'frail' in the use of space and activities, 'adoption of different social roles' and 'care received by these residents' (Hockey, 1990, pp.98-101; Froggatt, 2001, pp.319-332). Put in the other way, home staff may pay more attention to those who are functionally fit, leaving little time for those severely disabled who become neglected in daily residential living. However, as Cooney, Murphy and O'Shea (2009) suggest, it is vital for staff to practise a holistic and person-centered approach when carrying out daily caring tasks.

Across the two Care Homes under study in 2006, the researcher collected data on social interactions between older people and home staff, especially in the midst of daily routines and tight schedules. These included positive conversations and conflicts with staff, and whether their relationships are being affected in one way or another. Referring to the Questions No.44 and No.45, those having conversations and conflicts with staff 'rarely', 'sometimes' or 'frequently' show scores of '0', '1', or '2'. As observed from the cross-tabulation, a striking population of about 61 per cent of respondents in 2006 'rarely' talk with staff, when compared

to the lower proportion of merely one-fifth in 1990 (Table 9.14). In contrast, only 5 per cent have 'frequent' social dialogues with staff in 2006, and 34 per cent 'sometimes' do so. The picture in 1990 differed remarkably. Close to 19 per cent 'frequently' talk with staff, while approximately 61 per cent 'sometimes' do so. As indicated, the year of survey affects significantly the variable concerning 'conversation with staff' (Chi-square = 46.743, Sig. = .000). These findings echo the study by Mozley and others (2004), in which both verbal and physical contact between staff and residents are 'rarely observed'. It is particularly alarming to find that nearly half of the older respondents are observed to be 'silent', and only close to 14 per cent have verbal activity.

Referring to Table 9.15, several variables such as 'faeces incontinence' (r = -.150), 'hearing' (r = -.164), 'age' (r = -.152), and 'cognitive ability' (r = -.130) are found to have weak correlations with 'conversation with staff', and at the significance levels less than 0.05. There is also no strong relationship between 'conversation with staff' and several variables such as 'sex' (r = .045), 'mobility' (r = -.040), 'expressiveness' (r = -.034), where significance levels are greater than 0.05. Summing up, residents with lower ability levels (both physical and mental) are likely to encounter difficulty in relating to or talking with the home staff. With the substantially increased number of seriously impaired residents and the more or less same number of care staff in the two residential homes over the period, the workload became heavier. To a large extent, this must account for a reduction in social interactions and communication between staff and residents.

Concerning the dimension of 'conflict with staff', different patterns are also

identified at the two specific periods of time. In 1990, 71 per cent of older residents 'rarely' have conflict with staff, while a quarter 'sometimes' do so (Table 9.16). On the contrary, the corresponding proportions comprise of nearly 91 per cent and 7 per cent in 2006. This may be explained by the greater frailty and disability level of residents in 2006 as well as the increasing and demanding workload on staff. For those events involving in 'frequent' conflicts with staff, the proportions remain quite small, comprising of merely 4 per cent and 2 per cent at the two respective periods. Again, the year of survey affects significantly the variable 'conflict with staff' (Chi-square = 19.323, Sig. = .000).

No correlation is identified between 'conflict with staff' and all other variables. Referring to Table 9.17, these include 'sex' (r = .003), 'mobility' (r = .030), 'urine incontinence' (r = .010), 'faeces incontinence' (r = -.042), 'expressiveness' (r = -.001), 'vision' (r = .082), 'hearing' (r = .043), 'age' (r = -.021), and 'cognitive ability' (r = .026). All these do not approach statistical significance, with $p > 0.05$. In short, conflicts between older people and home staff rarely occurred across the two local Care Homes, and were even fewer in 2006. This suggests a lack of time for staff to interact closely or get involved in conflicts with the home residents.

Social contacts with family, relatives and friends

As well as maintaining interpersonal relationships within the residential setting, it is equally important for residents to keep in contact with the 'outside world' after their move to a care home. Maintaining social ties and having visits by family, relatives, and friends is a good sign of social support for older people after

their admission to residential homes. They allow some sense of personal control and achievement (Arling et al., 1986). Other studies (Seeman et al., 1996; Fiori et al., 2007) show that positive social support contributes to psychological well-being.

In a local study about 175 nursing home residents in Hong Kong, a lack of social support is clearly reflected in an average of only 0.6 network members per resident (Lee, L.Y.K. et al., 2005). Many of the respondents had no contacts at all. Likewise, in a local study by Cheng (2009), the sampled 72 elderly residents expressed a sense of social isolation and even 'a feeling of abandonment'. Few network members were identified, with an average of 2.6. These included immediate family members, home staff, and residents. Worse still, over two-third of older residents did not consider their children as part of their social network. This was due to infrequent contacts or visits from the younger generation as well as 'detached' relationships between the two parties. Some care facilities appear to 'discourage family visits as well as social interactions within the home' (p.163) through their management policies.

Taking up residence in a long-term care facility often disrupts an individual's social world and relationships with family and friends can be substantially affected (Lieberman and Tobin, 1983; Kane and Caplan, 1990). This is especially true if the location of the residential care setting is far away from the original living place of the older people's family, close relatives or friends. In the current research, respondents were asked about their social ties 'outside' the residential setting. As stated in the Question No.46, those being visited by relative 'rarely', 'sometimes', or 'frequently' acquire the respective scores of '0', '1', or '2',

while ‘3’ is attributed to those ‘not applicable’ cases, such as residents having no family member or relative at all. Findings in the present study indicate that a striking proportion of over one-third of older respondents (being 37%) is ‘rarely’ visited by relatives (Table 9.18). While the proportion in the 1990 situation was somewhat lower, comprising only 20 per cent. For those being ‘sometimes’ visited by relatives, the proportion represents some 39 per cent in 2006. It was lower than that in 1990; 48 per cent. On the other hand, the proportions of those experiencing ‘frequent’ visits stay close to about 25 per cent at both points in time. Through the use of cross-tabulation, the year of survey indicates significant difference in the variable ‘visit by relative’ (Chi-square = 18.264, Sig. = .000).

Observing Table 9.19, no correlation is detected between ‘visit by relative’ and the variables: ‘sex’ (r = .037), ‘mobility’ (r = .100), ‘urine incontinence’ (r = .060), ‘faeces incontinence’ (r = -.006), ‘expressiveness’ (r = .079), and ‘cognitive ability’ (r = -.007). All of them reach significance levels greater than 0.05. Concerning the other three variables of ‘vision’ (r = -.129), ‘age’ (r = -.122), and ‘hearing’ (r = -.108), there is only a very weak and indirect association with ‘visit by relative’, with the significance levels being less than 0.05.

To summarise, many residents of the two Care Homes are seldom or never visited by relatives. They appear to continue living in a state of social isolation or disconnectedness from the community. Social support is weak after their entry into these two residential homes of the Helping Hand. In this respect, the older people’s well-being and sense of control over life are adversely affected.

Chapter summary

The observations and findings reported here provide evidence that older people living in the two care institutions of the Helping Hand demonstrate patterns of passive or inactive participation in social activities. Despite the frequency of 'rehabilitative' or 'educational' programmes throughout the period from 1992 to 2006, these activities are somewhat 'solitary' and rarely interactive in nature. Moreover, the majority of respondents fail to 'help others' or show reluctance to do so. These findings are consistent with the literature in that involvement in social activities within institutions is affected most by the ability levels of residents, including both physical and cognitive aspects.

The residents appear to be rather detached in their daily social interactions across the two local Care Homes in this study. Relationships with fellow residents as well as with staff appear to be seen as undesirable, and tend almost towards a state of apathy. Compared with the 1990 pattern, less social dialogue or even less conflict is found to occur among residents as well as with staff in daily living. Generally friendships are not well established among residents or with home staff, and become rarer with the deteriorating ability levels of older adults. Through the use of a T-test, the significance levels of all the nine items are found to be statistically prominent, with $p < 0.01$ (Table 9.20). Furthermore, some variables such as 'helping others', 'willingness to help others', 'conversation with residents', 'conflict with residents', 'sociability level', 'conversation with staff' have p-values equating to .000. Summing up, the contrasting patterns of social participation of older people at the two specific points of 1990 and 2006 are clearly revealed. To a large extent, the

changes are associated with the greater frailty of residents as well as the ever-increasing and more demanding staff workload by 2006.

The residents also had less contact and support from the 'outside world'. This is reflected in the infrequent visits by family, relatives or friends. The majority of the respondents had been living in other institutional settings such as hospitals, and hostels prior to their admission to these two Care Homes. This suggests a lack of close relatives or friends in the case of some respondents even before entry to the homes. The data and observations made in this research show that psychosocial needs were often overlooked or underestimated in a context of high needs for basic physical care. There was considerable evidence of a social environment unlikely to generate the positive effects the literature describes in more socially supportive institutions.

Coupled with the greater disability levels in 2006, the daily tasks and workload of personal care staff were increasing and very demanding in the two residential homes. The staff had little time to engage in meaningful relationships or social dialogues with the residents. The literature is clear that staff having direct and close contacts with older people contributes positively to the quality of care in residential homes. Viewed in this light, are these two homes good places for older people to live the last years of their lives? The last chapter will discuss this important issue.

Chapter 10 Discussion and Conclusions

The chapter provides an overview of the research findings, and discusses the insights and limitations of this research. The main object of the research was to discover whether the introduction of the Standardised Care Need Assessment Mechanism (SCNAM) after 2000 has led to its intended consequences when applied to two care homes for older people in Hong Kong. This study investigates whether the aims of better target efficiency and cost-savings in long-term care were obtained by the introduction of the SCNAM. Evidence of unintended consequences is also examined, as well as who have been the beneficiaries and losers from the policy shift. As far as possible this thesis also explored questions to do with the values and assumptions that the introduction of the government's policy demonstrate, and the sources of these values and beliefs in habitual ways of thinking about old age and care in the wider society: that is to say assumed 'models of welfare'.

Better targeting

This research has discovered evidence for, and evaluated the impact of, the 'gatekeeping' policy after its implementation in November 2000. As stated by the HKSAR government, the SCNAM aims to reduce wastage of resources by targeting older people 'in greatest need'. The data collected for this research show that residents admitted to two Care Homes run by the Helping Hand charity were demonstrably more frail after the introduction of the new policy.

Comparing the populations in the homes of three years or less in the two periods of 1990 and 2006, those in 2006 are found to be much older. As shown in

Chapter 7, residents aged 80 and above represent 77 per cent in 2006 compared with 53 per cent in 1990 (Table 7.22). By 2006, the very old cohorts were the majority, and younger cohorts were a much reduced proportion. In terms of ability levels, residents in 2006 were more functionally impaired than those in 1990. The majority were less mobile and independent, with 51 per cent being wheel-chair bound in 2006 as compared to only 7 per cent in 1990 (Table 7.23). Between 1990 and 2006 the proportion with 'no urine incontinence' reduced from 75 per cent to 49 per cent (Table 7.26). It is clear that residents were much more frail and dependent in 2006; requiring substantial assistance in activities of daily living (ADLs) as well as instrumental activities of daily living (IADLs). In addition, the cognitive status of residents was generally lower, and wandering behaviour more common in 2006.

These outcomes are consistent with the recommendations of the Elderly Commission (1998, p.28), which greatly influenced the introduction of the new selection policy: that residential care services funded by the government should be provided only for older people 'with moderate or high levels of impairment, whether physical or cognitive …'. As Chapter 5 discusses, before 2000 people with mild or even no impairments were admitted to homes subsidised by the government. The Commission and subsequently the government regarded this as a misallocation of resources. In their view, admission only of those with more severe functional disabilities would be an appropriate use of resources.

In this limited sense 'improved target efficiency' was achieved by the formal 'gatekeeping' policy implementation in Hong Kong. As Walker (2005) has summarised, better target efficiency is achieved when the proportion of those

ineligible for admission is reduced while that of those eligible are increased. However, it is recognised that whether such target efficiency generates greater welfare or fairness in the use of resources depends very much on the definitions of eligibility applied, and the outcomes for those selected and for those not selected. The degree to which this study could answer these larger questions is limited by the availability of data on care and outcomes for both the residential populations studied here, and particularly for the whole population of older people in Hong Kong. However, it is argued that the findings described here, although limited to two homes and the populations within them, do allow some inferences about wider outcomes. They also reveal some gains and losses following the introduction of the selection policy which are likely to apply more widely in Hong Kong.

This research shows how the two Care Homes have become more selective and admit people with higher functional limitations and lower incomes. While some people with similar functional needs may continue to live in the community, clearly their numbers will be reduced if these and similar homes are targeting effectively in this way. In reviewing the findings this analysis has considered the question of the impact on older people whose needs are not captured by these functional assessments, but who may also need help. There is evidence that some will have been diverted to low cost private care homes which are generally of lower quality. It is also likely that more people with lower functional disabilities will be cared for informally by families and more will be coping on their own. While limited in its scope and ambitions, the success of the new selection policy is unlikely to have reduced overall welfare amongst the frail elderly and may even have increased it at

the margin.

'Improved' cost efficiency

An intended outcome of the SCNAM was to contain the costs of long-term care falling on the government of Hong Kong, particularly of residential care for older people. Partly as a consequence of government policies, these homes were themselves facing reductions in income, and looking for new sources and for ways of reducing costs. The Chairman (Father Sean P. Burke) pointed out that the Helping Hand charity had 'experienced a shortfall' in its recurrent expenditure, and needed to find 'new ways' of meeting recurrent costs (*1995-96 Annual Report*, p.8). In the *1998-99 Annual Report*, the Executive Director also stressed a need to 'exercise tight cost control measures in all areas' and to explore new income sources (p.10). Similarly, the Acting Executive Director later alerted all staff to the need 'to reduce the running costs', and find ways to 'trim down the total recurrent expenditure …' (*2001-02 Annual Report,* p.10).

The research reported here into the financial accounts of the two homes studied reveals substantial increases in total income and total expenditure following the introduction of the new selection policy. As discussed in Chapter 8, between 1991 and 2006, Chak On Care Home increased its total income by 333 per cent and total expenditure by 113 per cent (Table 8.3). The corresponding changes at Lai Yiu Bradbury Care Home were 319 per cent and 110 per cent. At the same time, expenditure on food showed a comparatively lower increase; being merely 17 per cent at Chak On and 22 per cent at Lai Yiu. It is apparent that cost control in both

residential care homes became very tight, especially on food. While further data is limited (expenditure on staffing has also been analysed) there are good reasons to conclude that some aspects of the quality of life in the homes had been severely restricted despite the higher functional needs of their populations.

The annual reports discuss how the Helping Hand organisation has received a reduced proportion of its income from the government in spite of the growing number of 'longer living elderly' having to be dealt with (*2004-05 Annual Report*, p.9). Subsidies from the Social Welfare Department contribute only about half of the total income of the two Care Homes. For Chak On, this represents 52 per cent and 53 per cent in 1991 and 2006 respectively (Table 8.6). As for Lai Yiu, this corresponds to 48 per cent and 52 per cent (Table 8.7). The Helping Hand organisation has to generate substantial income from donations every year. This source was some 13 per cent to 14 per cent for the two residential homes in 2006, compared with 5 per cent and 11 per cent in 1991. Knapp (1984) says technical or cost efficiency occurs when maximum output is produced from the minimum quantity of inputs. In this limited sense these two homes are likely to have increased cost efficiency. But, as earlier chapters have described, 'maximum output' may have been obtained at the cost of reduced support for individual older people in the homes.

The staff workload

The data collected in this study suggest that the populations in the home were likely to require much more help from staff. Over half of the total 152

respondents in 2006 cannot walk independently and require others' help, as compared to only 23 per cent in 1990 (Table 7.24). The proportion of residents with 'persistent incontinence' increases sharply: in the case of urine incontinence from 5 per cent in 1990 to 31 per cent in 2006 (Table 7.26). In the case of those requiring 'maximum assistance' in bathing, this rose from some 31 per cent in 1990 and 61 per cent in 2006. In Hong Kong, the weather is generally hot and humid in summer. It is a common practice for people here to take bath daily all year round. This applies to the frail residents in the two care and attention homes, and this level of help with bathing was a heavy workload for the personal care workers every day.

Generally the literature shows that as the aggregate dependency of residents increases, the need for more staff, and better trained staff, rises even faster (Knapp 1984, p.175). While in these homes staffing levels rose only slightly there is considerable evidence in the annual reports of the management's awareness that it was asking for greater commitment and output from staff. 'Staff restructuring' is reported to have been required in that duties performed by different ranks of staff are 'combined' and 'broadened' (*2002-03 Annual Report*, p.10). A strong emphasis on 'doing more for less' in the organisation is clear in reports after 2000. In 2005 it is reported that 59 out of 271 staff have been working in the charity's homes for over ten years (*2004-05 Annual Report*, p.5). In another report all the nurses, personal care workers, cleaners**,** cooks, kitchen staff, artisans, drivers are praised for their 'courage and professionalism', and for becoming 'heroes' in caring for residents, especially during the outbreak of SARS (*2003-04 Annual Report*, p.5). Clearly increases in staff efficiency relied on the professional and personal integrity of staff

more than on increased expenditure on staff wages or on higher skilled staff.

Quality of care

Observational evidence and other data reported in Chapter 9 show that the policy of greater selectivity had been managed at the cost of significant reductions in indicators of quality in the two homes. Interaction and communication between residents and staff fell substantially. The proportion of residents who 'rarely' talk with staff rises sharply from 21 per cent in 1990 to 61 per cent in 2006, while the measure 'having social conversation frequently' falls from 19 per cent to 5 per cent (Table 9.14). The frequency of 'conflicts between residents and staff' rises by 20 percentage points in the period (Table 9.16).

Previous studies (Mitchell and Kemp, 2000; Boerner and Reinhardt, 2003; Brown Wilson, Davies and Nolan, 2009) report the benefits of reciprocal interactions between staff and residents in care homes. Rubery and Urwin (2011, p.122) argue that quality cannot be disentangled from 'human interaction' between service users and carers, and that 'the attitudes, skills and commitments' of carers are important and closely connected. There is substantial evidence reported here that routine tasks were forcing out the softer interactions between staff and residents and this is also a well reported consequence of selectivity in the literature (Grasser, 1996, p.17). Increased skills and training are necessary in these contexts but there was little evidence of more intense training of staff in these two homes.

Quality of life

The literature shows that friendship is a key source of social support for residents in care homes. The development of companionship among fellow residents contributes positively to the quality of life of older people (Hubbard, Tester and Downs, 2003). Talking is found to be the most common activity among older people in care homes (Gutheil, 1991; Kovach and Robinson, 1996). But difficulties in vision, hearing, and communication may cause obstacles for interpersonal relationships, and limit participation in activities that preserve a healthy sense of self and well-being (Resnick, Fries and Verbrugge, 1997). Nonetheless, it is observed that residents develop various means of social interaction, using non-verbal behaviour to communicate and construct despite impairments (Hubbard, Tester and Downs, 2003).

The findings reported in Chapter 9 document are reduced social activities and increased isolation in the homes as dependency levels grew. The proportion of residents engaging 'frequently' in social activities fell from 18 per cent in 1990 to 12 per cent in 2006 (Table 9.1), whereas those who engaged 'rarely' rose from 26 per cent to 45 per cent. However, the indicator of 'mutual help among residents', usually rare in the literature, rose from 34 per cent to 76 per cent between the two periods (Table 9.4). Nonetheless the data shows that close to half of the residents in 2006 failed to establish friendships in the two Care Homes, compared with nearly 28 per cent in 1990 (Table 9.12). Many of the respondents do not maintain social ties with the outside community after home admission. About 37 per cent were 'rarely' visited by relatives in 2006 (Table 9.18).

Sadly, the findings in this research show that residents in the two care homes seldom interact, although there is some evidence of assistance given by one to another on occasion. The majority lives in a lonely and isolated state, and, overall, residents cannot expect support from each other because of their age and disabilities. Placing a dense population of seriously impaired frail old people together under one roof clearly has a negative impact upon social interactions and communication. The two Care Homes in this study appear mainly to offer accommodation for seriously disabled old persons to live in. The 'psychological' and 'social' welfare of the residents was being treated slightly or even overlooked.

Assumptions about family support and informal care in Hong Kong

This research has been hampered by a paucity of hard evidence about informal care in Hong Kong. Paradoxically, a near universal assumption on the part of policy makers and administrators that family care is normal in Hong Kong has led to it informing policy but not to funding for research or the collection of regular data that support the assumption. The government of Hong Kong assumes that the family 'naturally' takes up the role of looking after its older members. As stated in the *Annual Report* (Social Welfare Department, 2004), care and attention homes are meant to admit older people who are 'without family members to provide the necessary assistance, or causing great stress to the family'. The Ad Hoc Committee of the Elderly Commission (1998, p.5) suggested that in a Chinese society like Hong Kong, older people 'usually' live with their families. On the other hand, statistics show that though 75 per cent of older people have one or more children living in Hong Kong, a significant proportion of them do not receive regular support from the

family (Census and Statistics Department, 2005, p.108). Only about a quarter of elderly respondents are visited 'frequently' by relatives while the proportion of those being visited 'rarely' rose substantially from 20 per cent in 1990 to 37 per cent in 2006 (Table 9.18).

The Elderly Commission (1998, p.28), recommended that older people without any impairment or with only mild impairment be looked after in the community by community support services, including the provision of carers' support services. However, available evidence shows that about a quarter of older persons with no ADL impairment or mild impairment is living in largely private residential care homes (Census and Statistics Department, 2005, p.122). In addition there remain long waiting lists for residential places, reflecting a pattern of continuing felt need for formal and institutional care (Chapter 5).

Policy consequences of the residual model

Pinker (1990, p.126) argues residualists tend to regard the informal sector as 'a ready-made, under-utilised alternative to a variety of formal social services', and consequently promote policies that tend 'to weaken the links between the state and civil society and to reduce long-term dependency on the state'.

The HKSAR government accepts only a marginal role in providing welfare, while leaving the family and the market to operate on their own. This principle has not always been paramount. In the White Paper '*Social Welfare into the 1990s and Beyond'* (Hong Kong Government, 1991, p.14) it was suggested that social welfare services should be available to 'all who need them', and not to be confined to the

socially and financially disadvantaged. However, the SCNAM has not achieved its expectation of shorter waiting lists for subsidised places following a more targeted selection process (Elderly Commission, 1998, p.22). Numbers on waiting lists rose from 17468 in 1998-99 to 22293 in 2012 (*Social Welfare Services in Figures: 1982 to 2014 Editions*). Waiting times have not fallen either; these were 33.2 months in 1997 and 34 months in 2012 (Hong Kong Hansard, October 22, 1998; Hong Kong Hansard, March 2007).

Following findings reported by the Elderly Commission (1998, p.27) that some residents living in government-funded care and attention homes were 'in relatively good health and do not necessarily require care and attention service', policy makers assumed that subsidised care homes had been over-staffed and that the system was under-utilising resources by caring for relatively independent older people. As a result the success of the selection policy has not been accompanied by increases in staffing despite evidence they are needed (Chui and Research Team/The University of Hong Kong, 2009, pp.68-69). The evidence reported in this research demonstrates substantially increased workloads for staff in the two homes studied.

In the provision of different types of residential care services, Hong Kong has adopted a 'mixed economy of welfare' approach, or 'welfare pluralism'. Pinker (1990, p.126) suggests this can mean 'a system in which the range and variety of service providers is increased' while the government assumes the major responsibility for 'funding through transfer payments … with the ultimate goal of privatising the entire financial structure of social welfare'. This is close to the situation in Hong Kong, in which 'welfare pluralism' is implemented within a

residual welfare model. The government acts mainly as a funder; purchasing care places from residential homes in the NGOs or private sector through the Enhanced Bought Place Scheme (EBPS). Additionally in the absence of a universal pension scheme there is a substantial number of older people having to depend on CSSA and using that as a source of care funding.

As both Richard Titmuss and Robert Pinker warned, when a residual model is followed, there are risks to other parts of society; particularly risks to the family and then to the economy. These lead to costs and burdens being 'externalised' by the state and imposed on the family, the voluntary sector, and particularly on women. This study has been focused, because of the availability of evidence, on the effect of a new policy on two particular care homes. While it has been possible to show clear evidence that the homes now admit and support a more highly dependent population of older people, and do so at reduced costs per resident, this evidence of 'better targeting' and 'greater cost efficiency' can only be understood in the context of more general evidence of the likely impacts on the whole population of older people and their families.

Contributions and limitations of the study

The findings demonstrate improved targeting in selecting the most functionally frail applicants for admission into the two residential care homes studies. This is likely to imply greater vertical target efficiency in the use of publically subsidised residential care services in Hong Kong. However, this study has been limited in the degree to which it can describe or speculate on the

consequences of the new policy for horizontal target efficiency, that is the proportion of the whole population of older people in Hong Kong who are allocated to the most appropriate services. The findings can only be broadly generalised to all other residential homes in this territory, though the effects of the new policy (SCNAM) are likely to be similar.

Behind the policy shift (SCNAM) are winners and losers. The winners include the government of Hong Kong, private care home operators, taxpayers, those 'in greatest need', and their family members. Despite the higher frailty levels of residents, the Social Welfare Department subsidy to the NGOs was some only 50 per cent of total costs in 2006, a similar level to 1990. Without having to add further financial resources in the two Care Homes, the government has transferred to them more of the work of care. Another beneficiary has been private care home operators who benefit from increased demand for CSSA recipients who 'fail' the SCNAM but nonetheless have a felt need for institutional care. There has been a rapid increase in the total number of care places in the private sector; rising from 17700 in 1996 to 52917 in 2011, indicating rising levels of need and a shortage of community based services and family support.

There are a variety of different kinds of losers as a result of the success of the 'gatekeeping' policy. The older people who 'pass' SCNAM face a significantly reduced quality of care in the subsidised homes. The homes and their staff have different relationship. More are contract staff employed on lower wages, face higher workloads and enjoy fewer fringe benefits. In the wider community the costs and benefits of social care have been redistributed as older people and their families

have had to find alternative solutions to care needs that are not recognised by the SCNAM.

This thesis has tried to evaluate the wider social costs and benefits of the new selectivity but can only conclude that it is unlikely to have done more harm than good. The account of policy making and implementation reported in this thesis is an example of policy making that misunderstands the complexity of social care, makes apparently common sense assumptions about social behaviour and social needs, and is founded on ideology rather than evidence or understanding.

Bibliography

Abel, E.K. (1991). *Who cares for the elderly? Public policy and the experiences of adult daughters*. Philadelphia: Temple University Press.

Abel-Smith, B. and Titmuss K. (eds.) (1974). *The philosophy of welfare: selected writings of Richard M. Titmuss.* London: George Allen & Unwin Ltd..

Allen, I., Hogg, D. and Peace, S. (1992). *Elderly people: choice, participation and satisfaction*. London: Policy Studies Institute.

Andersen, R.M., McCutcheon, A., Aday, L.A., Chiu, G.Y. and Bell, R. (1983). Exploring dimensions of access to medical care. *Health Services Research*, 18 (1), 49-74.

Andersen, R.M., Rice, T.H. and Kominski, G.F. (2007). *Changing the U.S. health care system: key issues in health services, policy, and management*. John Wiley & Sons, Inc.

Andrews, G.J. and Phillips, D.R. (2000). Private residential care for older persons: local impacts of care in the community reforms in England and Wales. *Social Policy and Administration*, 34 (2), 206-222.

Arling, G., Harkins, E.B. and Capitman, J.A. (1986). Institutionalisation and personal control: a panel study of impaired older people. *Research on Aging*, 8 (1), 38-56.

Atchley, R.C. (1997). *Social forces and aging: an introduction to social gerontology*. Belmont, Calif.: Wadsworth Pub. Co..

Baldock, J. (1999). Culture: the missing variable in understanding social policy?. *Social Policy and Administration*, 33 (4), 458-473.

Baldock, J. (2000). Culture: the missing variable in understanding social policy?. In: Nick manning and Ian Shaw (eds.). *New Risks, New Welfare: Signposts for Social Policy.* Oxford: Blackwell Publishers Ltd., 121-136.

Baldock, J. (2001). Caring and dependency: age and disability. In: May, M. et al. (eds.). *Understanding social problems: issues in social policy*, 55-69.

Baldock, J. (2003). Social care in the United Kingdom: a pattern of discretionary social administration. In: Anttonen, A., Baldock, J. and Sipilä, J. (eds.). *The Young, the Old and the State: social care systems in five industrial nations*. Cheltenham: Edward Elgar, 109-142.

Baldock, J. (2004). Deficiencies in British social care services and the (efficiency) consequences of an administrative rather than a democratic politics of community care. In: Knapp, M., Challis, D., Fernandez, J.L. and Netten, A. (eds.) *Long-term care: matching resources and needs.* Aldershot: Ashgate, 35-44.

Baldock, J. and Ungerson, C. (1994). *Becoming consumers of community care*: *households within the mixed economy of care*. York: Joseph Rowntree Foundation.

Baldock, J., Mitton, L., Manning, N. and Vickerstaff, S. (eds.) (2012). *Social Policy*. Oxford: Oxford University Press, Chapter 8.

Ball, M.M., Whittington, F.J., Perkins, M.M., Patterson, V.L., Hollingsworth, C., King, S.V. and Combs, B.L. (2000). Quality of life in assisted living facilities: viewpoints of residents. *Journal of Applied Gerontology*, 19 (3), 304-325.

Baltes, P.B. and Baltes, M.M. (1990). Psychological perspectives on successful aging: the model of selective optimisation with compensation. In: P.B. Baltes and M.M. Baltes (eds.). *Successful aging: perspectives from the behavioural sciences*. New York: Cambridge University Press, 1-34.

Bartlett, H. (1995). Admission to residential aged care homes in Hong Kong: a study of policy and practice. *Hong Kong Journal of Gerontology*, 9 (2), 3-9.

Bauld, L., Chesterman, J., Davies, B., Judge, K. and Mangalore, R. (2000). *Caring for older people: an assessment of community care in the 1990s*. Aldershot: Ashgate.

Bear, M. (1990). Social network characteristics and the duration of primary relationships after entry into long-term care. *Journal of Gerontology*, 45 (4), 156-162.

Bebbington, A. and Darton, R. (1996). *Healthy life expectancy in England and Wales: recent evidence*. Discussion Paper No.1205. The Personal Social Services Research Unit, University of Kent at Canterbury.

Bebbington, A. and Davies, B. (1983). Equity and efficiency in the allocation of personal social services. *Journal of Social Policy*, 12 (3), 309-330.

Bebbington, A.C. (1996). *Health expectancy and long-term care costs*. Discussion Paper No.1185. The Personal Social Services Research Unit, University of Kent at Canterbury.

Bebbington, A.C., Brown, P., Darton, R.A., Miles, K. and Netten, A.P. (1999). *Survey of admissions to residential and nursing home care: 30 month follow-up*. Discussion Paper No.1537. The Personal Social Services Research Unit, University of Kent at Canterbury.

Bell, D. and Bowes, A. (2006). *Financial care models in Scotland and the UK*. York: Joseph Rowntree Foundation.

Berkman, L.F., Seeman, T.E., Albert M., Blazer, D. et al. (1993). High, usual and impaired functioning in community-dwelling older men and women: findings from the MacArthur Foundation research network on successful aging. *Journal of Clinical Epidemiology*, 46, 1129-1140.

Bernstein, L. (1992). A public health approach to functional assessment. *Caring*, 11 (12), 32-38.

Big Market, Small Government (September 18, 2006). Available from: <www.ceo.gov.hk/archive/2012/eng/press/200601-12.htm> (Accessed 18 April, 2013).

Bitzan, J.E. and Kruzich, J.M. (1990). Interpersonal relationships of nursing-home residents. *The Gerontologist*, 30 (3), 385-390.

Boerner, K. and Reinhardt, J.P. (2003). Giving while in need: support provided by disabled older adults. *Journal of Gerontology: Social Sciences*, 58B (5), S297-304.

Bowlby, J. (1984). *Attachment and loss*. Harmondsworth: Penguin Books.

Bowling, A. (1997). *Measuring health: a review of quality of life measurement scales.* Buckingham, Philadelphia: Open University Press.

Bowling, A. (2005). *Ageing well: quality of life in old age*. Maidenhead: Open University Press.

Bradshaw J. (1972). The taxonomy of social need. In: Cookson, R.A., Sainsbury, R. and Glendinning, C. (eds.) (2013). *Jonathan Bradshaw on Social Policy Selected Writings 1972-2011*. York: University of York.

Brandeis, G.H., Baumann, M.M., Hossain, M., Morris, J.N. and Resnick, N.M. (1997). The prevalence of potentially remediable urinary incontinence in frail older people: a study using the minimum data set. *Journal of the American Geriatrics Society*, 45 (2), 179-184.

Bravo, G., Charpentier, M., Dubois, Marie-France, De Wals, P. and Emond, A. (1998). Profile of residents in unlicensed homes for the aged in the eastern townships of Quebec. *Canadian Medical Association Journal*, 159 (2), 143-150.

Brodsky, J., Habib, J., Hirschfeld, M., Siegel, B. and Rockoff, Y. (2003). Choosing overall LTC strategies: a conceptual framework for policy development. In: *World Health Organisation collection on long-term care: key policy issues in long-term care. Geneva: World Health Organisation,* 245-270.

Brown Wilson, C., Davies, S. and Nolan, M. (2009). Developing personal relationships in care homes: realising the contributions of staff, residents and family members. *Ageing and Society*, 29 (7), 1041-1063.

Butler, R., Fonseka, S., Barclay, L., Sembhi, S. and Wells, S. (1998). The mental health of nursing home residents: a New Zealand study. *Aging and Mental Health*, 2 (1), 49-52.

Campbell, A.J., Bunyan, D., Shelton, E.J. and Caradoc-Davies, T. (1986). Changes in levels of dependency and predictors of mortality in elderly people in institutional care in Dunedin. *New Zealand Medical Journal*, 99 (805), 507-509.

Cantor, M. and Brennan, M. (2000). *Social care of the elderly: the effects of ethnicity, class, and culture*. New York: Springer.

Cantor, M.H. (1980). The informal support system: its relevance in the lives of the

elderly. In: Borgatta, E.F. and McCluskey, N.G. (eds.). *Aging and Society: current research and policy perspectives*. Beverly Hills, C.A.: Sage Publication, 111-146.

Carpenter, B. (ed.) (1997). *Families in context: emerging trends in family support and early intervention*. London: David Fulton Publishers.

Carpenter, B.D. (2002). Family, peer and staff social support in nursing home patients: contributions to psychological well-being. *Journal of Applied Gerontology*, 21 (3), 275-293.

Challis, D. and Hughes, J. (2002). Frail old people at the margins of care: some recent research findings. *The British Journal of Psychiatry*, 180, 126-130.

Challis, D., Hughes, J., Jacobs, S., Stewart, K. and Weiner, K. (2007). Are different forms of care-management for older people in England associated with variations in case-mix, service use and care-managers' use of time?. *Ageing and Society,* 27 (1), 25-48.

Challis, D., Mozley, C.G., Sutcliffe, C., Bagley, H., Price, L., Burns, A., Huxley, P. and Cordingley, L. (2000). Dependency in older people recently admitted to care homes. *Age and Ageing*, 29 (3), 255-260.

Chan, A.C.M., Cheng, S.T. and Phillips, D.R. (2002). *Quality of life of the Chinese elderly in Hong Kong: preliminary findings from two focus groups studies*. Hong Kong: Asia Pacific Institute of Ageing Studies, Lingnan University.

Chan, A.C.M., Leung, E.M.F., Lee, J.J., Cheng, S.T. and Wu, M.M.F. (1993). *Comparative experience of psychological symptoms of frail elderly people in need of residential care*. Hong Kong: Department of Applied Social Studies, City Polytechnic of Hong Kong.

Chan, H. and Lee, R.P.L. (1995). Hong Kong families: at the crossroads of modernism and traditionalism. *Journal of Comparative Family Studies*, 26 (1), 83-99.

Chan, K.L. (2007). *Population movement statistics in Hong Kong*. Paper presented at 2006 Conference of the International Association for Official Statistics (IAOS) held in Ottawa, Canada, September 6-8, 2006.

Chan, R.Y.K., Ho, L. and Tam, J. (1997). Chinese familism in transition: the case of Hong Kong. *International Review of Sociology*, 7 (3), 375-384.

Chattopadhyay, A. and Marsh, R. (1999). Changes in living arrangement and familial support for the elderly in Taiwan: 1963-1991. *Journal of Comparative Family Studies*, 30 (3), 523.

Chau P.H. and Woo J. (2008). *How well are seniors in Hong Kong doing? An international comparison*. Hong Kong: The Hong Kong Jockey Club.

Cheng, S.T. (2009a). Generativity in later life: perceived respect from younger generations as a determinant of goal disengagement and psychological well-being. *The Journals of Gerontology*, 64B (1), 45-54.

Cheng, S.T. (2009b). The social networks of nursing-home residents in Hong Kong. *Ageing and Society*, 29 (2), 163-178.

Cheng, S.T. and Chan, A.C.M. (2006). Social support and self-rated health revisited: is there a gender difference in later life?. *Social Science and Medicine*, 63 (1), 118-122.

Cheng, S.T., Chan, W. and Chan, A.C.M. (2008). Older people's realisation of generativity in a changing society: the case of Hong Kong. *Ageing and Society*, 28 (5), 609-627.

Cheng, Y.H., Chi, I., Boey, K.W., Ko, S.F. and Chou, K.L. (2002). Self-rated economic condition and the health of elderly persons in Hong Kong. *Social Science and Medicine*, 55 (8), 1415-1424.

Chi, I. (1998). Living arrangement choice of the elderly in Hong Kong. In: Lo, E. (ed.) *Housing and the elderly in Hong Kong*. Hong Kong: University of Hong Kong.

Chi, I. (2002). Long-term care policy for elders in Hong Kong. *Journal of Aging and Social Policy*, 13 (2/3), 137-153.

Chi, I. and Boey, K.W. (1994). *A mental health and social support study of the old-old in Hong Kong***.** Hong Kong: Department of Social Work and Social Administration, University of Hong Kong.

Chi, I. and Lee, J.J. (1989). *A health survey of the elderly in Hong Kong*. Hong Kong: Department of Social Work and Social Administration, University of Hong Kong.

Choi, N.G. (1991). Racial differences in the determinants of the living arrangements of widowed and divorced elderly women. *The Gerontologist*, 31 (4), 496-504.

Choi, N.G. and Wodarski, J.S. (1996). The relationship between social support and health status of elderly people: does social support slow down physical and functional deterioration?. *Social Work Research*, 20 (1), 52-63.

Choi, N.G.. (1999). No longer independent: the dynamics of care arrangements for frail elderly parents. *Journal of Gerontological Social Work*, 32 (3), 27-47.

Chong, A.M.L., Kwan, C.W., Chi. I., Lou, V.W.Q. and Leung, A.Y.M. (Epub April 17, 2014). Domestic helpers as moderators of spousal caregiver distress. *Journal of Gerontology Series B: Psychological Sciences and Social Sciences*. .

Chou, K.L. and Chi, I. (2001). Social support exchange among elderly Chinese people and their family members in Hong Kong: a longitudinal study. *International Journal of Aging and Human Development*, 53 (4), 329-346.

Chou, K.L., Chow, N.W.S. and Chi, I. (2004). Leisure participation amongst Hong Kong Chinese older adults. *Ageing and Society*, 24 (4), 617-629.

Chou, S.C., Boldy, D.P. and Lee, A.H. (2002). Resident satisfaction and its components in residential aged care. *The Gerontologist*, 42 (2), 188-198.

Chow, N. (1991). Does filial piety exist under Chinese communists?. *Journal of Aging and Social Policy*, 3 (1/2), 209-225.

Chow, N. (1993). The changing responsibilities of the State and family toward elders in Hong Kong. *Journal of Ageing and Social Policy*, 5, 111-126.

Chow, N. (1996). Filial piety in Asian Chinese communities. *Hong Kong Journal of Gerontology*, 10 (Supplement), 115-117.

Chow, N. and Chi, I. (1990). A study of the living arrangement of the elderly in Hong Kong. *Hong Kong Journal of Gerontology*, 4 (1), 11-18.

Chow, N. and Chi, I. (1998). *Housing and the elderly in Hong Kong*. Hong Kong: Department of Social Work and Social Administration, University of Hong Kong.

Chow, N. and Lum, T. (2008). *Trends in family attitudes and values in Hong Kong: final report, submitted to Central Policy Unit, Hong Kong SAR Government.* Hong Kong: Department of Social Work and Social Administration, University of Hong Kong.

Chow, N.W.S. (1981). Social security in Hong Kong. In: J.F. Jones (ed.) *The common welfare: Hong Kong's social services.* Hong Kong: Chinese University Press.

Chow, N.W.S. (1983). The Chinese family and the support of the elderly in Hong Kong. *The Gerontologist*, 23 (6), 584-588.

Chow, N.W.S. (1992). Family care of the elderly in Hong Kong. In: Kosberg, J.I. (ed.). *Family care of the elderly: social and cultural changes.* London: SAGE Publications, 123-137.

Chow, N.W.S. (2001). The practice of filial piety among the Chinese in Hong Kong. In: Chi, I., Chappell, N.L. and Lubben, J. (eds.). *Elderly Chinese in Pacific Rim Countries: social support and integration*. Hong Kong: Hong Kong University Press, 125-136.

Chow, N.W.S. and Kwan, A.Y.H. (1984). *A study of the changing life-style of the elderly in low income families in Hong Kong*. Hong Kong: Department of Social Work, Chinese University of Hong Kong.

Chow, N.W.S. and Mak, N. (1988). *Caregiving for the elderly awaiting admission into care and attention homes*. Hong Kong: Department of Social Work and Social Administration, University of Hong Kong.

Chow, W.S. and Chi, I. (2000). *Twilight: the happiness and worries of older people in Hong Kong*. (Chinese version). Hong Kong: Cosmos Books Ltd..

Chow, W.S.N. (1987). Factors influencing the support of the elderly by their families. *Hong Kong Journal of Gerontology*, 1 (1), 4-9.

Chu, I. (1996). *A study of the needs of family carers of the elderly with functional disabilities*. Hong Kong: Department of Applied Social Studies, Hong Kong Polytechnic University.

Chu, L., Kwok, K., Chan, S., Chu, M., Yip, K., Chan, F. and Ng, M. (1998). *A survey on the health and health care needs of elderly people living in Central and Western Districts*. Hong Kong: Elite Business Services Limited.

Chu, L.W. and Pei, C.K.W. (1997). Morbidity patterns of persons waiting for infirmary care in Hong Kong. *Hong Kong Medical Journal*, 3 (4), 362-368.

Chu, L.W., Chiu, A.Y. and Chi, I. (2008). Falls and subsequent health service utilisation in community-dwelling Chinese older adults. *Archives of Gerontology and Geriatrics*, 46 (2), 125-135.

Chui, E. (2011). Long-Term Care Policy in Hong Kong: Challenges and Future Directions. *Home Health Care Services Quarterly,* 30, 1-14.

Chui, E.W.T. (2008). Ageing in place in Hong Kong - challenges and opportunities in a capitalist Chinese city. *Ageing International*, 32 (3), 167-182.

Chui, E.W.T. and Research Team/The University of Hong Kong (2009). *Elderly Commission's Study on Residential Care Services for the Elderly: final report*. Hong Kong: Elderly Commission.

Cicirelli, V.G. (2010). Attachment relationships in old age. *Journal of Social and Personal Relationships*, 27 (2), 191-199.

Civil Service Bureau (2006). *Civil service pay scales 2004 and 2005*. Hong Kong: Government Secretariat.

Clark, P. and Bowling, A. (1989). Observational study of quality of life in NHS nursing homes and a long-stay ward for the elderly. *Ageing and Society*, 9 (2), 123-148.

Clarke, A.G. (March 1, 1961). Final budget speech. Available from: <*en.wikipedia.org/wiki/Arthur_Grenfell_Clarke*> (Accessed 28 April, 2013).

Cleary, B.L. (2004). *Conducting research in long-term care settings*. New York: Springer Publishing Company, Inc..

Cohen, M.A., Tell, E.J. and Wallack, S.S. (1986). Client-related risk factors of nursing home entry among elderly adults. *Journal of Gerontology*, 41 (6), 785-792.

Comas-Herrera A., Wittenberg, R., Pickard, L. and Knapp, M. (2007). Cognitive impairment in older people: future demand for long-term care services and the associated costs. *International Journal of Geriatric Psychiatry*, 22 (10), 1037-1045.

Comas-Herrera, A., Pickard, L., Wittenberg, R., Davies, B.P. and Darton, R.A. (2003).

Future demand for long-term care, 2001 to 2031: projections of demand for long-term care for older people in England. The Personal Social Services Research Unit, University of Kent at Canterbury.

Cook, G., Reed, J., Childs, S. and Hall, A. (2004). *Does money matter? Older people's views of their monetary resources*. York: Joseph Rowntree Foundation.

Cooney, A., Murphy, K. and O'Shea, E. (2009). Resident perspectives of the determinants of quality of life in residential care in Ireland. *Journal of Advanced Nursing*, 65 (5), 1029-1038.

Crosby, C., Evans, K.E. and Prendergast, A.L. (2000). *Factors affecting demand for primary health care services by residents in nursing homes and residential care homes*. Lewiston: The Edwin Mellen Press.

Culyer, A.J. (1976). *Need and the National Health Service: economics and social choice*. London: Martin Robertson.

Culyer, A.J. (1980). *The political economy of social policy*. New York: St Martin's Press.

Culyer, A.J. (2001). Economics and ethics in health care. *Journal of Medical Ethics,* 27, 217-222.

Culyer, A.J. and Wright, K.G. (eds.) (1978). *Economic aspects of health services*. London: Martin Robertson.

Cumming, E. and Henry, W.E. (1961). *Growing old: the process of disengagement*. New York: Basic Books.

Daly, M. (2002). Care as a good for social policy. *Journal of Social Policy*, 31 (2), 251-270.

Darton, R. and Miles, K. (1997). *Cross-sectional survey of residential and nursing homes for elderly people: comparisons of residents in residential and nursing homes for elderly people, 1981-1996.* The Personal Social Services Research Unit, University of Kent at Canterbury.

Davies, B. (1995). The reform of community and long-term care of elderly persons: an international perspective. In: Scharf, T. and Wenger, G.C. *International perspectives on community care for older people*. Aldershot: Avebury.

Davies, B. (2005). Delivering effective social/long term care to older people. In: Johnson, M.L., Bengtson, V.L., Coleman, P.G. and Kirkwood, T.B.L. (eds.). *The Cambridge Handbook of Age and Ageing.* Cambridge: Cambridge University Press, 622-629.

Davies, B. and Knapp, M. (1981). *Old people's homes and the production of welfare.* London: Routledge and Kegan Paul.

Davies, B., Fernandez, J. and Nomer, B. (2000). *Equity and efficiency policy in community care: needs, service productivities, efficiencies and their implications*.

Aldershot, Hants.: Ashgate.

Davies, B.P. and Challis, D. (1986). *Matching resources to needs in community care: an evaluated demonstration of a long-term care model*. Aldershot: Gower.

Davies, B.P., Bebbington, A.C., Charnley, H. in collaboration with Baines, B., Ferlie, E., Hughes, M. and Twigg, J. (1990). *Resources, needs and outcomes in community-based care: a comparative study of the production of welfare for elderly people in ten local authorities in England and Wales*. Aldershot: Avebury.

Day, P. and Klein, R. (1987). Quality of institutional care and the elderly: policy issues and options. *British Medical Journal*, 294, 384-387.

Deloitte and Touche Consulting Group (1997). *A study of the needs of the elderly people in Hong Kong for residential care and community support services*. Hong Kong: Deloitte Touche Tohmatsu International.

Department of Health (2006). *Annual Report 2005-06.* Hong Kong, 7-8.

Dunkle, R.E., Kart, C.S. and Luong, V.H. (2001). Long-term care. In Kart, C.S. and Kinney, J.M. (eds.). *The realities of aging: an introduction to gerontology*. Allyn and Bacon, 454-484.

Economic and Social Research Council (2007). *Introducing the map 2030 study: modelling an ageing population to 2030 and beyond*. LSE.

Elderly Commission (1998). *Assessment on the Demand of the Elderly for Housing and Residential Care Services and Strategy to Meet Long-term Needs: Executive Summary*. Hong Kong.

Erikson, E.H. (1963). *Childhood and Society*. Macmillan, New York.

Evandrou, M. (1995). Employment and care, paid and unpaid work: the socio-economic position of informal carers in Britain. In Phillips, J. (ed.). *Working Carers: international perspectives on working and caring for older people.* Aldershot: Avebury.

Feinstein, J.S. (1993). The relationship between socioeconomic status and health: a review of the literature. *The Milbank Quarterly*, 71 (2), 279-322.

Ferlie, E., Challis, D. and Davies, B. (1989). *Efficiency-improving innovations in social care of the elderly*. Aldershot, Hants: Gower.

Financial Secretary (2006). *The 2006-07 Budget*. Hong Kong: Government Logistics Department.

Financial Secretary (2011). *The 2011-12 Budget*. Hong Kong: Government Logistics Department.

Finch, J. and Mason, J. (1990). Filial obligations and kin support for elderly people. *Ageing and Society*, 10 (2), 151-175.

Finch, J. and Mason, J. (2001). Family relationships and family responsibilities. In: Abercrombie, N. and Warde, A. (eds.). *The Contemporary British Society Reader*. Cambridge: Polity Press, 170-177.

Fiori, K.L., Antonucci, T.C. and Cortina, K.S. (2006). Social network typologies and mental health among older adults. *Journal of Gerontology: Psychological Sciences*, 61B (1), 25-32.

Fiori, K.L., Smith, J. and Antonucci, T.C. (2007). Social network types among older adults: a multidimensional approach. *Journal of Gerontology: Psychological Sciences*, 62B (6), 322-330.

Flux, D. (various years). *Hong Kong Taxation: Law and Practice* (1990-91, 1994-95, 1998-99). Hong Kong: The Chinese University Press

Foley, D.J., Ostfeld, A.M., Branch, L.G., Wallace, R.B., McGloin, J. and Cornoni-Huntley, J.C. (1992). The risk of nursing home admission in three communities. *Journal of Aging and Health*, 4 (2), 155-173.

Freedman, V.A. (1996). Family structure and the risk of nursing home entry. *Journal of Gerontology: Social Sciences*, 51B (2), S61-S69.

Freedman, V.A., Berkman, L.F., Rapp, S.R. and Ostfeld, A.M. (1994). Family networks: predictors of nursing home entry. *American Journal of Public Health*, 84 (5), 843-845.

Fries, B.E. (1990). Comparing case-mix systems for nursing home payment. *Health Care Financing Review*, 11 (4), 103-119.

Fries, J.F. (1980). Aging, natural death, and the compression of morbidity. *New England Journal of Medicine*, 303 (3), 130-135.

Fries, J.F. (1989). The compression of morbidity: near or far? *The Milbank Quarterly*, 67 (2), 208-232.

Fries, J.F. (2000). Compression of morbidity in the elderly. *Vaccine,* 18, 1584-1589.

Fries, J.F. (2005). Compression of morbidity revisited? Frailty, heart disease, and stroke: the compression of morbidity paradigm. *American Journal of Preventive Medicine*, 29 (5S1), 164-168.

Fries, J.F., Bruce, B. and Chakravarty, E. (2011). Compression of morbidity 1980-2011: a focused review of paradigms and progress. *Journal of Aging Research*, 1-10.

Froggatt, K. (2001). Life and death in English nursing homes: sequestration or transition?. *Ageing and Society*, 21 (3), 319-332.

Garber, A.M. and MaCurdy, T. (1989). *Predicting nursing home utilisation among the high-risk elderly*. Cambridge, MA: National Bureau of Economic Research.

Gate-Keeping Consultant Team (2000). *Consultancy study on gatekeeping initiative*

for the elderly services: system of assessment for services matching and prioritisation of services. Hong Kong: Centre on Ageing, The University of Hong Kong.

George, V. and Wilding, P. (1996). *Ideology and social welfare.* New York: Routledge.

Gibson, A.J., Moyes, I.C. and Kenrick, D. (1980). Cognitive assessment of the elderly long-stay patient. *British Journal of Psychiatry*, 137, 551-557.

Gibson, D., Liu, Z. and Choi, C. (1993). *Changing patterns of residential care 1985 to 1992 supply and utilisation*. Canberra: Australian Institute of Health and Welfare.

Gibson, M.C., Carter, M.W., Helmes, E. and Edberg, A. (2010). Principles of good care for long-term care facilities. *International Psychogeriatrics,* 22 (7), 1072-1084.

Gilbert, N. (2000). Welfare pluralism and social policy. In: Midgley, J., Tracy, M.B., and Livermore, M. (eds.). *The Handbook of Social Policy*. Thousand Oaks: Sage Publications, Inc., 411-420.

Gilhooly, M. and Redpath, C. (1997). Private sector policies for caregiving employees: a survey of Scottish companies. *Ageing and Society*, 17 (4), 399-423.

Gill, T.M., Robison, J.T. and Tinetti, M.E. (1998). Difficulty and dependence: two components of the disability continuum among community-living older persons. *Annals of Internal Medicine*, 128 (2), 96-101.

Gill, T.M., Williams, C., Richardson, E.D. and Tinetti, M.E. (1996). Impairments in physical performance and cognitive status as predisposing factors for functional dependence among nondisabled older persons. *Journal of Gerontology: Medical Sciences*, 51A, M283-M288.

Gill, T.M., Williams, C., Richardson, E.D. and Tinetti, M.E. (1997). A predictive model for ADL dependence in community-living elders based on a reduced set of cognitive status items. *Journal of the American Geriatrics Society*, 45, 441-445.

Gilleard, C.J. and Pattie, A.H. (1977). The Stockton Geriatric Rating Scale: a shortened version with British normative data. *British Journal of Psychiatry*, 131, 90-94.

Glaser, K. (1997). The living arrangements of elderly people. *Reviews in Clinical Gerontology*, 7, 63-72.

Glendinning, C. (1992). Employment and 'community care': policies for the 1990s. *Work, Employment and Society*, 6, 103-111.

Glendinning, C., Davies, B., Pickard, L. and Comas-Herrera, A. (2004). *Funding long-term care for older people: lessons from other countries.* York: Joseph Rowntree Foundation.

Glennerster, H. (1998). Solutions for long-term care: Is there really a financial crisis or are there just too many agencies? *New Economy*, 5 (1), 24-29.

Glennerster, H. (2003). *Understanding the finance of welfare: what welfare costs and how to pay for it.* Bristol: The Policy Press.

Godfrey, M., Townsend, J. and Denby, T. (2004). *Building a good life for older people in local communities: the experience of ageing in time and place*. York: Joseph Rowntree Foundation.

Goffman E. (1963). *Stigma: notes on the management of spoiled identity.* London: Penguin.

Goldberg, E.M. and Connelly, N. (1982). *The effectiveness of social care for the elderly: an overview of recent and current evaluative research.* London: Heinemann Educational Books Ltd., 203-232.

Goldberg, E.M. and Connelly, N. (eds.) (1981). *Evaluative research in social care.* London: Heinemann Educational Books Ltd..

Grasser, C. (1996). Reciprocity in staff-resident interactions in nursing homes. *Journal of Women and Aging*, 8 (1), 5-19.

Grau, L., Chandler, B. and Saunders, C. (1995). Nursing home residents' perceptions of the quality of their care. *Journal of Psychosocial Nursing and Mental Health Services*, 33 (5), 34-41.

Greene, V.L. and Ondrich, J.I. (1990). Risk factors for nursing home admissions and exits: a discrete-time hazard function approach. *Journal of Gerontology: Social Sciences*, 45, S250-S258.

Grundy, E. (1992). Socio-demographic variations in rates of movement into institutions among elderly people in England and Wales: an analysis of linked census and mortality data 1971-1985. *Population Studies*, 46 (1), 65-84.

Grundy, E. (1997). Demography and gerontology: mortality trends among the oldest old. *Ageing and Society*, 17 (6), 713-725.

Grundy, E. and Glaser, K. (2000). Socio-demographic differences in the onset and progression of disability in early old age: a longitudinal study. *Age and Ageing*, 29 (2), 149-157.

Grundy, E. and Henretta, J.C. (2006). Between elderly parents and adult children: a new look at the intergenerational care provided by the 'sandwich generation'. *Ageing and Society*, 26 (5), 707-722.

Grundy, E. and Jitlal, M. (2007). Socio-demographic variations in moves to institutional care 1991-2001: a record linkage study from England and Wales. *Age and Ageing*, 36 (4), 424-430.

Guralnik, J.M., LaCroix, A.Z., Abbott, R.D., Berkman, L.F., Satterfield, S., Evans, D.A. and Wallace, R.B. (1993). Maintaining mobility in late life: demographic characteristics and chronic conditions. *American Journal of Epidemiology*, 137 (8), 845-857.

Gutheil, I. (1991). Intimacy in nursing home friendships. *Journal of Gerontological Social Work,* 17, 1/2, 59-73.

Hancock R., Arthur A., Jagger C. and Matthews, R. (2002). The effect of older people's economic resources on care home entry under the United Kingdom's long-term care financing system. *The Journals of Gerontology Series B*: *Psychological Sciences and Social Sciences*, 57B (5), S285-S293.

Hancock, R. (2000). Estimating the housing wealth of older home owners in Britain. *Housing Studies,* 15 (4), 561–579.

Hancock, R. and Jarvis, C. (1994). *The long term effects of being a carer*. London: HMSO.

Hanley, R.J., Alecxih, L.M.B., Wiener, J.M. and Kennell, D.L. (1990). Predicting elderly nursing home admissions: results from the 1982-1984 National Long-Term Care Survey. *Research on Aging*, 12 (2), 199-228.

Harper, S. (ed.) (2003). *Families in ageing societies*. Oxford: Oxford University Press.

Havighurst, R.J. (1968). Personality and patterns of ageing. *The Gerontologist*, 8, 20-23.

Hawes, C., Lux, L., Wildfire, J., Green, R., Packer, L. E., Iannacchione, V. and Phillips, C. (1995). *Study of North Carolina domiciliary care home residents*. Research Triangle Park, N.C. Research Triangle Institute.

Helping Hand (1991-2006). *Annual Report*. Hong Kong: Helping Hand Ltd..

Hessler, R.M., Eriksson, B.G., Dey, D., Steen, G., Sundh, V. and Steen, B. (2003). The compression of morbidity debate in aging: an empirical test using the gerontological and geriatric population studies. In: Göteborg, Sweden (H70). *Archives of Gerontology and Geriatrics*, 37 (3), 213-222.

Hill, M. (2013). *The public policy process*. Pearson Education Limited.

Hill, M. and Bramley, G. (1986). *Analysing social policy***.** Oxford: Blackwell.

Hills, J. (2001). The role of redistribution in social policy. In: Alcock, P., Glennerster, H., Oakley, A. and Sinfield, A. (eds.) (2001). *Welfare and wellbeing***:** *Richard Titmuss's Contribution to Social Policy*. Bristol: The Policy Press.

Hing, E. (1987). Use of nursing homes by the elderly: preliminary data from the 1985 National Nursing Home Survey. Hyattsville, MD: National Center for Health Statistics, *Vital and Health Statistics* (advance data), 135.

Hirschman, A.O. (1991). *The rhetoric of reaction***:** *perversity, futility, jeopardy*. Cambridge, MA: Harvard University Press.

Ho, H.K., Matsubayashi, K., Wada, T., Kimura, M., Kita, T. and Saijoh, K. (2002). Factors associated with ADL dependence: a comparative study of residential care

home and community-dwelling elderly in Japan. *Geriatrics and Gerontology International,* 2 (2), 80-86.

Ho, P.Y.A. (May 19, 2001). *Creating a supportive environment for elderly with chronic illness*. Paper presented at the plenary session of the Healthy Ageing Convention, Hong Kong.

Ho, S.C. (1991). Health and social predictors of mortality in a Chinese elderly cohort. *American Journal of Epidemiology*, 133 (9), 907- 921.

Ho, S.C. and Woo, J. (1994). *Social and health profile of the Hong Kong old-old population: a research report*. Hong Kong: The Chinese University of Hong Kong.

Ho, S.C., Woo, J., Chan, S.G., Yuen, Y.K. and Sham, A. (1997). Predictors of mobility decline: the Hong Kong old-old study. *Journal of Gerontology: Medical Sciences*, 52A (6), M356-M362.

Ho, S.C., Woo, J., Chan, S.S.G., Yuen, Y.K. and Sham, A. (1996). Risk factors for falls in the Chinese elderly population. *Journal of Gerontology: Medical Sciences*, 51A (5), M195-M198.

Ho, S.C., Woo, J., Sham, A., Chan, S.G. and Yu, A.L.M. (2001). A 3-year follow-up study of social, lifestyle and health predictors of cognitive impairment in a Chinese older cohort. *International Journal of Epidemiology*, 30 (6), 1389-1396.

Ho, S.C., Woo, J.L., Lau, J., Chan, S.G., Yuen, Y.K., Chan, Y.K. and Chi, I. (1995). Life satisfaction and associated factors in older Hong Kong Chinese. *Journal of the American Geriatrics Society*, 43 (3), 252-255.

Hockey, J. (1990). *Experiences of death: an anthropological account.* Edinburgh University Press, Edinburgh.

Holroyd, E. (2001). Hong Kong Chinese daughters' intergenerational caregiving obligations: a cultural model approach. *Social Science and Medicine*, 53 (9), 1125-1134.

Hong Kong Cancer Registry (various years). *Hong Kong Cancer Statistics 1981-2007.* Hong Kong: Hospital Authority.

Hong Kong Central Committee on Services for the Elderly (September 1988). *Report of the Central Committee on Services for the Elderly*. Hong Kong: Government Printer.

Hong Kong Chief Executive (various years). *The Policy Address (1997-2014)*. Hong Kong: Government Logistics Department.

Hong Kong Council of Social Service and the Social Welfare Department (1976). *The social service needs of the elderly in Hong Kong.* Hong Kong: Hong Kong Council of Social Service.

Hong Kong Government (1957). *Hong Kong Annual Report 1956*. Hong Kong: Government Printer.

Hong Kong Government (1959). *Hong Kong Annual Report 1958*. Hong Kong: Government Printer.

Hong Kong Government (1965). *Aims and policy for social welfare in Hong Kong*. Hong Kong: Government Printer.

Hong Kong Government (1973a). *Care in the community: the right basis for services to the elderly*. Hong Kong: Government Printer.

Hong Kong Government (1973b). *Services for the elderly: report by Working Party on the future needs of the elderly*. Hong Kong: Government Printer.

Hong Kong Government (1977). *Services for the elderly*. Hong Kong: Government Printer.

Hong Kong Government (1979). *Social Welfare in Hong Kong: the way ahead*. Hong Kong: Government Printer.

Hong Kong Government (1991). *Social Welfare into the 1990s and Beyond*. Hong Kong: Government Printer.

Hong Kong Hansard, 12 May 2003. *(LC Paper No. CB (2) 2015 / 02-03 (04)).*

Hong Kong Hansard, 20 January 2005. *(LC Paper No. CB (2) 661 / 04-05 (01)).*

Hong Kong Hansard, 24 January 2007. *(LC Paper No. CB (3) 409 / 06-07).*

Hong Kong Hansard, 8 January 2001. *(LC Paper No. CB (2) 770 / 00-01).*

Hong Kong Hansard, April 28, 1954.

Hong Kong Hansard, April 5, 2000.

Hong Kong Hansard, February 2014. *(LC Paper No. CB (2) 870 /13-14 (02)).*

Hong Kong Hansard, February 24, 1966.

Hong Kong Hansard, February 25, 1970.

Hong Kong Hansard, February 25, 1981.

Hong Kong Hansard, February 26, 1975.

Hong Kong Hansard, February 27, 1963.

Hong Kong Hansard, February 28, 1962.

Hong Kong Hansard, February 29, 1984.

Hong Kong Hansard, June 2005. *(LC Paper No. CB (2) 1769 / 04-05 (01)).*

Hong Kong Hansard, June 2007. *(LC Paper No. CB (2) 2048/06-07).*

Hong Kong Hansard, March 1, 1995.

Hong Kong Hansard, March 2, 1977.

Hong Kong Hansard, March 2, 1994.

Hong Kong Hansard, March 24, 1982.

Hong Kong Hansard, March 4, 1953.

Hong Kong Hansard, March 6, 1991.

Hong Kong Hansard, March 7, 1990.

Hong Kong Hansard, March, 2007.

Hong Kong Hansard, October 10, 1990.

Hong Kong Hansard, October 11, 1989.

Hong Kong Hansard, October 22, 1998.

Hong Kong Hansard, October 6, 1971.

Hong Kong Hansard, October 7, 1992.

Hong Kong Housing Authority (2001). Available from: <http://www.housingauthority.gov.hk/eng/ha/corp_99/> (Accessed 20 April, 2012).

Hong Kong Legislative Council Research Office (2014). *The 2014-2015 Budget.* Hong Kong: Legislative Council.

Hong Kong Legislative Council. *Official Record of Proceedings* on 28 July 1982; 12 November 1986; 29 November 1989; 20 November 1991; 22 October 1998; 5 April 2000; 7 March 2007; 29 January 2013; 4 March 2013.

Hong Kong Sheung Kung Hui Welfare Council and City University of Hong Kong/Division of Social Studies (2000). *A study on the community care patterns and the networking strategies of elderly persons in Hong Kong: final report*. City University of Hong Kong/Division of Social Studies.

Horgas, A.L., Wilms, H. and Baltes, M.M. (1998). Daily life in very old age: everyday activities as expression of successful living. *The Gerontologist*, 38 (5), 556-568.

Horowitz, A. (1994). Vision impairment and functional disability among nursing home residents. *The Gerontologist*, 34 (3), 316-323.

Horowitz, Z. (1997). The relationship between vision impairment and the assessment of disruptive behaviors among nursing home residents. *The Gerontologist*, 37 (5), 620-628.

Hospital Authority (various years). *Hospital Authority Statistical Reports (1981-2006).* Hong Kong: Hospital Authority.

House of Commons Debate (May 23, 1958). Available from:

<http://hansard.millbanksystems.com/commons/1958/may/23/hong-kong-textile-factories-hours> (Accessed 6 April, 2013).

Hubbard, G., Tester, S. and Downs, M. (2003). Meaningful social interactions between older people in institutional care settings. *Ageing and Society*, 23 (1), 99-114.

Hui, E., Wong, E.M.C. and Woo, J. (2004). Assessing life expectancies of institutionalised older persons in Hong Kong. *Gerontology*, 50 (3), 165-170.

Hussein, S. and Manthorpe, J. (2005). An international review of the long-term care workforce: policies and shortages. *Journal of Aging and Social Policy*, 17 (4), 75-94.

Inland Revenue Department (various years). *Annual Reports*. Hong Kong: Government Printer.

Jackson, E.M. (1997). Dimensions of care in five United States nursing homes: identifying invisible work in care-giving. *International Journal of Nursing Studies*, 34 (3), 192-200.

Jackson, M.E., Spector, W.D. and Rabins, P.V. (1997). Risk of behavior problems among nursing home residents in the United States. *Aging and Health*, 9 (4), 451-473.

Jagger, C. and Lindesay, J. (1997). Residential care for elderly people: the prevalence of cognitive impairment and behavioural problems. *Age and Ageing*, 26 (6), 475-480.

Jagger, C., Spiers, N.A. and Clarke, M. (1993). Factors associated with decline in function, institutionalisation and mortality of elderly people. *Age and Ageing*, 22 (3), 190-197.

Jenkins, W.I. (1978). *Policy analysis: a political and organisational perspective.* London: Martin Robertson.

Jette, A.M., Tennstedt, S. and Crawford, S. (1995). How does formal and informal community care affect nursing home use?. *Journal of Gerontology: Social Sciences,* 50B (1), S4-S12.

Johnson, J., Rolph, S. and Smith, R. (2010). *Residential care transformed: revisiting 'The Last Refuge'.* Palgrave Macmillan.

Johnson, M.L., Bengtson, V.L., Coleman, P.G. and Kirkwood, T.B.L. (eds.) (2005). *The Cambridge Handbook of Age and Ageing*. Cambridge: Cambridge University Press.

Johnson, R.A., Schwiebert, V.B. and Rosenmann, P.A. (1994). Factors influencing nursing home placement decisions: the older adult's perspective. *Clinical Nursing Research*, 3 (3), 269-281.

Joshi, H. (1995). The labour market and unpaid caring: conflict and compromise. In Allen, I. and Perkins, E. (eds.). *The future of family care for older people*. London, HMSO.

Kane, R.A. (1995). Expanding the home care concept: blurring distinctions among home care, institutional care, and other long-term care services. *The Milbank Quarterly*, 73 (2), 161-186.

Kane, R.A. (2003). Definition, measurement, and correlates of quality of life in nursing homes: towards a reasonable practice, research, and policy agenda. *The Gerontologist*, 43 (Special edition II), 28-36.

Kane, R.A. and Caplan, A.L. (1990). *Everyday ethics: resolving dilemmas in nursing home life*. New York: Springer.

Kane, R.A. and Kane, R.L. (1981). *Assessing the elderly: a practical guide to measurement*. The Rand Corporation.

Kane, R.A. and Kane, R.L. (1987). *Long term care: principles, programme and policies*. New York: Springer.

Kane, R.L. (2000). Changing the image of long-term care. *Age and Ageing,* 29, 481-483.

Kane, R.L. (2005). Changing the face of long-term care. *Journal of Aging and Social Policy*, 17 (4), 1-18.

Kane, R.L. and Kane, R.A. (1989). Transitions in long-term care. In: Ory, M. and Bond, K. (eds.). *Aging and Health Care: social science and policy perspectives*. New York: Routledge.

Kane, R.L. and Kane, R.A. (2000). *Assessing older persons: measures, meaning, and practical applications*. New York: Oxford University Press.

Kane, R.L. and Kane, R.A. (2005). Long term care. In: Johnson, M.L. et al. (eds.). *The Cambridge Handbook of Age and Ageing*. Cambridge: Cambridge University Press, 638-646.

Kane, R.L. and Kane, R.A. (eds.) (1982). *Values and long-term care*. Lexington, MA: DC Health.

Kane, R.L., Evans, J.G. and Macfadyen, D. (1990). *Improving the health of older people: a world view*. Oxford: Oxford University Press.

Kane, R.L., Matthias, R. and Sampson, S. (1983). The risk of placement in a nursing home after acute hospitalisation. *Medical Care*, 21 (11), 1055-1061.

Kart, C.S. and Kinney, J.M. (2001). *The realities of aging: an introduction to gerontology*. Allyn and Bacon.

Keller-Cohen, D., Fiori, K., Toler, A. and Bybee, D. (2006). Social relations, language and cognition in the 'oldest old'. *Ageing and Society*, 26 (4), 585-605.

Knapp, M. (1984). *The economics of social care*. London: Macmillan.

Knapp, M., Bauer, A., Perkins, M. and Snell, T. (2010). *Building community capacity:*

making an economic case. PSSRU Discussion Paper 2772. The Personal Social Services Research Unit, University of Kent at Canterbury.

Knoepfel, P., Larrue, C., Varone, F. and Hill, M. (2007). *Public policy analysis*. Bristol: Policy Press, 56-61.

Kodner, D.L. (2003). Long-term care integration in four European countries: a review. In: *World Health Organisation collection on long-term care: key policy issues in long-term care*. Geneva: World Health Organisation, 91-138.

Kolanowski, A. and Litaker, M. (2004). Factors that relate to activity engagement in nursing home residents. *The Gerontologist*, 44 (1), 599.

Kovach, S.S. and Robinson, J.D. (1996). The roommate relationship for the elderly nursing home resident. *Journal of Social and Personal Relationships*, 13 (4), 627-634.

Kraan, R.J., Baldock, J., Davies, B., Evers, A., Johansson, L., Knapen, M., Thorslund, M. and Tunissen, C.A. (1991). *Care for the elderly: significant innovations in three European countries*. Boulder, Colorado: Westview.

Kwan, A.Y.H. (1988). *A study on the residential life of the elderly in the private elderly homes in Hong Kong*. Hong Kong: Writers' and Publishers' Co-operative.

Kwan, A.Y.H. (1990). A review of the recreation and leisure activities patterns of older people in Hong Kong. *Hong Kong Journal of Gerontology*, 4 (2), 28-33.

Kwan, A.Y.H., Cheung, J.C.K. and Ng, S.H. (2003). *Revisit of the filial piety concept among the young, the adult, and the old in Beijing, Guangzhou, Hong Kong, Nanjing, Shanghai, Xiamen, and Xian: research report*. Hong Kong: Department of Applied Social Studies, City University of Hong Kong.

Kwok, T., Luk, J.K.H., Lau, E. and Woo, J. (1998). Attitudes of old people towards old age homes in Hong Kong. *Archives of Gerontology and Geriatrics,* 27 (1), 89-96.

Kwok, T., Woo, J., Ho, S.C. and Lau, E. (1996). The caregivers for the elderly Chinese in Hong Kong. *Hong Kong Journal of Gerontology*, 10 (Supplement), 184-185.

La Grange, A. and Yung, B. (2001). Aging in a tiger welfare regime: the single elderly in Hong Kong. *Journal of Cross-Cultural Gerontology,* 16 (3), 257-281.

Labour Department (n.d.). *Policy support - Importation of labour: foreign domestic helpers.* Available from: <http://www.labour.gov.hk/eng/plan/iwFDH.htm> (Accessed 3 July, 2013).

LaForge, R.G., Spector, W.D. and Sternberg, J. (1992). The relationship of vision and hearing impairment to one-year mortality and functional decline. *Journal of Aging and Health*, 4 (1), 126-148.

Lai, D.W.L. (2004). Predicting factors for intention of use of long-term care facilities

by aging Chinese-Canadians. *Journal of Social Work in Long-Term Care*, 3 (2), 31-46.

Lamberton, C.E., Ellingson, W.D. and Spear, K.R. (1986). Factors determining the demand for nursing home services. *Quarterly Review of Economics and Business*, 26 (4), 74-89.

Larizgoitia, I. (2003). Approaches to evaluating LTC systems. In: Brodsky, J., Habib, J. and Hirschfeld, M. (eds.). *World Health Organisation collection on long-term care: key policy issues in long-term care*. World Health Organisation, 227-244.

Lau, A.M. and Laird, G. (2013-14). *Hong Kong Taxation: Law and Practice.* Hong Kong: The Chinese University Press.

Lee, D.T.F. (1997). Chinese elderly people's perceptions of nursing homes in Hong Kong. *Journal of Clinical Nursing*, 6 (4), 333-334.

Lee, D.T.F., Woo, J. and Mackenzie, A.E. (2002). The cultural context of adjusting to nursing home life: Chinese elders' perspectives. *The Gerontologist*, 42 (5), 667-675.

Lee, J.J. and Lo, S.C. (2005). *Research on residential care service needs of the elders - summary report*. Hong Kong: Department of Social Work, The Chinese University of Hong Kong and Tung Wah Group of Hospitals.

Lee, L.Y.K., Lee, D.T.F. and Woo, J. (2005). Predictors of satisfaction among cognitively intact nursing-home residents in Hong Kong. *Research in Nursing and Health*, 28 (5), 376-387.

Lee, L.Y.K., Lee, D.T.F. and Woo, J. (2009). Tai Chi and health-related quality of life in nursing home residents. *Journal of Nursing Scholarship*, 41 (1), 35-43.

Lee, M.K. (1991). Family and social life. In: S.K. Lau, M.K. Lee, P.S. Wan and S.L. Wong (eds.). *Indicators of social development: Hong Kong.* Hong Kong: Institute of Asia-Pacific Studies, The Chinese University of Hong Kong, 41-66.

Lee, M.K. (1995). The family way. In: Lau, S.K., Lee, M.K., Wan, P.S. and Wong, S.L. (eds.) (1993). *Indicators of social development: Hong Kong*. Hong Kong: Institute of Asia-Pacific Studies, The Chinese University of Hong Kong, 1-19.

Lee, R.P.L., Lee, J.J., Yu, E.S.H., Sun, S.G. and Liu, W.T. (1997). *Living arrangements and elderly care: the case of Hong Kong*. Hong Kong: Faculty of Social Sciences, Lingnan College.

Legislative Council of the HKSAR (2013). *Survey report on the manpower resources on nursing in non-governmental organisations provided by Association of Hong Kong Nursing Staff on January 29, 2013.* LC Paper No. CB (2) 602/12-13 (01), Hong Kong.

Legislative Council Panel on Welfare Services (2010). *Consultancy study on residential care services for the elderly initiated by the Elderly Commission.* LC Paper No. CB (2) 668/09-10 (03), Hong Kong.

Leung, A. (2001). *Speech delivery by the Financial Secretary at the 2001 Hong Kong Awards for Services Awards Presentation Gala Dinner on December 10*, Hong Kong. Available from: <http://www.info.gov.hk/gia/general/200112/10/1210215.htm> (Accessed 18 April, 2013).

Leung, E.M.F. (1992). The problem of residential nursing care for the elderly. *Hong Kong Journal of Gerontology*, 6 (2), 13-19.

Leung, E.M.F. (2002). Changing needs and changing service delivery for long-term care in Hong Kong. *Journal of Aging and Social Policy*, 13 (2/3), 155-168.

Leung, E.M.F. and Lau, J.T.F. (1999). *Report on survey of health care needs in Kwun Tong*. Hong Kong: United Christian Hospital.

Leung, E.M.F., Chan, A.C.M., Lee, J.J. and Cheng, S.T. (1993). Residential care policy for elderly people in Hong Kong. *Asian Journal of Public Administration*, 15 (1), 3-31.

Leung, J.Y.Y., Yu, T.K.K., Cheung, Y.L., Ma, L.C., Cheung, S.P. and Wong, C.P. (2000). Private nursing home residents in Hong Kong - how frail are they and their need for hospital services. *Journal of the Hong Kong Geriatrics Society*, 10 (2), 65-69.

Leung, M.F. and Lo, B.N. (1997). Social and health status of elderly people in Hong Kong. In: S.K. Lam (ed.). *The health of the elderly in Hong Kong*. Hong Kong: The University of Hong Kong, 43-62.

Levasseur, M., Desrosiers, J. and Whiteneck, G. (2010). Accomplishment level and satisfaction with social participation of older adults: association with quality of life and best correlates. *Quality of Life Research*, 19 (5), 665-675.

Lewis, J. (2007). Families, individuals and the state. In: Hills, J., Le grand, J. and Piachaud, D. (eds.). *Making social policy work: essays in honour of Howard Glennerster*. Bristol: The Policy Press, 59-84.

Lewis, J. and Glennerster, H. (1996). *Implementing the new community care.* Buckingham: Open University Press.

Lewis, J. and West, A. (2014). Re-shaping social care services for older people in England: policy development and the problem of achieving 'good care'. *Journal of Social Policy*, 43 (1), 1-18.

Lieberman, M.A. and Tobin, S.S. (1983). *The experience of old age: stress, coping, and survival*. New York: Basic Books.

Litwak, E. (1985). *Helping the elderly: the complementary roles of informal networks and formal systems*. London: Guildford Press.

Litwin, H. (2001). Social network type and morale in old age. *The Gerontologist*, 41 (4), 516-524.

Liu, C.P. (1999). *Informal care patterns and health of the elderly in Hong Kong*.

Unpublished PhD Theses. Hong Kong: The University of Hong Kong.

Liu, E. and Wong, E. (1997). *Health care for elderly people.* Hong Kong: Provisional Legislative Council Secretariat, Research and Library Services Division, 47.

Liu, K. and Manton, K.G. (1989). The effect of nursing home use on Medicaid eligibility. *The Gerontologist*, 29 (1), 59-66.

Liu, L.F. and Tinker, A. (2001). Factors associated with nursing home entry for older people in Taiwan, Republic of China. *Journal of Interprofessional Care*, 15 (3), 245-255.

Liu, W.T. and Hal Kendig (2000). *Who should care for the elderly? An East-West value divide*. Singapore: University Press, National University of Singapore.

Liu, W.T., Lee, R.P.L., Yu, E.S.H., Lee, J.J. and Sun, S.G. (1993). *Health status, cognitive functioning and dementia among elderly community population in Hong Kong.* Hong Kong: Hong Kong Baptist College.

Lou, W.Q.V., Chui, W.T.E., Leung, Y.M.A., Tang, K.L., Chi, I., Leung, W.K.S.E. et al. (2009). *A study investigating factors that affect long term care use in Hong Kong*. Submitted to Food and Health Bureau Government Secretariat, The Government of the Hong Kong Special Administrative Region, Hong Kong.

Lowi, T.A. (1972). Four systems of policy, politics and choice. *Public Administration Review*, 32.

Lubben, J.E. and Chi, I. (1993). *Cross-national comparison of social support among the elderly Chinese and Chinese Americans*. Paper presented in the XIVth World Congress of Gerontology at Budapest, Hungary.

MacPherson, S. (1994). *A measure of dignity: report on the adequacy of public assistance rates in Hong Kong.* Hong Kong: Hong Kong Council of Social Service.

Marmot, M. and Wilkinson, R.G. (2001). Psychosocial and material pathways in the relation between income and health: a response to Lynch et al.. *British Medical Journal*, 322 (7296), 1233-1236.

Mason, F., Liu, Z. and Braun, P. (2001). *The probability of using an aged care home over a lifetime 1999-00*. Welfare Division: Working Paper No. 36, Australian Institute of Health and Welfare, Canberra.

Matthews, R.J., Smith, L.K., Hancock, R.M., Jagger, C. and Spiers, N.A. (2005). Socioeconomic factors associated with the onset of disability in older age: a longitudinal study of people aged 75 years and over. *Social Science and Medicine*, 61 (7), 1567-1575.

McFall, S. and Miller, B.H. (1992). Caregiver burden and nursing home admission of frail elderly persons. *Journal of Gerontology: Social Sciences,* 47 (2), S73-S79.

McLaughlin, E. (1993). 'Hong Kong: a residual welfare regime' in Cochrane, A. and Clarke, J. (eds.). *Comparing welfare states: Britain in international context*. London:

Sage Publications, 105-140.

McPherson, F.M., Gamsu, C.V., Kiemle, G., Ritchie, S.M., Stanley, A.M. and Tregaskis, D. (1985). The concurrent validity of the survey version of the Clifton Assessment Procedures for the Elderly (CAPE). *British Journal of Clinical Psychology*, 24 (2), 83-91.

Merton, R.K. (1936). The unanticipated consequences of purposive social action. *American Sociological Review*, 1 (6), 894-904.

Merz, E.M., Schuengel, C. and Schulze, H.J. (2008). Inter-generational relationships at different ages: an attachment perspective. *Ageing and Society*, 28 (5), 717-736.

Middleton, S., Hancock, R., Kellard, K., Beckhelling, J., Phung, V.H. and Perren, K. (2007). *Measuring resources in later life: a review of the data*. York: Joseph Rowntree Foundation.

Minichiello, V., Spencer, L., Lin, F., Wong, C.C. and Coulson, I. (2001). A survey of Hong Kong aged care workers' satisfaction with career opportunities and education training in gerontology. *Hong Kong Journal of Gerontology*, 15 (1/2), 3-9.

Mitchell J.M. and Kemp B.J. (2000). Quality of life in assisted living homes: a multidimensional analysis. *Journal of Gerontology: Psychological Sciences* 55B (2), 117-127.

Mitchell, P., Hayes, P. and Wang, J.J. (1997). Visual impairment in nursing home residents: the Blue Mountains Eye Study. *Medical Journal of Australia*, 166 (2), 73-76.

Mohler, M. and Lessard, W. (1991). *Nursing staff in nursing homes: additional staff needed and cost to meet requirements and intent of OBRA' 87*. Washington, D.C.: National Committee to Preserve Social Security and Medicare.

Mok, T.K. (1999). *An exploratory study about the policy of combating poverty in Hong Kong: rethinking social development*. (Chinese version). Hong Kong: Joint Publishing (HK) Co. Ltd.

Moos, R.H., David, T.G., Lemke, S. and Postle, E. (1984). Coping with an intra-institutional relocation: changes in resident and staff behavior patterns. *The Gerontologist*, 24 (5), 495-502.

Mor, V., Branco, K., Fleishman, J., Hawes, C., Phillips, C., Morris, J. and Fries, B. (1995). The structure of social engagement among nursing home residents. *Journal of Gerontology: Psychological Sciences*, 50B (1), 1-8.

Moxon, S., Lyne, K., Sinclair, I., Young, P. and Kirk, C. (2001). Mental health in residential homes: a role for care staff. *Ageing and Society*, 21 (1), 71-93.

Mozley, C., Sutcliffe, C., Bagley, H., Cordingley, L., Challis, D., Huxley, P. and Burns, A. (2004). *Towards quality care: outcomes for older people in care homes*. Ashgate, Aldershot.

Mulgrave, N.W. (1985). Clifton Assessment Procedures for the Elderly. In: Keyser, D.J. and Sweetland, R.C. (eds.). *Test Critiques*. Kansas City, Missouri: Test Corporation of America, 175-181.

Neill, J. (1989). *Assessing people for residential care: a practical guide*. National Institute of Social Work Research Unit, London.

Nelson, R., Furner, S. and Jesudason, V. (1998). Faecal incontinence in Wisconsin nursing homes: prevalence and associations. *Diseases of the Colon and Rectum*, 41 (10), 1226-1229.

Nelson, R., Furner, S. and Jesudason, V. (2001). Urinary incontinence in Wisconsin skilled nursing facilities: prevalence and associations in common with faecal incontinence. *Journal of Aging and Health*, 13 (4), 539-547.

Netten, A. (2002). Doing evaluation of health and social care interventions. In: Jamieson, A. and Victor, C.R. (eds.). *Researching ageing and later life: the practice of social gerontology*, Philadelphia, P.A.: Open University Press, 175-194.

Netten, A. (2011). *Overview of outcome measurement for adults using social care services and support.* The Personal Social Services Research Unit, University of Kent at Canterbury. .

Netten, A. and Darton, R. (2003). The effect of financial incentives and access to services on self-funded admissions to long-term care. *Social Policy and Administration*, 37 (5), 483-497.

Netten, A., Darton, R., Bebbington, A. and Brown, P. (2001a). Residential or nursing home care? The appropriateness of placement decisions. *Ageing and Society*, 21 (1), 3-23.

Netten, A., Darton, R., Bebbington, A., Forder, J., Brown, P. and Mummery, K. (2001b). Residential and nursing home care of elderly people with cognitive impairment: prevalence, mortality and costs. *Aging and Mental Health,* 5 (1), 14-22.

Netten, A.P., Bebbington, A.C., Darton, R.A., Forder, J. and Miles, K. (1998). *1996 Survey of care homes for elderly people: final report*. PSSRU Discussion Paper No.1423/2. The Personal Social Services Research Unit, University of Kent at Canterbury.

Newman, S., Struyk, R., Wright, P. and Rice, M. (1988). *Overwhelming odds: caregiving and the risk of institutionalisation.* Washington, D.C.: The Urban Institute, Project Report No.3691-01.

Ng, A.C.Y., Phillips, D.R. and Lee, W.K.M. (2002). Persistence and challenges to filial piety and informal support of older persons in a modern Chinese society: a case study in Tuen Mun, Hong Kong. *Journal of Aging Studies*, 16 (2), 135-153.

Ngan, M.H. and Cheng, C.K. (1992). The caring dilemma: stress and needs of caregivers for the Chinese frail elderly. *Hong Kong Journal of Gerontology*, 6 (2), 34-41.

Ngan, R. (1990). The availability of informal support networks to the Chinese elderly in Hong Kong and its implications for practice. *Hong Kong Journal of Gerontology*, 4 (2), 19-27.

Ngan, R. and Hong Kong Christian Service (1993). *Emigration and community care for elderly people in Hong Kong*. Hong Kong: Department of Applied Social Studies, City Polytechnic of Hong Kong.

Ngan, R. and Kwok, J. (1992). Informal caring networks among Chinese elderly with disabilities in Hong Kong. *International Journal of Rehabilitation Research*, 15 (3), 199-207.

Ngan, R. and Leung, E. (2001). Long-term care in Hong Kong: the myth of social support and integration. In: Chi, I., Chappell, N.L. and Lubben, J. (eds.). *Elderly Chinese in Pacific Rim Countries: social support and integration.* Hong Kong: Hong Kong University Press, 17-34.

Ngan, R. and Wong, W. (1995). Injustice in family care of the Chinese elderly in Hong Kong. *Journal of Aging and Social Policy*, 7 (2), 77-94.

Ngan, R., Leung, E.M.F., Kwan, A., Yeung, D. and Chong, A. (1996). *A study of the long-term care needs, pattern and impact of the elderly in Hong Kong: research report*. Department of Applied Social Studies, City University of Hong Kong.

Nikolova, R., Demers, L. and Béland, F. (2009). Trajectories of cognitive decline and functional status in the frail older adults. *Archives of Gerontology and Geriatrics*, 48 (1), 28-34.

Nolan, M., Davies, S., Brown, J., Keady, J. and Nolan, J. (2004). Beyond 'person-centred' care: a new vision for gerontological nursing. *Journal of Clinical Nursing,* 13 (3a), 45-53.

Nolan, M., Grant, G. and Keady, J. (1996). *Understanding family care: a multidimensional model of caring and coping*. Buckingham: Open University Press.

Nolan, M.R., Davies, S. and Grant, G. (eds.) (2001). *Working with older people and their families: key issues in policy and practice*. Open University Press, Buckingham.

Oldman, C. and Quilgars, D. (1999). The last resort? Revisiting ideas about older people's living arrangements. *Ageing and Society*, 19 (3), 363-384.

Organisation for Economic Co-operation and Development (1994). *Caring for frail elderly people: new directions in care*. Paris: Organisation for Economic Co-operation and Development.

Organisation for Economic Co-operation and Development (1996). *Caring for frail elderly people: policies in evolution*. Paris: Organisation for Economic Co-operation and Development.

Organisation for Economic Co-operation and Development (2005). *Long-term care for older people*. Paris: Organisation for Economic Co-operation and Development.

Orwell, G. (1958). *The Road to Wigan Pier*. New York: Harcourt Brace and Company.

Ouslander, J.G., Kane, R.L. and Abrass, I.B. (1982). Urinary incontinence in elderly nursing home patients. *The Journal of the American Medical Association*, 248 (10), 1194-1198.

Park, N.S. (2009). The relationship of social engagement to psychological well-being of older adults in assisted living facilities. *Journal of Applied Gerontology*, 28 (4), 461-481.

Pattie, A.H. (1981). A survey version of the Clifton Assessment Procedures for the Elderly (CAPE). *British Journal of Clinical Psychology*, 20 (3), 173-178.

Pattie, A.H. and Gilleard, C.J. (1975). A brief psychogeriatric assessment schedule - validation against psychiatric diagnosis and discharge from hospital. *British Journal of Psychiatry*, 127, 489-493.

Pattie, A.H. and Gilleard, C.J. (1976). The Clifton assessment schedule - further validation of a psychogeriatric assessment schedule. *British Journal of Psychiatry*, 129, 68-72.

Pattie, A.H. and Gilleard, C.J. (1979). *Manual of the Clifton Assessment Procedures for the Elderly (CAPE)*. Kent: Hodder and Stoughton.

Peace, S., Kellaher, L. and Willcocks, D. (1997). *Re-evaluating residential care*. Open University Press, Buckingham.

Pearson, V. (2005). Social Care in Hong Kong: the dynamics of the welfare mix. In: Kwon, Huck-ju (ed.). *Transforming the Developmental Welfare State in East Asia*. Basingstoke, Hampshire: Palgrave Macmillan, 209-228.

Peek, M.K., Ottenbacher, K.J., Markides, K.S. and Ostir, G.V. (2003). Examining the disablement process among older Mexican American adults. *Social Science and Medicine*, 57 (3), 413-425.

Peet, S.M., Castleden, C.M. and McGrother, C.W. (1995). Prevalence of urinary and faecal incontinence in hospitals and residential and nursing homes for older people. *British Medical Journal*, 311 (7012), 1063-1064.

Peet, S.M., Castleden, C.M., McGrother, C.W. and Duffin, H.M. (1996). The management of urinary incontinence in residential and nursing homes for older people. *Age and Ageing*, 25, 139-143.

Perri 6 (2010). When forethought and outturn part: types of unanticipated and unintended consequences. In: Margetts, H., Perri 6 and Hood, C. (eds.). *Paradoxes of modernisation: unintended consequences of public policy reform*. Oxford: Oxford University Press, 44-60.

Phillips, D.R. and Chan, A.C.M. (2002). *Ageing and long-term care: national policies in the Asia-Pacific*. Singapore: Institute of Southeast Asian Studies.

Phillips, D.R., Vincent, J. and Blacksell, S. (1988). *Home from home? Private residential care for elderly people*. Sheffield: Joint Unit for Social Science Research.

Pickard, L. (2002). The decline of intensive intergenerational care of older people in Great Britain, 1985-1995. *Population Trends*, 110, 31-41.

Pickard, L., Wittenberg, R., Comas-Herrera, A., Davies, B. and Darton, R. (2000). Relying on informal care in the new century? Informal care for elderly people in England to 2031. *Ageing and Society*, 20 (6), 745-772.

Pickard, L., Wittenberg, R., Comas-Herrera, A., King, D. and Malley, J. (2007). Care by *spouses, care by children: projections of informal care for older people in England to 2031. Social Policy and Society*, 6 (3), 353-366.

Piece, T. (2006). *Social exclusion of older people: future trends and policies*. London: Department for Communities and Local Government.

Pinker, R. (1971). *Social theory and social policy.* London: Heinemann Educational Books Ltd..

Pinker, R. (1973). *The welfare state: a comparative perspective.* London: Bookstall Publications.

Pinker, R. (1990). *Social work in an enterprise society.* London: Routledge, Chapter 8.

Pinker, R. (1992). Making sense of the mixed economy of welfare. *Social Policy and Administration,* 26 (4), 273-284.

Pope, A.M. and Tarlov, A.R. (eds.) (1991). *Disability in America: toward a national agenda for prevention*. Washington, D.C.: National Academy Press.

Powell, J.L. (2010). The power of global aging. *Ageing International*, 35 (1), 1-14.

Powell, M. (2007). The mixed economy of welfare and the social division of welfare. In: Powell, M. (ed.). *Understanding the mixed economy of welfare.* Bristol: The Policy Press, 1-20.

Power, W.E. (1989). Residential care for elderly people: characteristics of patients admitted to residential and nursing home care from hospital. *British Journal of Social Work*, 19 (1), 39-51.

Pruger, R. and Miller, L. (1991). *Efficiency and the social services*. The Haworth Press.

Race, D. (1982). *The residential and institutional services for the elderly: preliminary analysis of a research project*. Hong Kong: Department of Social Work, University of Hong Kong.

Reilly, S., Abendstern, M., Hughes, J., Challis, D., Venables, D. and Pedersen, I. (2006). Quality in long-term care homes for people with dementia: an assessment of specialist provision. *Ageing and Society*, 26 (4), 649-668.

Research and Statistics Section (1980). *Study of cases waitlisted to institutions for the aged*. Hong Kong: Research and Statistics Section, Social Welfare Department.

Research and Statistics Section (1985). *Review of clients waitlisting for care and attention homes*. Hong Kong: Research and Statistics Section, Social Welfare Department.

Resnick, H.E., Fries, B.E. and Verbrugge, L.M. (1997). Windows to their world: the effect of sensory impairments on social engagement and activity time in nursing home residents. *Journal of Gerontology: Social Sciences*, 52B (3), S135-S144.

Retsinas, J. and Garrity, P. (1985). Nursing home friendships. *The Gerontologist*, 25 (4), 376-381.

Ribbe, M.W., Ljunggren, G., Steel, K., Topinkova, E., Hawes, C., Ikegami, N., Henrad, J.C. and Jónsson, P.V. (1997). Nursing homes in 10 nations: a comparison between countries and settings. *Age and Ageing*, 26 (Supplement 2), 3-12.

Roos, N.P., Havens, B. and Black, C. (1993). Living longer but doing worse: assessing health status in elderly persons at two points in time in Manitoba, Canada, 1971and 1983. *Social Science and Medicine*, 36 (3), 273-282.

Rovner, B.W. (1986). Prevalence of mental illness in a community nursing home. *American Journal of Psychiatry*, 143 (11), 1446-1449.

Rowe, J.W. and Kahn, R.L. (1997). Successful aging. *The Gerontologist*, 37 (4), 433-440.

Rubery, J. and Urwin, P. (2011). Bringing the employer back in: why social care needs a standard employment relationship. *Human Resource Management Journal*, 21 (2), 122-137.

Rudberg, M.A, Furner, S.E., Dunn, J.E. and Cassel, C.K. (1993). The relationship of visual and hearing impairments to disability: an analysis using the longitudinal study of aging. *Journal of Gerontology: Medical Sciences*, 48 (6), M261-M265.

Rudberg, M.A., Sager, M.A. and Zhang, J. (1996). Risk factors for nursing home use after hospitalisation for medical illness. *Journal of Gerontology: Medical Sciences,* 51A (5), M189-M194.

Ryan, A.A. and Scullion, H.F. (2000). Nursing home placement: an exploration of the experiences of family carers. *Journal of Advanced Nursing,* 32 (5), 1187-1195.

Scanlon, J. (1988). Winners and losers: some thoughts about the political economy of disaster. *International Journal of Mass Emergencies and Disasters*, 6 (1), 47-63.

Scanlon, W. (1980). A theory of the nursing home market. *Inquiry* 17 (Spring), 25-41.

Schneider, D.P., Fries, B.E., Foley, W.F., Desmond, M. and Gormley, W.F. (1988). Case mix for nursing home payment: resource utilisation groups, version II. *Health Care Financing Review* (Annual Supplement), 39-52.

Schneider, E.L. and Brody, J.A. (1983). Aging, natural death, and the compression of morbidity: another view. *New England Journal of Medicine*, 309 (14), 854-856.

Schneider, J., Hallam, A., Kamrul Islam M., Murray, J., Foley, B., Atkins, L., Banerjee, S. and Mann, A. (2003). Formal and informal care for people with dementia: variations in costs over time. *Ageing and Society,* 23 (3), 303-326.

Schroll, M., Jonsson, P.V., Mor, V., Berg, K. and Sherwood, S. (1997). An international study of social engagement among nursing home residents. *Age and Ageing*, 26 (Supplement 2), 55-59.

Scott, A., Evandrou, M., Falkingham, J. and Rake, K. (2001). *Moves into residential care amongst older people in Britain*. Paper presented to the 2001 British Household Panel Survey Research Conference.

Seeman, T.E., Bruce, M.L. and McAvay, G.J. (1996). Social network characteristics and onset of ADL disability: the MacArthur studies of aging. *Journal of Gerontology: Social Sciences*, 51B (4), 191-200.

Shapiro, E. and Tate, R. (1988a). Survival patterns of nursing home admissions and their policy implications. *Canadian Journal of Public Health*, 79 (4), 268-274.

Shapiro, E. and Tate, R. (1988b). Who is really at risk of institutionalisation? *The Gerontologist*, 29 (2), 237-245.

Sheppard, M. (2006). *Social work and social exclusion: the idea of practice*. Ashgate, 81-97.

Sim, T.C. and Leung, E.M.F. (2000). Geriatric care for residents of private nursing homes. *Journal of the Hong Kong Geriatrics Society*, 10 (2), 85-89.

Sinclair, I. (ed.) (1988). *Residential care: the research reviewed*. London, HMSO.

Sing Tao Daily (dated January 4, 2014). Hong Kong: Sing Tao News Corporation Limited.

Smits, C.H.M., Deeg, D.J.H. and Jonker, C. (1997). Cognitive and emotional predictors of disablement in older adults. *Journal of Aging and Health*, 9 (2), 204-221.

Social Welfare Department (1993). *The Five-Year Plan for Social Welfare Development in Hong Kong - Review 1993*. Hong Kong: Social Welfare Department.

Social Welfare Department (2000). *Welfare Sector Subvention Reforms*. Available from: <http://www.swd.gov.hk/doc/ngo/SectorReform_eng.pdf> (Accessed 18 April 2012).

Social Welfare Department (2005). *Information on home help service*. Hong Kong: Social Welfare Department. Available from: <http://www.swd.gov.hk/en/print/page_619/> (Accessed 3 July, 2013).

Social Welfare Department (August 2007). *Leaflet on Day Care Centres and Day Care Units for the Elderly*. Available from: <http://www.swd.gov.hk/en/index/site_pubsvc/page_elderly/sub_csselderly/id_daycarecen/> (Accessed 18 April 2012).

Social Welfare Department (December 2009). Leaflet on *Elderly Services*. Available from:<http://www.swd.gov.hk/doc/elderly/ERCS/7Urdu-revised%2820140912%29.pdf> (Accessed 18 April 2012).

Social Welfare Department (July 2003). *Leaflet on Private Developers Scheme*. Available from: <http://www.swd.gov.hk/en/index/site_pubsvc/page_elderly/sub_residentia/id_schemetoen/> (Accessed 18 April 2012).

Social Welfare Department (n.d.). Available from: <http://www.swd.gov.hk/en/index/site_pubsvc/page_elderly/sub_residentia/id_enhancedbo/> (Accessed 18 April 2012).

Social Welfare Department (November 2007). *Waiting list for residential care services*. Hong Kong: Social Welfare Department.

Social Welfare Department (October 2005). *Code of Practice for Residential Care Homes (Elderly Persons)*, revised edition. Hong Kong: Social Welfare Department.

Social Welfare Department (various years). *Annual Report*. Hong Kong: Social Welfare Department.

Social Welfare Department (various years). *Social Welfare Services in Figures: 1982 Edition to 2014 Edition*. Hong Kong: Social Welfare Department.

Soldo, B.J. and Agree, E.M. (1988). America's elderly. *Population Bulletin*, 43 (3), 1-53.

South China Morning Post (dated March 25, 2013). Hong Kong: The SCMP Group.

Spector W.D. and Takada H.A. (1991). Characteristics of nursing homes that affect resident outcomes. *Journal of Aging and Health*, 3 (4), 427-454.

Spector, W.D. (1990). Functional disability scales. In: Spilker, R. (ed.). *Quality of life assessments in clinical trials*. New York: Raven Press.

Spicker, P. (1984, 2011). *Stigma and social welfare*. London: Croom Helm.

Spicker, P. (2006). *Policy analysis for practice: applying social policy*. Bristol: The Policy Press.

Stone, R., Cafferata, G.L. and Sangl, J. (1987). Caregivers of the frail elderly: a national profile. *The Gerontologist*, 27 (5), 616-631.

Strain, L.A., Grabusic, C.C., Searle, M.S. and Dunn, N.J. (2002). Continuing and ceasing leisure activities in later life: a longitudinal study. *The Gerontologist*, 42 (2), 217-223.

Street, D., Burge, S., Quadagno, J. and Barrett, A. (2007). The salience of social relationships for resident well-being in assisted living. *Journal of Gerontology: Social Sciences*, 62B (2), S129-S134.

Sturgess, I., Rudd, A.G. and Shilling, J. (1994). Unrecognised visual problems amongst residents of Part III homes. *Age and Ageing*, 23 (1), 54-56.

Tadd, W. and Bayer A. (2006). Dignity in health and social care for older Europeans: implications of a European project. *Ageing Health*, 2 (5), 771-779.

Tennstedt, S., Harrow, B. and Crawford, S. (1996). Informal care vs. formal services: changes in patterns of care over time. *Journal of Aging and Social Policy*, 7 (3/4), 71-91.

Ter Meulen, R. (2001). Care for the elderly in an era of diminishing resources. In Parker, M. and Dickenson, D. (eds.). *The Cambridge medical ethics workbook: case studies, commentaries and activities.* Cambridge: Cambridge University Press, 241-249.

The Basic Law of the Hong Kong Special Administrative Region of the People's Republic of China (Article 107). Available from: <http://www.basiclaw.gov.hk/en/basiclawtext/chapter_5.html> (Accessed 22 June, 2013).

The Budget (2012-13). Available from: <www.budget.gov.hk/2012 /eng/speech.html> (Accessed 22 June, 2014).

The Budget (2013-14). Available from: <www.budget.gov.hk/2013 /eng/speech.html> (Accessed 22 June, 2014).

The Budget (2014-15). Available from: <www.budget.gov.hk/2014/eng/ pdf/e_budgetspeech2014-15.pdf> (Accessed 2 July, 2014).

The Estimates for the year ending 31 March (various years). *General Revenue Account* (1989-2013). The government of HKSAR.

The University of Hong Kong/Research Team (2009). *Consultancy study on residential care services for the elderly: final report*. Hong Kong: The University of Hong Kong.

Thompson, J.R., Gibson, J.M. and Jagger, C. (1989). The association between visual impairment and mortality in elderly people. *Age and Ageing*, 18 (2), 83-88.

Thompson, N. (1995). *Age and dignity: working with older people*. London: Ashgate Publishing Group.

Tielsch, J.M., Javitt, J.C., Coleman, A., Katz, J. and Sommer, A. (1995). The prevalence of blindness and visual impairment among nursing home residents in

Baltimore. *New England Journal of Medicine*, 332 (18), 1205-1209.

Ting, K.F.C. and Stephen, W.K. (2002). Leaving the paternal home: Chinese culture in an urban context. *Journal of Marriage and Family*, 64 (3), 614-626.

Tisdall, C. (ed.) (1989). *In Times of Great Chaos.* Hong Kong: Helping Hand Ltd..

Titmuss, R.M. (1963). *Essays on 'The Welfare State'*. London: Unwin University Books.

Titmuss, R.M. (1968). *Commitment to welfare.* London: George Allen & Unwin Ltd..

Titmuss, R.M. *Social policy: an introduction.* Edited by Abel-Smith, B. and Titmuss, K. (1974). London: George Allen & Unwin Ltd..

Titmuss, R.M. The nation's wealth. In: Alcock, P., Glennerster, H., Oakley, A. and Sinfield, A. (2001). *Welfare and wellbeing: Richard Titmuss's contribution to social policy*. Bristol: The Policy Press, 1-17.

Tobin, G.W. and Brocklehurst, J.C. (1986). Faecal incontinence in residential homes for the elderly: prevalence, aetiology and management. *Age and Ageing*, 15 (1), 41-46.

Tomaka, J., Thompson, S. and Palacios, R. (2006). The relation of social isolation, loneliness, and social support to disease outcomes among the elderly. *Journal of Aging and Health*, 18 (3), 359-384.

Tomiak, M., Berthelot, J.M., Guimond, E. and Mustard, C.A. (2000). Factors associated with nursing-home entry for elders in Manitoba, Canada. *Journal of Gerontology: Medical Sciences*, 55A (5), M279-M287.

Tung, C.H. (2000). *Speech delivery by the Chief Executive at a Business Community Luncheon at the Hong Kong Convention and Exhibition Centre on October 16*, Hong Kong. Available from: <www.info.gov.hk/gia/general/200010/16/1016122.htm> (Accessed 12 February, 2014).

Twigg, J. (1996). Issues in informal care. In: OECD. *Caring for frail elderly people: policies in evolution*. OECD, Social Policy Studies No.19.

Twigg, J. (1997). Deconstructing the 'social bath': help with bathing at home for older and disabled people. *Journal of Social Policy*, 26 (2), 211-232.

Twigg, J. (1999). The spatial ordering of care: public and private in bathing support at home. *Sociology of Health and Illness*, 21 (4), 381-400.

Twigg, J. and Atkin, K. (1994). *Carers perceived: policy and practice in informal care*. Buckingham: Open University Press.

Unger, D.G. and Powell, D.R. (1980). Supporting families under stress: the role of social networks. *Family Relations*, 29 (4), 566-574.

Vabo, M. and Szebehely, M. (2012). A caring state for all older people?. In: Anttonen,

A., Haikio, L. and Stefansson, K. (eds.). *Welfare State, Universalism and Diversity.* Cheltenham: Edward Elgar Publishing Limited, 121-143.

Valk, M., Post, M.W., Cools, H.J. and Schrijvers, G.A. (2001). Measuring disability in nursing home residents: validity and reliability of a newly developed instrument. *Journal of Gerontology: Psychological Sciences*, 56B (3), 187-191.

Verbrugge, L.M. and Jette, A.M. (1994). The disablement process. *Social Science Medicine*, 38 (1), 1-14.

Victor, C., Scambler, S. and Bond, J. (2009). *The social world of older people: understanding loneliness and social isolation in later life*. McGraw-Hill: Open University Press.

Victor, C.R. (2005). *The social context of ageing*. London: Routledge.

Victor, C.R., Scambler, S.J., Bowling, A. and Bond, J. (2005). The prevalence of, and risk factors for, loneliness in later life: a survey of older people in Great Britain. *Ageing and Society*, 25 (6), 357-375.

Vierck, E. (2003). *Aging: demographics, health, and health services*. Westport, Conn.: Greenwood Press.

Waite, L.J. (1995). Does marriage matter?. *Demography*, 32 (4), 483-507.

Waite, L.J. (2000). The family as a social organisation: key ideas for the 21st Century. *Contemporary Sociology*, 29 (3), 463-469.

Walker, A. (1991). The relationship between the family and the state in the care of older people. *Canadian Journal on Aging*, 10 (2), 94-112.

Walker, R. (2005). *Social security and welfare: concepts and comparisons*. Open University Press, 177-200.

Walsh, K. and Shutes, I. (2013). Care relationships, quality of care and migrant workers caring for older people. *Ageing and Society*, 33 (3), 393-420.

Walters, P. and Bartlett, H. (2009). Growing old in a new estate: establishing new social networks in retirement. *Ageing and Society*, 29 (2), 217-236.

Warburton, R.W. (1994). *Home and away: a review of recent research evidence to explain why some elderly people enter residential care homes whilst others stay at home.* London: HMSO.

Weinstein, B.E. and Ventry, I.M. (1982). Hearing impairment and social isolation in the elderly. *Journal of Speech and Hearing Research*, 25 (4), 593-599.

Weissert, W., Chernew, M. and Hirth, R. (2003). Titrating versus targeting home care services to frail elderly clients: an application of agency theory and cost-benefit analysis to home care policy. *Journal of Ageing and Health*, 15 (1), 99-123.

Weissert, W.G. and Scanlon, W. (1983). *Determinants of institutionalisation of the*

aged: project to analyse existing long-term care data. Vol. III, 1-19, Washington, D.C.: The Urban Institute.

Wenger, G.C. (1992). *Help in old age - facing up to change: a longitudinal network study.* Liverpool: Liverpool University Press.

Wiener, J.M., Estes, C.L., Goldenson, S.M. and Goldberg, S.C. (2001). What happened to long-term care in the Health Reform Debate of 1993-1994? Lessons for the future. *The Milbank Quarterly,* 79 (2), 207-253.

Wiener, J.M., Hanley, R.J., Spence, D.A. and Murray, S.E. (1993). Financing and use of long-term care for the elderly. In: Manton, K.G., Singer, B.H. and Suzman, R.M. (eds.). *Forecasting the health of elderly populations.* New York: Springer-Verlag, 289-306.

Wilensky, H.L. and Lebeaux, C.N. (1965). *Industrial society and social welfare.* New York: Free Press, Chapter 6.

Wilkin, D. and Jolley, D.J. (1979). *Behavioural problems among old people in geriatric wards, psychogeriatric wards and residential homes, 1976-78*. Research Report No.1, Research Section, Psychiatric Unit, University Hospital of South Manchester.

Wingard, D.L., Jones, D.W. and Kaplan, R.M. (1987). Institutional care utilisation by the elderly: a critical review. *The Gerontologist*, 27 (2), 156-163.

Wittenberg, R., Comas-Herrera, A., King, D., Malley, J., Pickard, L. and Darton, R. (2006). *Future demand for long-term care, 2002 to 2041: projections of demand for long-term care for older people in England.* PSSRU Discussion Paper No. 2330. The Personal Social Services Research Unit, University of Kent at Canterbury.

Wittenberg, R., Comas-Herrera, A., Pickard, L. and Hancock, R. (2004). *Future demand for long-term care in the UK: a summary of projections of long-term care finance for older people to 2051.* Joseph Rowntree Foundation, York Publishing Services Ltd..

Wittenberg, R., Pickard, L., Comas-Herrera, A., Davies, B. and Darton, R. (1998). *Demand for long-term care: projections of long-term care finance for elderly people*. The Personal Social Services Research Unit, University of Kent at Canterbury.

Wolf, D.A. and Soldo, B.J. (1988). Household composition choices of older unmarried women. *Demography*, 25 (3), 387-403.

Wolff J.L. and Kasper, J.D. (2006). Caregivers of frail elders: updating a National Profile. *The Gerontologist*, 46 (3), 344-356.

Wolinsky, F.D., Callahan, C.M., Fitzgerald J.F. and Johnson, R.J. (1992). The risk of nursing home placement and subsequent death among older adults. *Journal of Gerontology: Social Sciences*, 47 (4), S173-S182.

Woo, J. and Chau, P.H. (2009). Aging in Hong Kong: the institutional population.

Journal of American Medical Directors Association, 10 (7), 478-485.

Woo, J., Chi, I., Hui, E., Chan, F. and Sham, A. (2005). Low staffing level is associated with malnutrition in long-term residential care homes. *European Journal of Clinical Nutrition*, 59, 474-479.

Woo, J., Ho, S.C. and Yu, A.L.M. (2000a). The influence of income on morbidity, mortality and dependency in elderly Hong Kong Chinese. *Archives of Gerontology and Geriatrics*, 30 (1), 55-61.

Woo, J., Ho, S.C., Lau, J. and Yuen, Y.K. (1994a). Age and marital status are major factors associated with institutionalisation in elderly Hong Kong Chinese. *Journal of Epidemiology and Community Health*, 48 (3), 306-309.

Woo, J., Ho, S.C., Lau, S., Lau, J. and Yuen, Y.K. (1994b). Prevalence of cognitive impairment and associated factors among elderly Hong Kong Chinese aged 70 years and over. *Neuroepidemiology*, 13 (1/2), 50-58.

Woo, J., Ho, S.C., Yu, A.L.M. and Lau, J. (2000b). An estimate of long-term care needs and identification of risk factors for institutionalisation among Hong Kong Chinese aged 70 years and over. *Journal of Gerontology: Medical Sciences*, 55A (2), M64-M69.

Woo, J., Ho, S.C., Yu, L.M., Lau, J. and Yuen, Y.K. (1998). Impact of chronic diseases on functional limitations in elderly Chinese aged 70 years and over: a cross-sectional and longitudinal survey. *Journal of Gerontology: Medical Sciences,* 53A (2), M102-M107.

Working Group on Care for the Elderly (1994). *Report of the Working Group on care for the elderly*. Hong Kong: Government Printer.

Working Group on Housing for the Elderly (June 1989). *Report of the Working Group on housing for the elderly*. Hong Kong: Government Printer.

World Health Organisation (1980). *International classification of impairments, disabilities, and handicaps*. Geneva: World Health Organisation.

World Health Organisation (2000). *Active ageing: a policy framework*. Copenhagen: World Health Organisation.

World Health Organisation (2002). *Active ageing: a policy framework*. Madrid, Spain: World Health Organisation.

Wu, S.C., Li, C.Y. and Chang, A.L. (1997). The influence of intergenerational exchange on nursing home admission in Taiwan. *Journal of Cross-Cultural Gerontology*, 12 (2), 163-174.

Yang, K. and Victor, C. (2011). Age and loneliness in 25 European nations. *Ageing and Society*, 31 (8), 1368-1388.

Yeung, A.K.C. (2000). *A study on the community care patterns and the networking strategies of elderly persons in Hong Kong: final report*. Hong Kong: Division of

Social Studies, City University of Hong Kong.

Zahava, G. and Bowling, A. (2004). Quality of life from the perspectives of older people. *Ageing and Society*, 24 (5), 675-691.

Zimmer, J.G., Rothenberg, B.M. and Andresen, E.M. (1997). Functional assessment. In: Andresen, E.M., Rothenberg, B.M. and Zimmer, J.G. (eds.). *Functional assessment in assessing the health status of older adults.* New York: Springer Publishing Company, Inc., 1-41.

Zimmerman, S., Scott, A.C., Park, N.S., Hall, S.A., Wetherby, M.M., Gruber-Baldini, A.L. and Morgan, L.A. (2003). Social engagement and its relationship to service provision in residential care and assisted living. *Social Work Research*, 27 (1), 6-18.

Statistical Reports

Census and Statistics Department (1977). *Hong Kong By-Census 1976 Main Report: Volume II.* Hong Kong: Government Printer.

Census and Statistics Department (1982). *Hong Kong 1981 Census Main Report: Volume II.* Hong Kong: Census and Statistics Department.

Census and Statistics Department (1987). *Hong Kong 1986 By-Census Main Report: Volume II.* Hong Kong: Census and Statistics Department.

Census and Statistics Department (1990). 'Domestic Helpers' in *Social Data Collected by the General Household Survey: Special Topics Report No.VI.* Hong Kong: Census and Statistics Department, 89-104.

Census and Statistics Department (1992). *Hong Kong 1991 Population Census Main Tables.* Hong Kong: Census and Statistics Department.

Census and Statistics Department (1993a). 'Domestic Helpers' in *Social Data Collected by the General Household Survey: Special Topics Report No.VIII.* Hong Kong: Census and Statistics Department, 57-66.

Census and Statistics Department (1993b). 'Domestic Helpers' in *Social Data Collected by the General Household Survey: Special Topics Report No.IX.* Hong Kong: Census and Statistics Department, 3-20.

Census and Statistics Department (June 1993). *Hong Kong 1991 Population Census: Main Report.* Hong Kong: Census and Statistics Department.

Census and Statistics Department (1995a). 'Domestic Helpers' in *Social Data*

Collected by the General Household Survey: Special Topics Report No.11. Hong Kong: Census and Statistics Department, 33-48.

Census and Statistics Department (1995b). 'Domestic Helpers' in *Social Data Collected by the General Household Survey: Special Topics Report No.12*. Hong Kong: Census and Statistics Department, 3-10.

Census and Statistics Department (1996). 'Hong Kong residents married in Mainland China' in *Social Data Collected by the General Household Survey: Special Topics Report No.15*. Hong Kong: Census and Statistics Department.

Census and Statistics Department (1997a). 'Domestic Helpers' in *Social Data Collected by the General Household Survey: Special Topics Report No.14*. Hong Kong: Census and Statistics Department, 67-78.

Census and Statistics Department (1997b). *1996 Population By-Census Main Tables.* Hong Kong: Census and Statistics Department.

Census and Statistics Department (1999a). 'A Profile of Elderly Persons Aged 60 and Over Living Alone' in *Social Data Collected Via the General Household Survey: Special Topics Report No.24*. Hong Kong: Census and Statistics Department, 54.

Census and Statistics Department (1999b). 'Hong Kong Residents with Spouses/Children in the Mainland of China' in *Social Data Collected Via the General Household Survey: Special Topics Report No.22*. Hong Kong: Census and Statistics Department.

Census and Statistics Department (May 2000). 'A Profile of applicants under the residential care services delivery system for the elderly, 1999' in *Hong Kong Monthly Digest of Statistics*. Hong Kong: Census and Statistics Department, FB1-FB16.

Census and Statistics Department (2000a). 'Persons from the Mainland of China Having Resided in Hong Kong for Less Than 7 Years' in *Social Data Collected Via the General Household Survey: Special Topics Report No.25*. Hong Kong: Census and Statistics Department.

Census and Statistics Department (2000b). *Thematic Household Survey Report No.3 - Health Status of Hong Kong Residents.* Hong Kong: Census and Statistics Department, 23.

Census and Statistics Department (2001a). 'Aspiration and Experience of Taking Up Residence in the Mainland of China' in *Thematic Household Survey Report No.7*. Hong Kong: Census and Statistics Department, 1-73.

Census and Statistics Department (June 2001). 'Mortality Trends of the Elderly in Hong Kong, 1961-1999' in *Hong Kong Monthly Digest of Statistics*. Hong Kong: Census and Statistics Department, FB1-FB14.

Census and Statistics Department (2001b). 'Socio-Demographic, Health and Economic Profiles of Elderly People and Soon-to-be-old People' in *Social Data Collected via the General Household Survey Special Topics Report No.27*. Hong Kong: Census and Statistics Department, 80.

Census and Statistics Department (2001c). 'Views on Employment of Domestic Helpers' in *Thematic Household Survey Report No.5*. Hong Kong: Census and Statistics Department.

Census and Statistics Department (2002a). *Hong Kong 2001 Population Census Main Tables*. Hong Kong: Census and Statistics Department.

Census and Statistics Department (2002b). *Hong Kong 2001 Population Census Main Report: Volume I*. Hong Kong: Census and Statistics Department.

Census and Statistics Department (2002c). *2001 Population Census Thematic Report : Older Persons*. Hong Kong: Census and Statistics Department.

Census and Statistics Department (2002d). *Demographic Trends in Hong Kong 1981-2001*. Hong Kong: Census and Statistics Department.

Census and Statistics Department (2002e). *Thematic Household Survey Report No. 8 - Health Status of Hong Kong Residents*. Hong Kong: Census and Statistics Department, p.23.

Census and Statistics Department (2002f). *Women and Men in Hong Kong: key statistics*. Hong Kong: Census and Statistics Department.

Census and Statistics Department (2003a). 'Characteristics of Dependent Parents' in *Thematic Household Survey Report No.11*. Hong Kong: Census and Statistics Department, 1-23.

Census and Statistics Department (2003b). 'Health Status of Hong Kong Residents'

in *Thematic Household Survey Report No.12*. Hong Kong: Census and Statistics Department, p.34.

Census and Statistics Department (2004a). 'Hong Kong Residents' Experience of and Aspiration for Taking Up Residence in the Mainland' in *Thematic Household Survey Report No.18.* Hong Kong: Census and Statistics Department, 1-97.

Census and Statistics Department (2004b). 'Needs of Persons from the Mainland Having Resided in Hong Kong for 3 Years and Less' in *Thematic Household Survey Report No.17.* Hong Kong: Census and Statistics Department.

Census and Statistics Department (July 2004). 'Statistics on Comprehensive Social Security Assistance Scheme, 1994-2003' in *Hong Kong Monthly Digest of Statistics***.** Hong Kong: Census and Statistics Department.

Census and Statistics Department (2005). 'Socio-Demographic Profile, Health Status and Long-Term Care Needs of Older Persons Residing in Domestic Households' in *Thematic Household Survey Report No.21***.** Hong Kong: Census and Statistics Department.

Census and Statistics Department (2007a). *2006 Population By-Census Thematic Report: Older Persons***.** Hong Kong: Census and Statistics Department.

Census and Statistics Department (2007b). *Demographic Trends in Hong Kong 1981-2006.* Hong Kong: Census and Statistics Department.

Census and Statistics Department (2007c). *Hong Kong 2006 Population By-Census Main Report: Volume One.* Hong Kong: Census and Statistics Department.

Census and Statistics Department (2007d). *Special Report on Gross Domestic Products***.** Hong Kong: Census and Statistics Department.

Census and Statistics Department (2009). 'Socio-demographic Profile, Health Status and Self-care Capability of Older Persons' in *Thematic Household Survey Report No.40.* Hong Kong: Census and Statistics Department.

Census and Statistics Department (July 2005). 'Statistics on Comprehensive Social Security Assistance Scheme, 1995-2004' in *Hong Kong Monthly Digest of Statistics*. Hong Kong: Census and Statistics Department.

Census and Statistics Department (December 2007). 'The mortality trend in Hong Kong: 1981 to 2006' in *Hong Kong Monthly Digest of Statistics*. Hong Kong: Census and Statistics Department, FC4.

Census and Statistics Department (July 2007). 'Statistics on Comprehensive Social Security Assistance Scheme, 1996 to 2006' in *Hong Kong Monthly Digest of Statistics*. Hong Kong: Census and Statistics Department.

Census and Statistics Department (March 2013). 'The Profile of Persons Residing in Private Elderly Homes in 2012' in *Hong Kong Monthly Digest of Statistics*. Hong Kong: Census and Statistics Department.

Census and Statistics Department (September 2012). 'Statistics on Comprehensive Social Security Assistance Scheme, 2001-2011' in *Hong Kong Monthly Digest of Statistics*. Hong Kong: Census and Statistics Department.

Census and Statistics Department (various years). *Hong Kong Annual Digest of Statistics: 1990 Edition to 2013 Edition.* Hong Kong: Census and Statistics Department.

Census and Statistics Department (various years). *Hong Kong Monthly Digest of Statistics* (September 1990, March 1995, March 2002, November 2004, May 2007). Hong Kong: Census and Statistics Department.

Appendix 1: Clifton Assessment Procedures for the Elderly (CAPE); revised version

Resident Assessment Form

1. Month of filling in the form: ☐☐ Month ☐☐ Year

2. Name of Home: ☐☐☐

   Chak On Care Home = COC

   Lai Yiu Bradbury Care Home = LYC

3. Person filling in the form: _____

4. Resident No.: ☐☐☐☐☐☐

5. Sex: ☐ Male ☐ Female

6. Use of walking aid

   ☐ 0 No need to use any walking aid

   ☐ 1 Use of walking stick

   ☐ 2 Use of quadripod

   ☐ 3 Use of walking frame

   ☐ 4 Use of wheelchair

   ☐ 5 Chair bound

   ☐ 6 Bed-ridden

7. Mobility

   ☐ 0 Can walk independently without aid

   ☐ 1 Can walk with walking aid

   ☐ 2 Can walk with the help of others

   ☐ 3 Cannot walk

8. He / She is incontinent of urine

☐ 0 Never ☐ 1 Once or less per week ☐ 2 Once daily

☐ 3 Persistent

9. He / She is incontinent of faeces

☐ 0 Never ☐ 1 Once or less per week ☐ 2 Once daily

☐ 3 Persistent

10. Communication ability with others (by speaking, writing, or gesturing)

☐ 0 Well enough to make oneself easily understood at all times

☐ 1 Can be understood sometimes

☐ 2 Can rarely or never be understood for whatever reason

11. Comprehension ability (when others speaking, writing, or gesturing)

☐ 0 Understand almost everything others communicate

☐ 1 Understand some of what others communicate

☐ 2 Understand almost nothing of what others communicate

12. Vision

☐ 0 Can see without glasses

☐ 1 Can see with glasses

☐ 2 Partially blind

☐ 3 Totally blind

13 Hearing

☐ 0 No hearing difficulties, without hearing aid

☐ 1 Some hearing problems

☐ 2 Totally deaf

14. Use of hearing aid

☐ 0 No need to use hearing aid

☐ 1 Need to use hearing aid

☐ 2 Totally deaf

15. What is your name?

☐ 0 Correct ☐ 1 Partly correct ☐ 2 Wrong

16. How old are you?

☐ 0 Correct ☐ 1 Partly correct ☐ 2 Wrong

17. What is your date of birth?

☐ 0 Correct ☐ 1 Partly correct ☐ 2 Wrong

18. What is this place you live now?

☐ 0 Correct ☐ 1 Partly correct ☐ 2 Wrong

19. What is the name of this region you live now?

☐ 0 Correct ☐ 1 Partly correct ☐ 2 Wrong

20. What day is it now?

☐ 0 Correct ☐ 1 Partly correct ☐ 2 Wrong

21. What month is it now?

☐ 0 Correct ☐ 1 Partly correct ☐ 2 Wrong

22. What year is it now?

☐ 0 Correct ☐ 1 Partly correct ☐ 2 Wrong

23. Will you count up from 1 to 10?

☐ 0 Correct ☐ 1 Partly correct ☐ 2 Wrong

24. When toileting, he / she requires

☐ 0 No assistance ☐ 1 Some assistance

☐ 2 Maximum assistance

25. When dressing, he / she requires

☐ 0 No assistance ☐ 1 Some assistance

☐ 2 Maximum assistance

26. When feeding, he / she requires

☐ 0 No assistance ☐ 1 Some assistance

☐ 2 Maximum assistance

27. When washing hands and face, he / she requires

☐ 0 No assistance ☐ 1 Some assistance

☐ 2 Maximum assistance

28. When bathing, he / she requires

☐ 0 No assistance ☐ 1 Some assistance

☐ 2 Maximum assistance

29. When shopping, he / she requires

☐ 0 No assistance ☐ 1 Some assistance

☐ 2 Maximum assistance

30. When managing money, he / she requires

☐ 0 No assistance ☐ 1 Some assistance

☐ 2 Maximum assistance

31. When grooming, he / she requires

☐ 0 No assistance ☐ 1 Some assistance

☐ 2 Maximum assistance

32. When bed making, he / she requires

☐ 0 No assistance ☐ 1 Some assistance

☐ 2 Maximum assistance

33. Wandering within the residential home without specific purpose?

☐ 0 Rarely or Never ☐ 1 Sometimes

☐ 2 Frequently

34. He / She exhibits behavioural disturbance to others during the day (e.g. loud or constant talking, interfering in others' affairs)

☐ 0 Rarely or Never ☐ 1 Sometimes

☐ 2 Frequently

35. He / She exhibits behavioural disturbance to others during the night (e.g. loud or constant talking, interfering in others' affairs)

☐ 0 Rarely or Never ☐ 1 Sometimes

☐ 2 Frequently

36. Accusing others of stealing own personal possessions

☐ 0 Rarely or Never ☐ 1 Sometimes

☐ 2 Frequently

37. Sleep pattern at night

☐ 0 Rarely or Never awake ☐ 1 Sometimes awake

☐ 2 Often awake

38. Helping out in the residential home

☐ 0 Frequently ☐ 1 Sometimes ☐ 2 Rarely or Never

39. Participating in some constructive activities in the Home

☐ 0 Frequently ☐ 1 Sometimes ☐ 2 Rarely or Never

40. Showing willingness to help others

☐ 0 Frequently ☐ 1 Sometimes ☐ 2 Rarely or Never

41. Having social conversation with other residents

☐ 0 Frequently ☐ 1 Sometimes ☐ 2 Rarely or Never

42. Having conflict with other residents

☐ 0 Frequently ☐ 1 Sometimes ☐ 2 Rarely or Never

43. Socialising with other residents

☐ 0 Establish good relationship with others

☐ 1 Maintain average relationship with others

☐ 2 Rarely or Never interact with others

44. Having social conversation with staff

☐ 0 Rarely or Never ☐ 1 Sometimes ☐ 2 Frequently

45. Having conflict with staff

☐ 0 Rarely or Never ☐ 1 Sometimes ☐ 2 Frequently

46. Being visited by relative

☐ 0 Rarely or Never ☐ 1 Sometimes ☐ 2 Frequently

☐ 3 Not applicable

47. Source of referral

☐ 1 Helping Hand ☐ 2 Housing Department

☐ 3 Social Welfare Department ☐ 4 Not applicable

48. What is your age? _____

49. Marital status

☐ 0 married ☐ 1 never married

☐ 2 widowed ☐ 3 divorced / separated

50. Education level

☐ 0 Primary ☐ 1 Lower secondary

☐ 2 Upper secondary

☐ 3 Post-secondary or above ☐ 4 Illiterate

51. Whom do you live with before home admission (can choose more than one answer)?

☐ 0 spouse ☐ 1 son ☐ 2 daughter ☐ 3 brother

☐ 4 sister ☐ 5 grandson ☐ 6 granddaughter

☐ 7 relative / friend ☐ 8 living alone

☐ 9 living in other forms of residential facility

52. Living arrangement prior to home admission

☐ 0 private building ☐ 1 private housing unit

☐ 2 bedspace ☐ 3 public housing unit

☐ 4 temporary housing unit

☐ 5 under Home Ownership Scheme

☐ 6 squatter hut / cottage ☐ 7 privately-run home

☐ 8 government-subsidised home

53. Financial situation (can choose more than one answer)

☐ 0 Comprehensive Social Security Assistance

☐ 1 Old Age Allowance ☐ 2 Disability Allowance

☐ 3 Personal savings ☐ 4 Family members

☐ 5 Relatives ☐ 6 Friends

54. Date of home admission: ☐☐ Month ☐☐ Year

- Thanks for your help -

Appendix 2: List of Abbreviations

ADLs	Activities of Daily Living
BPS	Bought Place Scheme
BRS	Behaviour Rating Scale
CAPE	Clifton Assessment Procedures for the Elderly
CAS	Cognitive Assessment Scale
CBDB	Commercial and Business Development Branch
CCPI	Composite Consumer Price Index
CSSA	Comprehensive Social Security Assistance
DA	Disability Allowance
DECC(s)	District Elderly Community Centre(s)
EBPS	Enhanced Bought Place Scheme
EHCCSTs	Enhanced Home and Community Care Services Teams
EN	Enrolled Nurse
FDH	Foreign Domestic Helpers
FI	Faeces Incontinence
GDP	Gross Domestic Product
HD	Housing Department
HDA	Higher Disability Allowance
HKHA	Hong Kong Housing Authority
HKSAR	Hong Kong Special Administrative Region
HOAA	Higher Old Age Allowance
IADLs	Instrumental Activities of Daily Living
IHCSTs	Integrated Home Care Services Teams
LEGCO	Legislative Council
LSGSS	Lump Sum Grant Subvention System

MDS-HC	Minimum Data Set - Home Care
MPF	Mandatory Provident Fund
MPS	Master Pay Scale
NEC(s)	Neighbourhood Elderly Centre(s)
NGO(s)	Non-governmental Organisation(s)
NHDI	Nursing Home Disabilities Instrument
NHS	National Health Service
NDA	Normal Disability Allowance
NOAA	Normal Old Age Allowance
OAA	Old Age Allowance
OECD	Organisation for Economic Co-operation and Development
PACE	Program of All-Inclusive Care for the Elderly
PCW(s)	Personal Care Worker(s)
RCHE(s)	Residential Care Home(s) for the Elderly
RN	Registered Nurse
SARS	Severe Acute Respiratory Syndrome
SCNAM	Standardised Care Need Assessment Mechanism
SWD	Social Welfare Department
UI	Urine Incontinence
WAIS	Wechsler Adult Intelligent Scale
WHO	World Health Organisation

Appendix 3: List of Tables

Table 1.1 Age groups and gender of older people in Hong Kong: 1981-2006

Age Group	Sex	1981	1991	2001	2006	Changes in no. of older people 1981-2006	Changes in proportion of all older people 1981-2006
65-69	M	68200	89550	127943	125200	+83.6%	-35.1%
	F	76300	95547	121068	116600	+52.8%	-31.7%
70 - 74	M	39900	61908	101648	112400	+181.7%	-1.4%
	F	57000	73018	107595	115900	+103.3%	-9%
75 - 79	M	19300	38084	63006	82300	+326.4%	+50.4%
	F	37300	50771	79730	96300	+158.2%	+15.4%
80 - 84	M	8200	15414	33377	44800	+446.3%	+93.2%
	F	21700	28985	50958	67900	+212.9%	+150.9%
85+	M	3500	6919	19210	28500	+714.3%	+192%
	F	12900	21844	42517	62200	+382.2%	+115.9%
Total no. of male		139100	211875	345184	393200	+182.7%	N.A.
Total no. of female		205200	270165	401868	458900	+123.6%	N.A.
Total no. of older people		344300	482040	747052	852100	+147.5%	N.A.
Total whole population		5183400	5522281	6708389	6857100	+32.3%	N.A.

Total numbers from different surveys do not match exactly with each other.

Source: Working Group on Care for the Elderly (1994). Census and Statistics Department (2002c, 2007c).

Table 1.2 Life expectancy at birth by sex: 1971-2006

Year	Age	
	Male	Female
1971	68.0	75.6
1981	72.4	78.1
1991	75.2	80.7
1996	76.2	81.8
1999	77.2	82.4
2001	78.4	84.6
2005	78.8	84.5
2006	79.4	85.5
Increase of life expectancy 1971-2006	11.4 years	9.9 years

Source: Census and Statistics Department (June 2001). Hong Kong Annual Digest of Statistics, 2007 Edition.

Table 1.3 Life expectancy of older people at selected age

Age	Sex	1977	1982	1991	1996	2001	2005	Change
60	male	16.4	18.0	19.3	20.4	21.7	21.7	↑ 5.3 years
	female	21.1	22.1	23.4	24.9	26.5	26.2	↑ 5.1 years
80	male	5.6	6.6	7.0	7.6	8.4	8.1	↑ 2.5 years
	female	7.7	8.3	8.9	9.8	11.0	10.1	↑ 2.4 years

Source: Hospital Authority (1997-1998, 2004-2005, 2005-2006).

Table 1.4 Age-specific mortality rates of older people

Rate per 1,000 population of the age group

Age Group	Sex	1981	1991	2001	2006	Rate of Change 1981 to 2006
60-64	male	19.5	15.4	10.3	9.9	48.7% ↓
	female	9.8	7.3	4.8	4.4	53.1% ↓
65-69	male	30.8	23.6	18.0	15.4	44.5% ↓
	female	16.6	13.2	9.3	7.0	55.4% ↓
70-74	male	47.4	39.7	30.0	26.7	40.9% ↓
	female	25.0	23.1	15.5	13.1	41.2% ↓
75-79	male	68.1	60.8	48.4	45.0	30.8% ↓
	female	41.9	38.2	26.9	23.8	39.1% ↓
80-84	male	97.9	90.6	77.0	75.9	17.6% ↓
	female	71.4	62.5	46.2	43.2	30.3% ↓
85+	male	119.9	126.6	128.8	129.5	7.5% ↑
	female	122.1	113.5	101.9	98.2	19.5% ↓

Source: Hong Kong Monthly Digest of Statistics (December 2007).

Table 1.5 Mortality from neoplasm

No. of deaths per 100,000 population

Age Group	Sex	1981	1991	2001	2004	Rate of Change 1981-2004	
						Male	Female
45-49	male	207	163	127	112	46% ↓	34.5% ↓
	female	113	99	80	74		
50-54	male	320	284	218	181	43.4% ↓	32.3% ↓
	female	174	152	125	118		
55-59	male	497	405	382	325	34.6% ↓	42% ↓
	female	274	209	209	159		
60-64	male	703	675	546	537	23.6% ↓	31.7% ↓
	female	300	254	527	205		
65-69	male	948	925	863	749	21% ↓	26.2% ↓
	female	507	487	376	374		
70-74	male	1290	1305	1240	1073	16.8% ↓	3.1% ↓
	female	580	714	609	562		
75-79	male	1336	1655	1761	1550	↑ 16%	6.8% ↓
	female	792	977	888	738		
80-84	male	1396	1906	2226	2054	↑ 47.1%	↑ 20%
	female	972	1208	1267	1166		
85+	male	1270	2036	2982	2620	↑ 106.3%	↑ 44.3%
	female	1049	1260	1636	1514		

Source: Census and Statistics Department (2002d). Hong Kong Cancer Registry (2007). Hospital Authority (1981-2004).

Table 1.6 Mortality rates of disease groups for the population aged 45 to 64

Rate per 100,000 population of the age group

Disease Group	1961	1971	1981	1991	2000
infectious and parasitic	185.1	103.0	26.3	17.6	7.1
neoplasm	263.6	312.8	313.5	289.2	208.3
endocrine, nutritional, metabolic immunity disorder and blood	11.2	12.1	10.2	4.9	8.7
nervous system, sense organs and mental disorder	5.0	4.6	4.1	3.5	3.8
circulatory system	298.7	260.1	210.4	148.4	79.6
respiratory system	91.5	132.9	91.4	63.7	29.5
digestive system	66.0	69.0	42.6	36.5	18.0
genitourinary system	26.4	26.8	33.3	24.2	10.8
skin, subcutaneous tissue and musculo-keltal system	1.1	1.4	1.7	0.9	1.8
symptoms, signs and ill-defined conditions	94.7	27.5	5.1	4.7	5.2
injury and poisoning	46.7	55.8	48.1	42.3	35.1

Source: Hospital Authority (2001-02).

Table 1.7 Mortality rates of disease groups for the population aged 65+

Rate per 100,000 population of the age group

Disease Group	1961	1971	1981	1991	2000
infectious and parasitic	316.7	232.7	113.0	138.9	78.9
neoplasm	510.5	743.2	852.4	1002.5	1044.8
endocrine, nutritional, metabolic immunity disorder and blood	32.0	58.2	56.3	51.0	105.7
nervous system, sense organs and mental disorder	13.0	10.4	11.9	22.9	35.7
circulatory system	1639.4	1604.9	1442.6	1262.2	1120.1
respiratory system	580.4	944.6	806.5	770.8	698.7
digestive system	164.8	181.7	160.0	146.5	151.5
genitourinary system	115.9	136.1	155.4	198.9	176.9
skin, subcutaneous tissue and musculoskeletal system	9.0	4.4	2.6	2.4	10.6
symptoms, signs and ill-defined conditions	1052.0	741.0	313.1	119.0	26.9
injury and poisoning	85.9	110.3	120.2	94.6	74.7

Source: Hospital Authority (2001-2002).

Table 1.8 Mortality by diseases of the circulatory system

No. of deaths per 100,000 population

Age Group	Sex	1981	1991	2001	Rate of Change 1981 to 2001	
					Male	Female
45-49	male	207	163	127	38.7% ↓	29.2% ↓
	female	113	99	80		
50-54	male	176	104	84	52.3% ↓	63.9% ↓
	female	83	63	30		
55-59	male	320	201	143	55.3% ↓	67.6% ↓
	female	185	119	60		
60-64	male	703	675	546	22.3% ↓	27.6% ↓
	female	351	300	254		
65-69	male	984	686	461	53.2% ↓	58.9% ↓
	female	632	416	260		
70-74	male	1719	1199	808	53% ↓	44.3% ↓
	female	1009	788	562		
75-79	male	2450	1844	1475	39.8% ↓	34% ↓
	female	1596	1476	1053		
80-84	male	3204	3086	2559	20.1% ↓	31.8% ↓
	female	2794	2410	1906		
85+	male	3499	3913	4513	↑ 29%	↑ 5.4%
	female	3985	3996	4200		

Source: Census and Statistics Department (2002d).

Table 1.9 Mortality by diseases of the respiratory system

No. of deaths per 100,000 population

Age Group	Sex	1981	1991	2001	Rate of Change 1981 to 2001	
					Male	Female
55-59	male	146	98	63	56.8% ↓	↑ 83.9%
	female	56	37	9		
60-64	male	293	200	123	58% ↓	79% ↓
	female	119	54	25		
65-69	male	584	359	258	55.8% ↓	64.2% ↓
	female	215	154	77		
70-74	male	921	769	527	42.8% ↓	59.6% ↓
	female	394	371	159		
75-79	male	1585	1410	1057	33.4% ↓	43.3% ↓
	female	739	663	419		
80-84	male	2573	2346	1992	22.6% ↓	29.5% ↓
	female	1365	1182	960		
85+	male	3330	3847	4525	↑ 35.9%	8.9% ↓
	female	3247	2998	2957		

Source: Census and Statistics Department (2002d).

Table 1.10 Cancer incidence rate for the population aged 45 and above

Per 100,000 Population of the Age Group

Age Group	Sex	1983	1991	2001	2004	Rate of Change 1983 to 2004 Male	Female
45-49	male	411.9	307.7	264.4	227.5	44.8% ↓	11.3% ↓
	female	344.1	357.8	327.9	305.1		
50-54	male	660.2	532.1	398.7	358.6	45.7% ↓	18.9% ↓
	female	481.0	400.0	379.0	404.7		
55-59	male	931.9	763.5	647.8	611.8	34.3% ↓	20.7% ↓
	female	609.0	511.8	476.0	483.2		
60-64	male	1401.2	1162.3	948.4	963.8	31.2% ↓	24.3% ↓
	female	792.0	657.6	605.1	599.4		
65-69	male	1772.4	1522.4	1406.9	1297.2	26.8% ↓	21.7% ↓
	female	975.3	905.0	808.2	763.2		
70-74	male	2339.2	2097.7	1979.5	1813.9	22.5% ↓	26% ↓
	female	1270.2	1249.0	1036.1	939.4		
75-79	male	2500.0	2413.1	2474.1	2366.8	5.3% ↓	8.8% ↓
	female	1414.8	1528.9	1309.7	1290.8		
80-84	male	2921.3	3000.0	2827.5	2747.0	6% ↓	↑ 1.8%
	female	1655.2	1841.6	1517.3	1684.2		
85+	male	2750.0	2946.7	2821.4	2855.4	↑ 3.8%	2.2% ↓
	female	1884.4	1779.3	1983.7	1842.8		

Source: Hong Kong Cancer Registry (various years). Hospital Authority (1983 to 2004).

Table 1.11 Mortality and morbidity for selected diseases: 1981-2005

Per 100,000 Population

Diseases	1981	1986	1991	1996	2001	2005
cancer	521.6	773.6	923.2	1149.1	1254.6	1202.6
cerebrovascular disease	213.4	247.7	282.1	309.0	368.2	360.8
ischaemic heart disease	84.6	113.1	167.0	266.7	328.5	367.0
end stage renal failure	N.A.	N.A.	N.A.	633.9	741.1	1116.1
chronic lung disease	434.0	465.0	434.6	580.6	714.6	599.1
diabetes mellitus	114.6	159.3	184.6	217.5	246.5	204.6

Source: Hospital Authority (2005-2006).

Table 1.12 Persons with diseases that required long-term follow-up by doctors

Type of Diseases	aged <15	15-24	25-34	35-44	45-54	55-64	65+
disease of the heart or circulatory system	4.3%	3.6%	5.2%	15.6%	32.5%	47.2%	57.3%
endocrine and metabolic disease	2.3%	7.2%	10.4%	17.4%	20.1%	26.2%	26.1%
musculoskeletal disease	2.7%	3.9%	10.9%	16.6%	21%	21%	22.8%
disease of the ear / nose /throat	42.5%	43.3%	26.2%	16%	9%	6.8%	5.7%
lung disease	33.1%	15%	8.9%	6%	5.3%	5.9%	9.1%
disease of the eye	5%	4.1%	3.5%	2.4%	3.9%	6.6%	14.8%
stomach and intestinal disease	0.7%	3.7%	9%	9.3%	6.3%	6.2%	4.8%
mental disorder	1.9%	6%	9%	8.4%	6.2%	4.1%	4.7%
disease of the nervous system	0.8%	1.5%	1.1%	1.1%	1.7%	3.2%	6.6%
skin disease	8.2%	6.7%	5.7%	5%	2.3%	2.2%	1.7%
cancer	1%	1.1%	1.6%	2.6%	3.9%	3.5%	2.7%
liver disease	0%	5%	10%	6.9%	2.8%	1.6%	0.7%
kidney disease	1.4%	1.7%	1.4%	2.5%	2.8%	2.1%	2.1%
disease of the blood	1.9%	3.6%	4%	3.1%	2.1%	1%	0.8%
genital disease	0.4%	0.1%	1.2%	2.6%	1.8%	1.5%	1.3%
immune disease	0.7%	0.4%	0.9%	1.3%	0.9%	0.8%	1.1%
complications of previous injury	0%	0.7%	1.2%	1.7%	0.7%	0.3%	0.6%

Source: Census and Statistics Department (2003b).

Table 1.13 Persons (aged 65+) with diseases that required long-term follow-up by doctors

Type of Diseases	Year			
	2000		2002	
	No. of people	Rate	No. of people	Rate
hypertension	147900	43.4%	164500	44.7%
diabetes	76700	22.5%	87100	23.7%
heart disease	55100	16.2%	61400	16.7%
arthritis / rheumatism / low back pains	41200	12.1%	44400	12.1%
eye disease	32600	9.6%	33700	9.2%
asthma	5500	1.6%	12800	3.5%
ENT problem	11300	3.3%	6400	1.7%
peptic ulcer	5700	1.7%	17800	4.8%
mental disorder	7800	2.3%	8800	2.4%
chronic bronchitis / emphysema / bronchiectasis	12800	3.8%	19100	5.2%
thyroid disease	14500	4.3%	4500	1.2%
cancer	12800	3.8%	10300	2.8%
high cholesterol	7700	2.3%	14600	4%
skin disease	12500	3.7%	6700	1.8%
others	54100	15.9%	53000	14.4%
Total no. of people	340900		368100	

Source: Census and Statistics Department (2000c, 2002e).

Table 1.14 Older people with chronic illnesses

Number of chronic illnesses	Percentage
No	28.4%
One	28.3%
Two	21%
Three	11.6%
Four	5.9%
Five	2.9%
Six and more	2%
	(N=10000)

Source: Census and Statistics Department (2005).

Table 1.15 Older people admitted to hospital in the last 12 months

Admitted to hospital in the last 12 months	Percentage
No	85.4%
One time	10%
Two times	2.3%
Three times	1%
Four or more	1.3%
Total	100% (N=10000)

Source: Census and Statistics Department (2005).

Table 1.16 Number of older people having stayed in public hospital

Year	No. and Percentage of patients aged 65 and above			No. of patients of all ages		
	Male	Female	Total	Male	Female	Total
1996	60848 12.4%	70341 14.4%	131189 26.8%	222381	267604	489985
1997	65284 12.9%	75158 14.9%	140442 27.8%	232930	272958	505888
1998	71760 13.5%	82581 15.5%	154341 29%	247583	286413	533998
1999	78495 14%	90215 16.2%	168710 30.2%	257782	300952	558736
2000	85294 14.6%	96986 16.6%	182280 31.2%	267106	316829	583938
2001	89424 14.8%	101040 16.6%	190464 31.4%	277419	329654	607076
2002	93429 15.6%	101551 17%	194980 32.6%	275116	323573	598691
2003	85441 16.5%	89678 17.3%	175119 33.8%	241014	276136	517150
2004	92754 16.6%	97585 17.4%	190339 34%	259439	301210	560650
2005	95424 16.8%	98593 17.4%	194017 34.1%	262512	305770	568282
Rate of Change 1996-2005	↑ 56.8%	↑28.7%	↑47.9%	↑18.1%.	↑14.3%	↑16%

Total numbers do not match the sum of male and female because there is missing information on a few data.

Source: Hospital Authority Statistical Report (various years).

Table 1.17 Total number of days of older people stayed in public hospital

Year	Total no. of days stayed in hospital					
	aged 65 and above					
	Male	Female	Total	Male	Female	Total
1996	1413447 19%	1614962 21.7%	3028409 40.6%	3490106	3961040	7451146
1997	1544898 20.1%	1737720 22.6%	3282618 42.7%	4038605	3648423	7687028
1998	1651682 20.3%	1924501 23.7%	3576183 44%	4331108	3797327	8128438
1999	1840670 21.9%	2079004 24.7%	3919674 46.6%	4411046	4006927	8417999
2000	1885470 22.2%	2130432 25.1%	2098902 47.3%	4467146	4467146	8501178
2001	2112279 22.3%	2171983 23%	4284262 45.3%	5276693	4180183	9456891
2002	1960607 23.3%	2211795 26.2%	4172402 49.5%	4229528	4199504	8429034
2003	1805870 22.6%	2231068 27.9%	4036938 50.5%	3935540	4055977	7991517
2004	1796623 23.5%	1926112 25.2%	3722735 48.7%	3978445	3679133	7657585
2005	1811735 23.2%	1938923 24.9%	3750658 48.1%	4060565	3742262	7802827
Rate of Change 1996 - 2005	↑28.2%	↑20.1%	↑23.9%	↑16.4%	↓5.5%	↑4.7%

Total numbers do not match the sum of male and female because there is missing information on a few data.

Source: Hospital Authority Statistical Report (various years).

Table 1.18 Self-perceived general health condition

Self-perceived general health condition	aged 15-24	aged 25-34	aged 35-44	aged 45-54	aged 55-64	aged 65+	Total
Excellent	1.5%	1.4%	0.8%	0.9%	0.8%	0.2%	0.9%
Very good	15.6%	13.5%	13.2%	10.8%	9%	5.2%	11.6%
Good	48.7%	45.7%	43.5%	38.5%	30.5%	25.6%	40%
Fair	32.3%	36.7%	38.9%	43.7%	50%	46%	40.4%
Poor	1.8%	2.7%	3.7%	6%	9.8%	23%	7%
Total	100% 852300	100% 984400	100% 1290800	100% 997200	100% 516000	100% 771000	100% 5411700

Source: Census and Statistics Department (2003b).

Table 1.19 Instrumental activities of daily living

No. of IADLs that cannot be performed independently	aged 60-64	65-69	70-74	75+	Total
0	93%	89.3%	78.5%	60.2%	78.8%
1 - 2	5.7%	7.7%	14%	19.5%	12.2%
3 - 4	0.5%	1.3%	3.6%	8.5%	3.9%
5 - 7	0.8%	1.6%	3.9%	11.8%	5.1%
Total	100%	100%	100%	100%	100% (N=10000)

Source: Census and Statistics Department (2005).

Table 1.20 People receiving DA due to physical handicap

Age Group	1996		2001		2005	
	No.	%	No.	%	No.	%
55-59	3019	7%	2188	6.2%	2635	8.2%
60-64	4271	9.9%	2745	7.8%	2088	6.5%
65-69	5613	13%	3702	10.5%	2633	8.2%
70-74	6396	14.9%	4696	13.4%	3466	10.8%
75-79	6559	15.2%	4984	14.2%	3700	11.6%
80 and over	17206	40%	16788	47.8%	17441	54.6%
	43064		35103		31963	

Source: Hospital Authority Statistical Report (various years).

Table 1.21 People receiving DA due to visual impairment

Age Group	1996		2001		2005	
	No.	%	No.	%	No.	%
55-59	661	6.6%	549	6.1%	664	7.9%
60-64	782	7.7%	703	7.8%	594	7.1%
65-69	990	9.8%	818	9.1%	689	8.2%
70-74	1336	13.3%	962	10.7%	773	9.3%
75-79	1525	15.1%	1138	12.7%	827	9.9%
80 and over	4782	47.5%	4800	53.5%	4811	57.6%
Total	10076	100%	8970	100%	8358	100%

Source: Hospital Authority Statistical Report (various years).

Table 1.22 People receiving DA due to hearing impairment

Age Group	1996		2001		2005	
	No.	%	No.	%	No.	%
55-59	452	10.7%	421	10.3%	793	18.4%
60-64	555	13.1%	482	11.8%	439	10.2%
65-69	646	15.2%	533	13%	498	11.6%
70-74	708	16.7%	624	15.3%	551	12.8%
75-79	709	16.7%	636	15.6%	523	12.2%
80 and over	1174	27.7%	1395	34.1%	1509	35%
Total	4244	100%	4091	100%	4313	100%

Source: Hospital Authority Statistical Report (various years).

Table 1.23 Cognitive impairment level

Level of cognitive impairment	aged 60-64	65-69	70-74	75 and over	Total
No cognitive impairment	246000 95.6%	233000 91.2%	184900 92%	198800 77.5%	862900 88.9%
Sometimes confused	8100 3.2%	19400 7.6%	11200 5.6%	31700 12.4%	70500 7.3%
Always confused but not disruptive to others	1600 0.6%	2400 0.9%	3000 1.5%	10100 4%	17100 1.8%
Always confused and disruptive to others	1500 0.6%	700 0.3%	1700 0.8%	15900 6.2%	19700 2%
Total	257400	255500	200800	256500	970300

Source: Census and Statistics Department (2001c).

Table 2.1 Domestic households of older people by household size

Household size	1991	1996	2001	2006
1	60147	72114	85393	98829
2	75847	105678	134961	171598
3	62574	87625	111694	131820
4	53524	75525	86114	93100
5	51273	64866	64192	59412
6	35745	39254	35560	27729
7+	27412	25236	16645	12242
Total no. of domestic households	366522	470298	534559	594730

Source: Census and Statistics Department (2002c, 2007c).

Table 2.2 Marital status of older people

Age Group		1991			2001		
		65-74	75-84	85+	65-74	75-84	85+
Never married	M	7373 (4.9%)	2009 (3.8%)	220 (3.2%)	12690 (5.5%)	4340 (4.5%)	573 (3%)
	F	7148 (4.2%)	5617 (7%)	1432 (6.6%)	4614 (2%)	5414 (4.1%)	2828 (6.7%)
Married	M	124544 (82.2%)	38461 (71.9%)	3839 (55.5%)	191011 (83.2%)	69041 (71.6%)	10730 (55.9%)
	F	86004 (51%)	21451 (26.9%)	3428 (15.7%)	131133 (57.3%)	38854 (29.7%)	6491 (15.3%)
Widowed	M	17321 (11.4%)	12334 (23.1%)	2787 (40.3%)	19770 (8.6%)	21279 (22.1%)	7618 (39.7%)
	F	72851 (43.2%)	51701 (64.8%)	16846 (77.1%)	87155 (38.1%)	84738 (64.8%)	32911 (77.4%)
Divorced / Separated	M	2220 (1.5%)	694 (1.3%)	73 (1.1%)	6133 (2.7%)	1710 (1.8%)	289 (1.5%)
	F	2562 (1.5%)	987 (1.2%)	138 (0.6%)	5763 (2.5%)	1683 (1.3%)	284 (0.7%)
Total no. of older people		320023	133254	28763	458269	227059	61724

Source: Census and Statistics Department (2002c).

Table 2.3 Older people living with spouse

Older people living with spouse	Year			Rate of Change 1991-2001
	1991	1996	2001	
No.	71139	101695	137590	↑ 93.4%
Percentage	14.8%	16.2%	18.4%	↑ 24.3%

Source: Census and Statistics Department (2002c).

Table 2.4 Older people living with spouse by sex and age group in 2001

Age Group	Older people living with spouse			
	Male		Female	
	No.	% of the Age Group	No.	% of the Age Group
65-69	26847	21%	24767	20.5%
70-74	25136	24.7%	18604	17.3%
75-79	16774	26.6%	9390	11.8%
80-84	7963	23.9%	3493	6.9%
85+	3643	19%	973	2.3%
Total no.	80363		57227	
% of older population	23.3%		14.2%	

Source: Census and Statistics Department (2002c).

Table 2.5 Older people living with spouse and children

Older people living with spouse and children	Year			Rate of Change 1991-2001
	1991	1996	2001	
No.	137141	202390	239680	↑ 74.8%
Percentage	28.5%	32.1%	32.1%	↑ 12.6%

Source: Census and Statistics Department (2002c).

Table 2.6 Older people living with spouse and children by sex and age group in 2001

Age Group	Male		Female	
	No.	% of the Age Group	No.	% of the Age Group
65-69	70962	55.5%	43971	36.3%
70-74	47366	46.6%	24868	23.1%
75-79	23732	37.7%	10602	13.3%
80-84	9979	29.9%	3073	6%
85+	4270	22.2%	857	2%
Total no.	156309		83371	
% of older population	45.3%		20.7%	

Source: Census and Statistics Department (2002c).

Table 2.7 Older people living with children

Older people living with children	Year			Rate of Change 1991-2001
	1991	1996	2001	
No.	138685	177538	184328	↑ 32.9%
Percentage	28.8%	28.2%	24.7%	4.1% ↓

Source: Census and Statistics Department (2002c).

Table 2.8 Older people living with children by sex and age group in 2001

Age Group	Male		Female	
	No.	% of the Age Group	No.	% of the Age Group
65-69	9729	7.6%	35217	29.1%
70-74	10347	10.2%	40826	37.9%
75-79	8466	13.4%	34389	43.1%
80-84	5935	17.8%	20951	41.1%
85+	3712	19.3%	14752	34.7%
Total no.	38189		146135	
% of older population	11.1%		36.4%	

Source: Census and Statistics Department (2002c).

Table 2.9 Older people living with non-immediate family members

Older people living with non-immediate family members	Year			Rate of Change 1991-2001
	1991	1996	2001	
No.	44284	40994	32736	26.1% ↓
Percentage	9.2%	6.5%	4.4%	52.2% ↓

Source: Census and Statistics Department (2002c).

Table 2.10 Older people living with non-immediate family members by sex and age group in 2001

Age Group	Male		Female	
	No.	% of the Age Group	No.	% of the Age Group
65-69	3309	2.6%	3413	2.8%
70-74	2722	2.7%	4898	4.6%
75-79	1871	3%	5160	6.5%
80-84	1233	3.7%	4900	9.6%
85+	870	4.5%	4360	10.3%
Total no.	10005		22731	
% of older population	2.9%		5.7%	

Source: Census and Statistics Department (2002c).

Table 2.11 Domestic households with older people living with non-elderly persons

	Older people living with non-elderly persons							
	1991		1996		2001		2006	
Household size	No. of house-holds	No. of persons	No. of house-holds	No. of persons	No. of house-holds	No. of persons	No. of house-holds	No. of persons
2	50941	50841	67956	67956	85429	85429	104504	104504
3	61254	78084	86517	113865	110514	148202	130911	178077
4	53427	65711	75383	95890	85987	109809	93041	119736
5	51251	60680	64761	79117	64152	78869	59402	74464
6	35745	43891	39233	50229	35554	46568	27719	36800
7 and above	27396	36411	25173	34950	16625	23839	12242	17554
Total	280014	335718	359023	442007	398261	492716	427819	531135

Source: Census and Statistics Department (2002b, 2007c).

Table 2.12 Older people living alone

Older people living alone	1991	1996	2001	2006	Rate of Change 1991-2006
No.	61001	72114	85393	98829	↑ 62%
% of older population	12.7%	11.5%	11.4%	11.6%	↓ 1.1%

Source: Census and Statistics Department (2002c, 2007c).

Table 2.13 Older people living alone by sex and age group in 2001

	Older people living alone in 2001			
	Male		Female	
Age Group	No.	%	No.	%
65-69	12133	9.5%	10283	8.5%
70-74	11231	11%	13817	12.8%
75-79	7248	11.5%	12230	15.3%
80-84	3477	10.4%	7707	15.1%
85+	1929	10%	4712	11.1%
Total	36018	10.4%	48749	12.1%

Source: Census and Statistics Department (2002c).

Table 2.14 Marital status of older people (aged 60+) living alone

Marital status	Male		Female	
	No. of persons	Percentage	No. of persons	Percentage
Never married	11300	28.7%	5300	11.7%
Ever married	28100	71.3%	40100	88.3%
Total	39400	100%	45400	100%

Source: Census and Statistics Department (1999a).

Table 2.15 Aged singletons (aged 60+) with children living in Hong Kong

Status of children	No.	Percentage
Older people who were never married	16600	19.6%
Did not have any children or did not have any children living in Hong Kong	25300	29.8%
Children living apart after marriage	28900	34.1%
Children living apart for other reasons	14000	16.5%
Total	84800	100%

Source: Census and Statistics Department (1999a).

Table 2.16 Domestic households with older people only

Household Size	1991		1996		2001		2006	
	No. of households	No. of older people	No. of house-holds	No. of older people	No. of households	No. of older people	No. of households	No. of older people
1	60147	60147	72114	72114	85393	85393	98829	98829
2	24906	49812	37722	75444	49532	99064	67094	134188
3 and above	1455	4573	1439	5166	1373	4475	988	3073
Total	86508	114532	111275	152724	136298	188932	166911	236090

Source: Census and Statistics Department (2002b, 2007c).

Table 2.17 Educational attainment of older people

Year	No schooling / Kindergarten		Primary		Secondary		Tertiary	
	Male	Female	Male	Female	Male	Female	Male	Female
1981	26.4%	78.6%	51.2%	16.4%	17%	3.9%	5.4%	1.1%
1991	29.5%	70.4%	46.8%	21.4%	18.4%	6.8%	5.3%	1.4%
2001	23.3%	58.9%	49.5%	30.3%	21.4%	8.8%	5.9%	2%
2006	19.6%	49.7%	45.2%	34.1%	25.4%	12.4%	9.7%	3.9%

Source: Census and Statistics Department (1981, 1991. 2001 and 2006).

Table 2.18 Educational attainment of older people by sex and age group in 2001

Education Attainment		No schooling / Kindergarten	Primary	Secondary	Tertiary
65-69	M	17.2%	49.3%	25.7%	7.9%
	F	47.2%	37.9%	11.7%	3.2%
70-74	M	24%	52.1%	19.3%	4.6%
	F	59.2%	31.1%	8%	1.6%
75-79	M	26.2%	51%	18.5%	4.2%
	F	62.4%	27.8%	8.2%	1.5%
80-84	M	30.7%	45.3%	18.6%	5.4%
	F	67.9%	23.6%	7.2%	1.3%
85+	M	36.9%	39.7%	18.1%	5.3%
	F	74.3%	19.1%	5.4%	1.2%

Source: Census and Statistics Department (2002c).

Table 2.19 Occupation of older people with employment

Occupation	1991	1996	2001
Managers and administrators	10.2%	15%	15.9%
Professionals	1.6%	1.6%	2.8%
Associate professionals	2%	2.8%	5.1%
Clerks	5.9%	6.6%	6.6%
Service workers and shop sales workers	11.2%	11.3%	13.6%
Craft and related workers	7.7%	7%	8.2%
Plant and machine operators and assemblers	5.1%	4.8%	7%
Elementary occupations	53.4%	48.2%	39.5%
Skilled agricultural and fishery workers	2.9%	2.6%	1.3%
Total No.	66419	60098	52911

Source: Census and Statistics Department (2002c).

Table 2.20 Comparison of owner occupier with and without mortgage between older people* and the whole population

Year	Owner occupiers with mortgage		Owner occupiers without mortgage	
	Older people	Whole population	Older people	Whole population
2001	30186 (17.8%)	537230 (51.1%)	139083 (82.2%)	505375 (48.5%)
2006	26755 (16.6%)	561112 (47.8%)	134157 (83.4%)	613020 (52.2%)

*Head of household who is older person.

Source: Census and Statistics Department (2002b, 2007a, and 2007c).

Table 2.21 Types of assets owned by older people

Types of assets	No.	Percentage
Cash / savings or fixed deposits	935300	96.4%
Self-occupied properties	233600	24.1%
Non-self-occupied properties	21800	2.3%
Stocks / bonds / investment funds	42900	4.4%
Have retirement fund or pension	162200	16.7%
Did not have any assets	26800	2.8%
Did not have retirement fund	808100	83.3%

Source: Census and Statistics Department (2001b).

Table 2.22 Parents being financially supported by their children

Age of parents	Only supported by children whom they lived with	Only supported by children living apart	Supported by all children	Total
<50	93600 (15.7%)	10300 (4.3%)	9100 (3.2%)	113000
50 -54	111900 (18.7%)	17700 (7.4%)	27300 (9.8%)	156900
55 - 59	76000 (12.7%)	19900 (8.3%)	30200 (10.8%)	126000
60 - 64	85000 (14.2%)	37000 (15.4%)	43200 (15.4%)	165200
65- 69	80200 (13.4%)	45700 (19.1%)	51100 (18.3%)	177000 (100%)
70+	150700 (25.2%)	109400 (45.6%)	118800 (42.5%)	378900 (100%)
Total	597400 (53.5%)	240000 (21.5%)	279600 (25%)	1117000 (100%)

Source: Census and Statistics Department (2003a).

Table 2.23 Children providing financial support to parents

Whether providing financial support to parents in the past 12 months			
Age of children	Yes	No	Total
15 - 19	4.8%	95.2%	446800
20 - 29	51.3%	48.7%	985000
30 - 39	50.2%	49.8%	1262600
40 - 49	31.9%	68.1%	1217300
50 - 59	15.7%	84.3%	689200
60 and above	2.2%	97.8%	983000
All age groups	30.1%	69.9%	5583900

Source: Census and Statistics Department (2003a).

Table 2.24 Older people's intention to live in residential homes when becoming frail

Choice	No. of older persons	Percentage
Intend to move to government-funded residential care homes	249000	2.5%
Intend to move to private care homes	2500	0.3%
Will not move to residential care homes	958400	97.2%
Total	1209900	100%

Source: Census and Statistics Department (2005).

Table 2.25 Older people's choices when becoming frail

Choice	No. of older persons	Percentage
Prefer to remain living at own home	775400	80.9%
Prefer to move to residential home	183000	19.1%
Total	958400	100%

Source: Census and Statistics Department (2005).

Table 2.26 Labour force participation rates of older people

Age group	Sex	1991	1996	2001
65-74	Male	28.1%	21.2%	17%
	Female	10.3%	5.3%	3.8%
75-84	Male	9.6%	8.4%	4.4%
	Female	3.5%	1.8%	1.2%
85+	Male	4.4%	3.9%	2.2%
	Female	0.7%	0.6%	0.4%
Total		14.1%	9.8%	7.2%

Source: Census and Statistics Department (2002c).

Table 2.27 Monthly income of older people with employment

	1991			2001			2006		
Monthly Income (HK$)	Male	Female	All working population	Male	Female	All working population	Male	Female	All working population
<$2000	13.6%	39.1%	6.8%	5.7%	13.9%	1.8%	4.3%	8.2%	2%
$2000 – $3999	45.1%	48.3%	20.8%	10.7%	26.4%	8.6%	10.4%	`18.9%	9.7%
$4000 – $5999	21.9%	8.3%	29.6%	23.8%	29.4%	8.3%	22.9%	25.5%	9.8%
$6000 – $7999	6.6%	1.5%	17.2%	18.1%	9%	12.3%	16.6%	13.1%	13.8%
$8000 – $9999	2.3%	0.7%	8.3%	9.7%	5.5%	12.2%	9.4%	7.7%	12.5%
$10000 – $14999	4.4%	1%	9.1%	12.8%	6.8%	23%	13.9%	11.6%	20.7%
$15000 – $19999	1.5%	0.3%	3.1%	5.3%	2.2%	11.5%	5.7%	4.3%	10.6%
≧ $20000	4.4%	0.8%	5.1%	13.9%	6.8%	22.3%	16.7%	10.7%	20.9%
Total No.	45837	18662	2681583	41902	9152	3229107	44261	13250	3344986
Median Monthly Income	$3300	$2000	$5170	$6500	$4200	$10000	$7000	$5500	$10000

Source: Census and Statistics Department (2002c, 2007a).

Table 2.28 People receiving CSSA due to old age

Year	Receiving CSSA due to old age		Total no. of cases	Total population
	No. of cases	Percentage		
1991-1992	48020	65.8%	72969	5752000
1992-1993	53397	65.1%	81975	5800500
1993-1994	61026	64.2%	95104	5901000
1994-1995	72468	66.2%	109 461	6035400
1995	80882	62.6%	129245	6156100
1996	95104	59.5%	159837	6435500
1997	109150	58.4%	186932	6489300
1998	121778	53.5%	227454	6543700
1999	133613	57.9%	230681	6606500
2000	134230	58.9%	228060	6665000
2001	138232	57.2%	241673	6724900
2002	142762	53.6%	266571	6787000
2003	147032	50.7%	290206	6803100
2004	149821	50.7%	295694	6882600
2004-2005	150399	50.7%	296688	6935900
2005-2006	151918	51.1%	297434	6857100
2006-2007	152918	52%	294204	6921200
Rate of Change 1991-2007	↑ 218.4%	21% ↓	↑ 303.2%	↑ 20.3%

Source: Census and Statistics Department (1995 to 2007).

Table 4.1 Estimation of revenue and expenditure

Year	HK$ billion					
	Revenue			Expenditure		
	Forecast	Actual	Error	Forecast	Actual	Error
2004	223	264	-41	266	242	24
2005	243	247	-3	254	233	21
2006	257	288	-31	252	229	23
2007	273	359	-86	248	235	13
2008	308	317	-9	315	315	0
2009	262	318	-56	302	293	9
2010	292	377	-85	317	301	16
2011	370	438	-68	378	364	14
2012	390	442	-52	394	377	17
2013	435	448	-13	440	436	4
			-444			141

Source: Hong Kong Legislative Council Research Office (2014).

Table 4.2 Reserves

Foreign Exchange Reserve		
Year	In HK$ million	HK$
	Total	Per capita
1992-1993	$944057	$162754
1997-1998	$3568835	$549957
2002-2003	$2428936	$357881
2012-2013	$5724529	$800119
Fiscal Reserve		
Year	In HK$ million	HK$
	Total	Per capita
1992-1993	$121033	$20866
1997-1998	$457543	$84376
2002-2003	$311402	$45882
2012-2013	$733914	$102579

Table 4.3 Recurrent expenditure, recurrent revenue and total expenditure

Year	Elderly services expenditure / Total recurrent revenue	Elderly services expenditure / Total government expenditure
1989/90	0.28%	0.29%
1990/91	0.36%	0.34%
1991/92	0.41%	0.44%
1992/93	0.47%	0.49%
1993/94	0.45%	0.42%
1994/95	0.61%	0.55%
1995/96	0.76%	0.62%
1996/97	0.82%	0.77%
1997/98	0.82%	0.84%
1998/99	1.38%	0.96%
1999/00	1.40%	1.06%
2000/01	1.60%	1.18%
2001/02	1.97%	1.25%
2002/03	2.09%	1.36%
2003/04	1.96%	1.39%
2004/05	1.79%	1.39%
2005/06	1.57%	1.38%
2006/07	1.33%	1.36%
2007/08	1.19%	1.41%
2008/09	1.32%	1.18%
2009/10	1.49%	1.34%
2010/11	1.33%	1.32%
2011/12	1.27%	1.19%
2012/13	1.42%	1.30%

Source: The Estimates of the Budget (1989-2013).

Table 4.4 Expenditure on elderly services as % of GDP

Year	Expenditure on Elderly Services / GDP
1989/90	0.04%
1990/91	0.04%
1991/92	0.05%
1992/93	0.07%
1993/94	0.06%
1994/95	0.08%
1995/96	0.10%
1996/97	0.11%
1997/98	0.13%
1998/99	0.19%
1999/00	0.19%
2000/01	0.21%
2001/02	0.23%
2002/03	0.26%
2003/04	0.27%
2004/05	0.25%
2005/06	0.22%
2006/07	0.19%
2007/08	0.19%
2008/09	0.22%
2009/10	0.22%
2010/11	0.21%
2011/12	0.21%
2012/13	0.23%

Source: The Estimates of the Budget (1989-2013).

Table 5.1 Waiting lists for residential care

Year	Hostel for the Elderly	Home for the Aged	Care and Attention Home	Nursing Home
1980-1981	1486	969	668	N.A.
1981-1982	1490	1076	704	N.A.
1982-1983	1216	1509	3575	N.A.
1983-1984	1205	1857	2414	N.A.
1984-1985	1305	1818	3046	N.A.
1985-1986	1345	2163	4312	N.A.
1986-1987	1150	2019	5386	N.A.
1987-1988	1261	2492	7038	N.A.
1988-1989	1164	3164	7669	N.A.
1989-1990	1166	3875	8769	N.A.
1991-1992	746	3934	8941	N.A.
1992-1993	634	4302	10135	N.A.
1993-1994	772	4889	11228	N.A.
1994-1995	342	5395	12299	N.A.
1995-1996	226	6337	14425	N.A.
1996-1997	259	7483	17834	N.A.
1997-1998	279	7135	19278	622
1998-1999	118	6989	17468	3399
1999-2000	108	6485	18121	3922
2000-2001	93	6194	17948	4729
2001-2002	73	5647	17370	5484
2002-2003	139	3663	17341	5667
2003-2004	5	1671	16631	5265
2004-2005	0	871	15323	5195
2005-2006	0	613	15574	5734
2006-2007	0	390	16191	6063

N.A. = Not Applicable

Social Welfare Department lacks figures about 1990-1991.

Source: Social Welfare Services (1982 to 2007).

Table 5.2 Gross domestic product

HK$ million dollars

Year	GDP		Per Capita GDP	
1991	668512	+14.8	116223	+13.8
1992	791319	+16.8	136423	+15.9
1993	912809	+15.4	154687	+13.4
1994	1047470	+12.9	173554	+10.4
1995	1115739	+6.5	181241	+4.4
1996	1229481	+10.2	191047	+5.4
1997	1365024	+11.0	210350	+10.1
1998	1292764	-5.3	197559	-6.1
1999	1266702	-2.0	191736	-2.9
2000	1314789	+3.8	197268	+2.9
2001	1298813	-1.2	193135	-2.1
2002	1276757	-1.7	188118	-2.6
2003	1233983	-3.4	181385	-3.6
2004	1291568	+4.7	187657	+3.5
2005	1382052	+7.0	199261	+6.2
2006	1474329	+6.7	215008	+7.9
Rate of Change 1991-2006	↑ 120.5%	N.A.	↑ 85%	N.A

N.A. = Not Applicable

Source: Census and Statistics Department (2007d).

Table 5.3 Government revenue and expenditure

HK$ million dollars

Year	Revenue	Expenditure	Surplus/(Deficit)
1991-1992	114699	92191	22508
1992-1993	135311	113332	21979
1993-1994	164412	149307	15105
1994-1995	174998	164155	10843
1995-1996	180045	183158	(3113)
1996-1997	202276	187164	15112
1997-1998	281226	194360	86866
1998-1999	216115	239356	(23241)
1999-2000	232995	223043	9952
2000-2001	225060	232893	(7833)
2001-2002	175559	238890	(63331)
2002-2003	177489	239177	(61688)
2003-2004	207338	247466	(40128)
2004-2005	263591	242235	21356
2005-2006	247035	233071	13964
Rate of Change 1991-2006	↑ 115.4%	↑ 152.8%	N.A.

Source: Census and Statistics Department (1991 to 2006).

Table 5.4 Expenditure of Social Welfare Department

HK$ million dollars

Year	Departmental expenditure	Social security payment	Subvention to NGOs	Total
1990-91	679	3127	1236	5060
1991-92	763	3687	1587	6036
1992-93	863	4390	1824	7077
1993-94	993	5571	2217	8781
1994-95	1171	6649	2698	10517
1995-96	1415	8527	3326	13268
1996-97	1686	11183	3991	16860
1997-98	1925	13877	4598	20400
1998-99	2228	17784	5419	25431
1999-00	2310	18519	6065	26894
2000-01	2352	18700	6453	27505
2001-02	2541	19656	6960	29157
2002-03	3108	21423	6817	31348
2003-04	3313	22529	6922	32764
2004-05	3106	22889	6532	32527
2005-06	3087	23116	6340	32543
2006-07	2843	23161	6449	32453

Source: Census and Statistics Department (1990 to 2007).

Table 5.5 Government expenditure on social services for older people

HK$ million dollars

Year	Government expenditure on social services for older people			Government subvention to NGOs	Total government expenditure
	Government sector	NGOs	Total		
1997-1998	259.3	1364.1	1623.4	4598	194360
1998-1999	305.4	1998.9	2304.3	5419	239356
1999-2000	108.6	2350.3	2458.9	6065	223043
2000-2001	122.1	2618.7	2740.8	6453	232893
2001-2002	133.5	2745.5	2978.5	6960	238890
2002-2003	125.7	3072.6	3198.6	6817	239177
2003-2004	224.8	3111.5	3336.3	6922	247466
2004-2005	171.1	2958.4	3129.5	6532	242235
2005-2006	171.8	2903.5	3075.3	6340	233071
2006-2007	173.0	2914.2	3087.2	6435	230441
Rate of Change 1997-2007	↓ 33.3%	↑ 113.6%	↑ 90.2%	↑ 40%	↑ 18.6%

Source: The Estimates for the Year Ending 31 March, General Revenue Account, The Government of HKSAR.

Table 5.6 Waiting times for Care and Attention Homes

	No. of Months		
Year	Government-funded Care and Attention Homes	Government bought places in private homes	Average time
1982	30	N.A.	N.A.
1986	35	N.A.	N.A.
1991	36 to 48	N.A.	N.A.
1995	32.9	N.A.	N.A.
1996	33.4	N.A.	N.A.
1997	33.2	N.A.	N.A.
1998	24 to 36	N.A.	N.A.
2004	30.1	10.7	N.A.
2005	32.3	10.4	24
2006	32.5	9.2	22
2007	33	10	33
2010	33	8	N.A.
2011	34	8	N.A.
2012	34	7	N.A.
2013	34	7	N.A.

N.A. = Not Applicable

Data was missing during the period 1999-2003 and 2008-2009.

Source: Hong Kong Legislative Council. Official Record of Proceedings on 28 July 1982, 12 November 1986, 29 November 1989, 20 November 1991, 22 October 1998, 5 April 2000, 7 March 2007, 29 January 2013, 4 March 2013. Liu and Wong (1997). Health care for elderly people.

Table 7.1 Comparison between two cohorts of residents in 2006

Items	t	Sig. (2-tailed)	Mean 3 years or less	Mean Over 3 years
sex	-.074	.941	1.30	1.31
walking aid	-1.921	.057	2.60	3.11
mobility	-2.177	.031	1.30	1.58
urine incontinence	-1.072	.285	1.08	1.31
faeces incontinence	-1.274	.205	.74	1.00
expressiveness	-1.724	.087	.52	.72
comprehension	-1.038	.301	.55	.67
vision	-1.020	.310	.74	.88
hearing	-2.992	.003	.42	.75
hearing aid	-1.888	.061	.20	.36
state ‘name’	-.542	.588	.20	.25
state ‘age’	-.436	.663	1.14	1.19
state ‘date of birth’	.832	.406	1.78	1.69
state ‘living place’	1.816	.071	1.20	.94
state ‘region’	2.445	.016	1.41	1.06
state ‘day’	-.215	.830	1.40	1.43
state ‘month’	-.761	.448	1.26	1.38
state ‘year’	.988	.325	1.60	1.47
counting	-2.016	.046	.46	.72
toileting	-.765	.445	.74	.85
dressing	-.028	.978	.79	.79
feeding	-.504	.615	.42	.49
washing	.030	.976	.59	.58
bathing	.407	.685	1.34	1.28
shopping	.377	.707	1.60	1.56
managing money	1.244	.216	1.36	1.19
grooming	-.994	.322	.49	.62
bed making	-.946	.346	1.59	1.69
wandering	1.264	.208	.26	.15
day disturbance	.426	.671	.20	.17
night disturbance	-.193	.847	.11	.12
accusing	-.780	.437	.16	.22
sleep pattern	.196	.845	.79	.76
age	-2.742	.007	84.39	87.78

Table 7.2 Age distribution of two cohorts at the two Care Homes in 2006

Age range	60-69	70-79	80-89	90 and above	Total no. of residents
3 years or less	4 (5%)	14 (17.5%)	41 (51.1%)	21 (26.3%)	80
Over 3 years	2 (2.8%)	7 (9.7%)	32 (44.4%)	31 (43.1%)	72
Total	6	21	73	52	152

Table 7.3 Hearing capacity of two cohorts in 2006

Length of stay	Normal	Some difficulties	Deaf	Total no. of residents
3 years or less	50 (62.5%)	26 (32.5%)	4 (5%)	80
Over 3 years	31 (43.1%)	28 (38.9%)	13 (18.1%)	72
Total	81	54	17	152

Table 7.4 Residents' conditions (3 years or less stay) across the two Care Homes as at 2006

Items	Mean		t	Sig. (2-tailed)
	Chak On	Lai Yiu		
sex	1.32	1.28	.338	.737
walking aid	2.44	2.77	-.869	.387
mobility	1.17	1.44	-1.460	.148
urine incontinence	1.10	1.05	.157	.876
faeces incontinence	.68	.79	-.405	.687
expressiveness	.76	.28	3.143	.002
comprehension	.68	.41	1.838	.070
vision	.71	.77	-.363	.718
hearing	.46	.38	.594	.554
hearing aid	.17	.23	-.580	.564
state 'name'	.37	.03	2.833	.006
state 'age'	1.20	1.08	.665	.508
state 'date of birth'	1.76	1.79	-.313	.755
state 'living place'	1.02	1.38	-1.932	.057
state 'region'	1.24	1.59	-1.841	.069
state 'day'	1.27	1.54	-1.404	.164
state 'month'	1.10	1.44	-1.680	.097
state 'year'	1.51	1.69	-1.117	.268
counting	.59	.33	1.524	.131
toileting	.71	.77	-.323	.748
dressing	.73	.85	-.552	.583
feeding	.44	.41	.172	.864
washing	.51	.67	-.839	.404
bathing	1.44	1.23	1.036	.303
shopping	1.51	1.69	-1.145	.256
managing money	1.20	1.54	-1.954	.054
grooming	.54	.44	.552	.582
bed making	1.37	1.82	-2.865	.005
wandering	.20	.33	-1.012	.315
day disturbance	.10	.31	-1.859	.067
night disturbance	.07	.15	-.925	.358
accusing	.12	.21	-.920	.361
sleep pattern	.93	.64	1.746	.085
Age	83.32	85.51	-.789	.433

Table 7.5 Residents' conditions (over 3 years' stay) across the two Care Homes as at 2006

Items	Mean Chak On	Mean Lai Yiu	t	Sig. (2-tailed)
sex	1.31	1.30	.042	.966
walking aid	2.90	3.36	-1.260	.212
mobility	1.38	1.82	-2.421	.018
urine incontinence	1.44	1.15	.897	.373
faeces incontinence	.92	1.09	-.539	.592
expressiveness	.79	.64	.962	.340
comprehension	.69	.64	.330	.742
vision	.85	.91	-.293	.771
hearing	.64	.88	-1.356	.180
hearing aid	.23	.52	-2.090	.040
state 'name'	.23	.27	-.306	.760
state 'age'	1.23	1.15	.408	.684
state 'date of birth'	1.72	1.67	.336	.738
state 'living place'	.72	1.21	-2.438	.017
state 'region'	.77	1.39	-2.932	.005
state 'day'	1.36	1.52	-.743	.460
state 'month'	1.38	1.36	.097	.923
state 'year'	1.49	1.45	.157	.876
counting	.54	.94	-2.056	.043
toileting	.79	.91	-.526	.601
dressing	.77	.82	-.228	.821
feeding	.41	.58	-.932	.355
washing	.44	.76	-1.583	.118
bathing	1.31	1.24	.302	.763
shopping	1.44	1.70	-1.487	.141
managing money	1.00	1.42	-2.121	.037
grooming	.51	.76	-1.159	.250
bed making	1.46	1.97	-3.620	.001
wandering	.23	.06	1.682	.097
day disturbance	.21	.12	.797	.428
night disturbance	.18	.06	1.233	.222
accusing	.28	.15	1.029	.307
sleep pattern	.95	.55	2.375	.020
age	87.51	88.09	-.329	.743

Table 7.6 Characteristics of two cohorts of residents at Chak On in 2006

Items	Mean 3 years or less	Mean Over 3 years	t	Sig. (2-tailed)
sex	1.32	1.31	.089	.929
walking aid	2.44	2.90	-1.221	.226
mobility	1.17	1.38	-1.160	.250
urine incontinence	1.10	1.44	-1.124	.264
faeces incontinence	.68	.92	-.867	.389
expressiveness	.76	.79	-.236	.814
comprehension	.68	.69	-.058	.954
vision	.71	.85	-.749	.456
hearing	.46	.64	-1.183	.241
hearing aid	.17	.23	-.521	.604
state ‘name’	.37	.23	.884	.380
state ‘age’	1.20	1.23	-.180	.858
state ‘date of birth’	1.76	1.72	.278	.782
state ‘living place’	1.02	.72	1.577	.119
state ‘region’	1.24	.77	2.265	.026
state ‘day’	1.27	1.36	-.437	.663
state ‘month’	1.10	1.38	-1.386	.170
state ‘year’	1.51	1.49	.134	.893
counting	.59	.54	.263	.793
toileting	.71	.79	-.443	.659
dressing	.73	.77	-.187	.852
feeding	.44	.41	.168	.867
washing	.51	.44	.427	.671
bathing	1.44	1.31	.679	.499
shopping	1.51	1.44	.445	.658
managing money	1.20	1.00	1.026	.308
grooming	.54	.51	.128	.899
bed making	1.37	1.46	-.528	.599
wandering	.20	.23	-.291	.772
day disturbance	.10	.21	-1.228	.223
night disturbance	.07	.18	-1.186	.239
accusing	.12	.28	-1.478	.143
sleep pattern	.93	.95	-.139	.890
age	83.32	87.51	-2.347	.021

Table 7.7 Characteristics of two cohorts of residents at Lai Yiu in 2006

Items	Mean 3 years or less	Mean Over 3 years	t	Sig. (2-tailed)
sex	1.28	1.30	-.192	.848
walking aid	2.77	3.36	-1.582	.118
mobility	1.44	1.82	-2.179	.033
urine incontinence	1.05	1.15	-.323	.747
faeces incontinence	.79	1.09	-.952	.345
expressiveness	.28	.64	-2.389	.020
comprehension	.41	.64	-1.483	.142
vision	.77	.91	-.702	.485
hearing	.38	.88	-3.153	.002
hearing aid	.23	.52	-2.298	.025
state ‘name’	.03	.27	-2.833	.006
state ‘age’	1.08	1.15	-.446	.657
state ‘date of birth’	1.79	1.67	.932	.355
state ‘living place’	1.38	1.21	.892	.375
state ‘region’	1.59	1.39	1.052	.296
state ‘day’	1.54	1.52	.122	.904
state ‘month’	1.44	1.36	.344	.732
state ‘year’	1.69	1.45	1.322	.191
counting	.33	.94	-3.367	.001
toileting	.77	.91	-.663	.509
dressing	.85	.82	.126	.900
feeding	.41	.58	-.956	.342
washing	.67	.76	-.435	.665
bathing	1.23	1.24	-.052	.959
shopping	1.69	1.70	-.029	.977
managing money	1.54	1.42	.625	.534
grooming	.44	.76	-1.553	.125
bed making	1.82	1.97	-1.480	.143
wandering	.33	.06	2.240	.028
day disturbance	.31	.12	1.412	.162
night disturbance	.15	.06	.996	.322
accusing	.21	.15	.496	.621
sleep pattern	.64	.55	.540	.591
age	85.51	88.09	-1.518	.133

Table 7.8 Residents' characteristics (3 years or less stay) in 1990 and 2006

Items	t	Sig. (2-tailed)	Mean 1990	Mean 2006
sex	-.074	.941	1.30	1.30
walking aid	-2.773	.006	1.98	2.60
mobility	-1.531	.127	1.10	1.30
urine incontinence	-4.674	.000	.39	1.08
faeces incontinence	-3.990	.000	.24	.74
expressiveness	-1.036	.301	.43	.52
comprehension	-3.013	.003	.30	.55
vision	.523	.601	.80	.74
hearing	-2.194	.029	.26	.42
hearing aid	-.567	.571	.16	.20
state 'name'	-1.935	.054	.07	.20
state 'age'	-5.032	.000	.54	1.14
state 'date of birth'	-11.733	.000	.53	1.78
state 'living place'	-3.835	.000	.71	1.20
state 'region'	-3.458	.001	.96	1.41
state 'day'	-2.274	.024	1.10	1.40
state 'month'	-2.101	.037	.98	1.26
state 'year'	-3.628	.000	1.14	1.60
counting	-1.033	.303	.35	.46
toileting	-3.109	.002	.40	.74
dressing	-1.807	.072	.57	.79
feeding	-2.560	.011	.20	.42
washing	.321	.749	.62	.59
bathing	-3.377	.001	.92	1.34
shopping	-3.779	.000	1.15	1.60
managing money	-4.559	.000	.81	1.36
grooming	1.788	.075	.69	.49
bed making	-3.493	.001	1.16	1.59
wandering	-.296	.767	.24	.26
day disturbance	1.393	.165	.32	.20
night disturbance	2.011	.046	.26	.11
accusing	.025	.980	.16	.16
sleep pattern	-.577	.564	.73	.79
age	-3.482	.001	80.39	84.39

Table 7.9 Age distribution of residents (3 years or less stay) in 1990 and 2006

	Age group				
Year	60-69	70-79	80-89	90+	Total no. of residents
1990	9 (7.4%)	48 (39.3%)	49 (40.2%)	16 (13.1%)	122
2006	4 (5%)	14 (17.5%)	41 (51.1%)	21 (26.3%)	80
Total	13	62	90	37	202

Table 7.10 Use of walking aid

	Use of walking aid							
Year	0 Do not need	1 Cane	2 Quadripod	3 Walking frame	4 Wheel-chair bound	5 Chair-bound	6 Bed-ridden	Total no. of residents
1990	25 (20.5%)	26 (21.3%)	22 (18%)	33 (27%)	8 (6.6%)	8 (6.6%)	0 (0%)	122
2006	15 (18.8%)	12 (15%)	6 (7.5%)	7 (8.75%)	38 (47.5%)	1 (1.3%)	1 (1.3%)	80
Total	40	38	28	40	46	9	1	202

Table 7.11 Urine incontinence: shorter-stay cohort

	Urine incontinence				
Year	0 No incontinence	1 Once or less per week	2 Once daily	3 Persistent	Total no. of residents
1990	92 (75.4%)	19 (15.6%)	5 (4.1%)	6 (4.9%)	122
2006	43 (53.7%)	10 (12.5%)	5 (6.3%)	22 (27.5%)	80
Total	135	29	10	28	202

Table 7.12 Faeces incontinence: shorter-stay cohort

Year	Faeces incontinence				Total no. of residents
	0 No incontinence	1 Once or less per week	2 Once daily	3 Persistent	
1990	98 (80.3%)	19 (15.6%)	5 (4.1%)	0 (0%)	122
2006	56 (70%)	6 (7.5%)	1 (1.3%)	17 (21.2%)	80
Total	154	25	6	17	202

Table 7.13 Toileting

Year	Toileting			Total no. of residents
	0 No assistance	1 Some assistance	2 Maximum assistance	
1990	86 (70.4%)	23 (18.8%)	13 (10.6%)	122
2006	42 (52.5%)	17 (21.2%)	21 (26.2%)	80
Total	128	40	34	202

Table 7.14 Bathing

Year	Bathing			Total no. of residents
	0 No assistance	1 Some assistance	2 Maximum assistance	
1990	48 (39.3%)	36 (29.5%)	38 (31.1%)	122
2006	23 (28.7%)	7 (8.7%)	50 (62.5%)	80
Total	71	43	88	202

Table 7.15 Two Care Homes as at 1990

Items	t	df	Sig. (2-tailed)	Mean Chak On	Mean Lai Yiu
sex	-.673	120	.502	1.27	1.32
walking aid	-1.422	120	.158	1.78	2.16
mobility	-2.249	120	.026	.90	1.29
urine incontinence	-1.179	120	.241	.30	.47
faeces incontinence	-.092	120	.927	.23	.24
expressiveness	-1.616	120	.109	.33	.52
comprehension	-.932	120	.353	.25	.34
vision	-.421	120	.674	.77	.84
hearing	.890	120	.375	.30	.23
hearing aid	-1.028	120	.306	.10	.21
state ‘name’	.774	120	.440	.10	.05
state ‘age’	1.628	120	.106	.67	.42
state ‘date of birth’	1.534	120	.128	.65	.42
state ‘living place’	2.715	120	.008	.93	.50
state ‘region’	2.427	120	.017	1.17	.76
state ‘day’	1.156	120	.250	1.20	1.00
state ‘month’	1.206	120	.230	1.08	.87
state ‘year’	3.005	120	.003	1.40	.89
counting	2.208	120	.029	.50	.21
toileting	-1.099	120	.274	.33	.47
dressing	-.344	120	.732	.55	.60
feeding	.265	120	.792	.22	.19
washing	-.340	120	.735	.60	.65
bathing	-1.098	120	.274	.83	1.00
shopping	-.170	120	.866	1.13	1.16
managing money	.273	120	.785	.83	.79
grooming	.638	120	.525	.73	.65
bed making	-1.172	120	.244	1.07	1.26
wandering	.883	120	.379	.28	.19
day disturbance	2.227	120	.028	.45	.19
night disturbance	3.296	120	.001	.43	.10
accusing	.534	120	.594	.18	.15
sleep pattern	-1.296	120	.197	.65	.81
age	.376	120	.707	80.67	80.11

Table 7.16 Residents' characteristics at Chak On: 1990 and 2006

Items	Chak On (3 years or less residence period) Mean 1990	Mean 2006	t	Sig. (2-tailed)
sex	1.27	1.32	-.545	.587
walking aid	1.78	2.44	-2.179	.032
mobility	.90	1.17	-1.554	.123
urine incontinence	.30	1.10	-3.993	.000
faeces incontinence	.23	.68	-2.646	.009
expressiveness	.33	.76	-3.098	.003
comprehension	.25	.68	-3.639	.000
vision	.77	.71	.345	.731
hearing	.30	.46	-1.446	.151
hearing aid	.10	.17	-.837	.404
state 'name'	.10	.37	-2.276	.025
state 'age'	.67	1.20	-2.835	.006
state 'date of birth'	.65	1.76	-6.832	.000
state 'living place'	.93	1.02	-.486	.628
state 'region'	1.17	1.24	-.409	.683
state 'day'	1.20	1.27	-.358	.721
state 'month'	1.08	1.10	-.074	.942
state 'year'	1.40	1.51	-.646	.520
counting	.50	.59	-.498	.620
toileting	.33	.71	-2.551	.012
dressing	.55	.73	-1.091	.278
feeding	.22	.44	-1.765	.081
washing	.60	.51	.573	.568
bathing	.83	1.44	-3.595	.001
shopping	1.13	1.51	-2.237	.028
managing money	.83	1.20	-2.083	.040
grooming	.73	.54	1.190	.237
bed making	1.07	1.37	-1.694	.093
wandering	.28	.20	.758	.450
day disturbance	.45	.10	2.791	.006
night disturbance	.43	.07	3.055	.003
accusing	.18	.12	.769	.444
sleep pattern	.65	.93	-1.953	.054
age	80.67	83.32	-1.544	.126

Table 7.17 Residents' characteristics at Lai Yiu: 1990 and 2006

Items	Lai Yiu (3 years or less residence period) Mean 1990	Mean 2006	t	Sig. (2-tailed)
sex	1.32	1.28	.426	.671
walking aid	2.16	2.77	-1.817	.072
mobility	1.29	1.44	-.754	.453
urine incontinence	.47	1.05	-2.669	.009
faeces incontinence	.24	.79	-2.978	.004
expressiveness	.52	.28	1.864	.065
comprehension	.34	.41	-.603	.548
vision	.84	.77	.375	.708
hearing	.23	.38	-1.646	.103
hearing aid	.21	.23	-.160	.873
state 'name'	.05	.03	.459	.647
state 'age'	.42	1.08	-4.533	.000
state 'date of birth'	.42	1.79	-10.158	.000
state 'living place'	.50	1.38	-5.437	.000
state 'region'	.76	1.59	-4.745	.000
state 'day'	1.00	1.54	-2.937	.004
state 'month'	.87	1.44	-2.956	.004
state 'year'	.89	1.69	-4.541	.000
counting	.21	.33	-1.018	.311
toileting	.47	.77	-1.889	.062
dressing	.60	.85	-1.472	.144
feeding	.19	.41	-1.833	.070
washing	.65	.67	-.134	.894
bathing	1.00	1.23	-1.265	.209
shopping	1.16	1.69	-3.119	.002
managing money	.79	1.54	-4.484	.000
grooming	.65	.44	1.364	.176
bed making	1.26	1.82	-3.488	.001
wandering	.19	.33	-1.161	.248
day disturbance	.19	.31	-1.015	.313
night disturbance	.10	.15	-.684	.496
accusing	.15	.21	-.729	.468
sleep pattern	.81	.64	1.179	.241
age	80.11	85.51	-3.528	.001

Table 7.18 Living arrangements prior to home admission

Year	Living alone	Living with immediate family	Living with relatives	Living in various types of institutions	Total no. of residents
1992	26.7%	32.8%	10.4%	30.1%	299
1993	26.8%	28.1%	6.9%	38.2%	306
1994	29.5%	24.4%	6.4%	39.7%	312
1995	22.7%	28.7%	8.6%	40%	314
1996	30.7%	28.3%	9.5%	31.5%	336
1997	29.6%	30.7%	9.6%	30.1%	335
1998	20.6%	27.2%	2.8%	49.4%	324
1999	35.2%	27%	8.2%	29.6%	318
2000	28.8%	31.4%	7.2%	32.6%	334
2001	16.4%	23.8%	3.6%	56.2%	336
2002	13.2%	24.3%	3.3%	59.2%	333
2003	14.1%	20.1%	2.4%	63.4%	339
2004	14.5%	19%	3%	63.5%	331
2005	16.1%	19.7%	0.6%	63.6%	335
2006	19.1%	24.5%	0.6%	55.8%	330

Home admission includes the two Care Homes under study.

Source: Helping Hand (1991-2006).

Table 7.19 Financial circumstances

Year	Family or relative support	On CSSA	Retirement fund	Total no. of residents
1992	12.7%	87.3%	0%	299
1993	16%	84%	0%	306
1994	14%	86%	0%	312
1995	14.4%	85.6%	0%	314
1996	12.3%	87.7%	0%	323
1997	15.3%	84.7%	0%	324
1998	9%	91%	0%	330
1999	8.3%	91.4%	0.3%	325
2000	10.1%	89.3%	0.6%	337
2001	10.4%	88.4%	1.2%	336
2002	10.5%	89.5%	0%	333
2003	13.3%	86.4%	0.3%	339
2004	12.1%	87.9%	0%	331
2005	13.2%	86.2%	0%	335
2006	12.7%	86.4%	0.9%	330

Source: Helping Hand (1991-2006).

Table 7.20 Sources of referral

Year	Sources of referral				
	Social Welfare Department	Housing Department	Other NGOs	Independent application and internal transfer	Total no. of residents
1991	44.5%	13.4%	0%	42.1%	290
1992	49.5%	19.7%	4%	26.8%	299
1993	46.1%	18.9%	3.6%	31.4%	306
1994	47.4%	17.3%	1%	34.3%	312
1995	55.7%	16.2%	1%	27.1%	314
1996	68.1%	13.6%	0%	18.3%	323
1997	67.6%	14.2%	0%	18.2%	324
1998	68.5%	15.4%	0%	16.1%	324
1999	69.9%	13.8%	0%	16.3%	325
2000	75.1%	12.2%	0%	12.7%	337
2001	74.7%	11.3%	2.4%	11.6%	336
2002	79.9%	11.1%	0%	9%	333
2003	91.8%	4.1%	0%	4.1%	339
2004	90.3%	0.9%	5.2%	3.6%	331
2005	95.5%	0.9%	0%	3.6%	335
2006	100%	0%	0%	0%	330

Source: Helping Hand (1991-2006).

Table 7.21 Home residents in 1990 and 2006

Items	t	Sig. (2-tailed)	Mean 1990	Mean 2006
sex	-.135	.893	1.30	1.30
walking aid	-4.526	.000	1.98	2.84
mobility	-3.114	.002	1.10	1.43
urine incontinence	-5.881	.000	.39	1.18
faeces incontinence	-5.095	.000	.24	.86
expressiveness	-2.345	.020	.43	.62
comprehension	-4.094	.000	.30	.61
vision	.006	.995	.80	.80
hearing	-4.370	.000	.26	.58
hearing aid	-1.780	.076	.16	.28
state ‘name’	-2.528	.012	.07	.22
state ‘age’	-6.250	.000	.54	1.16
state ‘date of birth’	-13.914	.000	.53	1.74
state ‘living place’	-3.393	.001	.71	1.08
state ‘region’	-2.518	.012	.96	1.24
state ‘day’	-2.855	.005	1.10	1.41
state ‘month’	-2.982	.003	.98	1.32
state ‘year’	-3.743	.000	1.14	1.54
counting	-2.479	.014	.35	.59
toileting	-4.006	.000	.40	.79
dressing	-2.106	.036	.57	.79
feeding	-3.199	.002	.20	.45
washing	.388	.699	.62	.59
bathing	-3.683	.000	.92	1.31
shopping	-4.382	.000	1.15	1.58
managing money	-4.575	.000	.81	1.28
grooming	1.375	.170	.69	.55
bed making	-4.909	.000	1.16	1.64
wandering	.409	.683	.24	.21
day disturbance	1.989	.048	.32	.18
night disturbance	2.412	.017	.26	.12
accusing	-.504	.614	.16	.19
sleep pattern	-.544	.587	.73	.78
age	-5.824	.000	80.39	85.99

Table 7.22 Age distribution of residents

Year	Age range				Total no. of residents
	60-69	70-79	80-89	90 and above	
1990	9 (7.4%)	48 (39.3%)	49 (40.2%)	16 (13.1%)	122
2006	6 (3.9%)	21 (13.8%)	73 (48%)	52 (34.2%)	152
Total	15	69	122	68	274

Table 7.23 Mobility condition of residents

Year	Use of walking aid							Total no. of residents
	Do not need	Cane	Quadripod	Walking frame	Wheel chair - bound	Chair-bound	Bed-ridden	
1990	25 (20.5%)	26 (21.3%)	22 (18%)	33 (27%)	8 (6.6%)	8 (6.6%)	0 (0%)	122
2006	25 (16.4%)	17 (11.2%)	7 (4.6%)	20 (13.2%)	77 (50.6%)	3 (2%)	3 (2%)	152
Total	50	43	29	53	85	11	3	274

Table 7.24 Mobility level

Year	Mobility level				Total no. of residents
	Walk without walking aid	Walk with walking aid	Walk with personal help	Cannot walk	
1990	34 (27.8%)	60 (49.2%)	10 (8.2%)	18 (14.8%)	122
2006	23 (15.1%)	48 (31.6%)	73 (48%)	8 (5.3%)	152
Total	57	108	83	26	274

Table 7.25 Residents' mobility condition in all residential homes of the Helping Hand

Year	Fully ambulant	Walk with walking frame	Walk with aid (cane, quadripod)	Wheelchair/ Chairbound	Completely bed-bound	Total no. of residents
1991	33.8%	24.8%	29.7%	11.7%	0%	290
1992	30.8%	23.4%	28.7%	17.1%	0%	299
1993	27.1%	26.5%	29.1%	17.3%	0%	306
1994	22.1%	23.4%	31.4%	21.5%	1.6%	312
1995	23.9%	21%	32.8%	22.3%	0%	314
1996	22.3%	25.1%	34%	18.6%	0%	323
1997	20.7%	21%	38.3%	19.4%	0.6%	324
1998	20.7%	25.3%	36.4%	17.6%	0%	330
1999	22.1%	23.4%	39.7%	14.2%	0.6%	325
2000	24%	26.4%	34.1%	15.5%	0%	337
2001	26.8%	16%	28.6%	28.6%	0%	336
2002	18.9%	26.7%	33.4%	21%	0%	333
2003	18%	25.4%	33%	23%	0.6%	339
2004	22.6%	23%	23%	29.6%	1.8%	311
2005	17.9%	21.5%	27.5%	31.6%	1.5%	335
2006	16.1%	27.6%	21.8%	33%	1.5%	330

Source: Helping Hand (1991-2006).

Table 7.26 Urine incontinence

Year	Urine incontinence				Total no. of residents
	No incontinence	Once or less per week	Once daily	Persistent	
1990	92 (75%)	19 (15.6%)	5 (4.1%)	6 (5%)	122
2006	74 (49%)	23 (15.1%)	8 (5.3%)	47 (31%)	152
Total	166	42	13	53	274

Table 7.27 Faeces incontinence

Year	Faeces incontinence				Total no. of residents
	No incontinence	Once or less per week	Once daily	Persistent	
1990	98 (80%)	19 (15.6%)	5 (4.1%)	0 (0%)	122
2006	97 (64%)	16 (10.5%)	2 (1.3%)	37 (24%)	152
Total	195	35	7	37	274

Table 7.28 Expressiveness

Year	Expressiveness			Total no. of residents
	Normal	Some difficulties	Inarticulate	
1990	79 (64.8%)	34 (27.9%)	9 (7.4%)	122
2006	78 (51.3%)	54 (35.5%)	20 (13.2%)	152
Total	157	88	29	274

Table 7.29 Comprehension

Year	Comprehension			Total no. of residents
	Normal	Some difficulties	Unable to comprehend others' messages	
1990	90 (73.8%)	28 (23%)	4 (3.3%)	122
2006	78 (51.3%)	56 (36.8%)	18 (11.8%)	152
Total	168	84	22	274

Table 7.30 Vision

Year	Vision				Total no. of residents
	Normal	Wear spectacles	Partially blind	Totally blind	
1990	66 (54.1%)	16 (13.1%)	38 (31.1%)	2 (1.6%)	122
2006	62 (40.8%)	66 (43.4%)	16 (10.5%)	8 (5.3%)	152
Total	128	82	54	10	274

Table 7.31 Hearing

Year	Hearing			Total no. of residents
	Normal	Some difficulties	Deaf	
1990	91 (74.6%)	30 (24.6%)	1 (0.8%)	122
2006	81 (53.3%)	54 (35.5%)	17 (11.2%)	152
Total	172	84	18	274

Table 7.32 Activities of daily living

Items	No assistance		Some assistance		Maximum assistance	
	1990 N=122	2006 N=152	1990 N=122	2006 N=152	1990 N=122	2006 N=152
toileting	86 (70.5%)	78 (51.3%)	23 (18.9%)	28 (18.4%)	13 (10.7%)	46 (30.3%)
dressing	71 (58.2%)	82 (54%)	32 (26.2%)	20 (13.2%)	19 (15.6%)	50 (32.9%)
feeding	101 (82.9%)	106 (69.7%)	17 (13.9%)	23 (15.1%)	4 (3.3%)	23 (15.1%)
washing	64 (52.5%)	98 (64.5%)	40 (32.8%)	19 (12.5%)	18 (14.8%)	35 (23%)
bathing	48 (39.4%)	45 (29.6%)	36 (29.5%)	15 (9.9%)	38 (31.2%)	92 (60.5%)

Table 7.33 Cognitive orientation ability of residents

Items	Correct		Partly correct		Wrong	
	1990 N=122	2006 N=152	1990 N=122	2006 N=152	1990 N=122	2006 N=152
state ‘name’	117 (95.9%)	129 (84.9%)	1 (0.8%)	12 (7.9%)	4 (3.3%)	11 (7.2%)
state ‘age’	84 (68.9%)	38 (25%)	10 (8.2%)	51 (33.6%)	28 (23%)	63 (41.4%)
state ‘date of birth’	84 (68.9%)	12 (7.9%)	11 (9%)	16 (10.5%)	27 (22.1%)	124 (81.6%)
state ‘living place’	72 (59%)	52 (34.2%)	13 (10.7%)	36 (23.7%)	37 (30.3%)	64 (42.1%)
state ‘region’	57 (46.7%)	49 (32.2%)	13 (10.7%)	17 (11.2%)	52 (42.6%)	86 (56.6%)
state ‘day’	50 (41%)	39 (25.7%)	10 (8.2%)	11 (7.2%)	62 (50.8%)	102 (67.1%)
state ‘month’	59 (48.4%)	46 (30.3%)	7 (5.7%)	12 (7.9%)	56 (45.9%)	94 (61.8%)
state ‘year’	50 (41%)	29 (19.1%)	5 (4.1%)	12 (7.9%)	67 (54.9%)	111 (73%)
counting	98 (80.3%)	93 (61.2%)	5 (4.1%)	29 (19.1%)	19 (15.6%)	30 (19.7%)

Total number of residents in 1990 is 122.

Total number of residents in 2006 is 152.

Table 7.34 Scores attained in 'cognitive orientation' questions

Total no. of scores	1990 (N=122)	2006 (N=152)
0	30 (24.6%)	5 (3.3%)
1	4 (3.3%)	1 (0.7%)
2	9 (7.4%)	5 (3.3%)
3	7 (5.7%)	5 (3.3%)
4	7 (5.7%)	6 (3.9%)
5	5 (4.1%)	10 (6.6%)
6	6 (4.9%)	10 (6.6%)
7	5 (4.1%)	6 (3.9%)
8	5 (4.1%)	8 (5.3%)
9	2 (1.6%)	5 (3.3%)
10	6 (4.9%)	9 (5.9%)
11	5 (4.1%)	8 (5.3%)
12	8 (6.6%)	15 (9.9%)
13	5 (4.1%)	10 (6.6%)
14	8 (6.6%)	18 (11.8%)
15	2 (1.6%)	8 (5.3%)
16	4 (3.3%)	5 (3.3%)
17	0 (0%)	9 (5.9%)
18	4 (3.3%)	9 (5.9%)

Table 7.35 Instrumental activities of daily living

Items	No assistance		Some assistance		Maximum assistance	
	1990	2006	1990	2006	1990	2006
	N=122	N=152	N=122	N=152	N=122	N=152
shopping	42 (34.4%)	21 (13.8%)	20 (16.4%)	22 (14.5%)	60 (49.2%)	109 (71.7%)
managing money	59 (48.4%)	37 (24.3%)	27 (22.1%)	35 (23%)	36 (29.5%)	80 (52.6%)
grooming	60 (49.2%)	104 (68.4%)	40 (32.8%)	12 (7.9%)	22 (18%)	36 (23.7%)
bed making	41 (33.6%)	19 (12.5%)	20 (16.4%)	17 (11.2%)	61 (50%)	116 (76.3%)

Table 7.36 Behavioural disturbance

Items	rarely		sometimes		frequently	
	1990	2006	1990	2006	1990	2006
	N=122	N=152	N=122	N=152	N=122	N=152
wandering	101 (82.8%)	129 (84.7%)	13 (10.7%)	14 (9.2%)	8 (6.6%)	9 (5.9%)
day disturbance	95 (77.9%)	130 (85.5%)	14 (11.5%)	16 (10.5%)	12 (9.8%)	6 (3.9%)
night disturbance	99 (81.1%)	138 (90.8%)	14 (11.5%)	10 (6.6%)	9 (7.4%)	4 (2.6%)
accusing	103 (84.4%)	128 (84.2%)	18 (14.8%)	19 (12.5%)	1 (0.8%)	5 (3.3%)
sleep pattern	48 (39.3%)	62 (40.9%)	59 (48.4%)	62 (40.8%)	15 (12.3%)	28 (18.4%)

Table 7.37 Comparison of residents' characteristics between the two Homes as at 2006

Items	t	df	Sig. (2-tailed)	Mean Chak On	Mean Lai Yiu
sex	.277	150	.782	1.31	1.29
walking aid	-1.417	150	.158	2.66	3.04
mobility	-2.599	150	.010	1.28	1.61
urine incontinence	.767	150	.444	1.26	1.10
faeces incontinence	-.631	150	.529	.80	.93
expressiveness	2.943	150	.004	.78	.44
comprehension	1.552	150	.123	.69	.51
vision	-.431	150	.667	.78	.83
hearing	-.547	150	.585	.55	.61
hearing aid	-1.888	150	.061	.20	.36
state 'name'	1.764	150	.080	.30	.14
state 'age'	.778	150	.438	1.21	1.11
state 'date of birth'	.014	150	.989	1.74	1.74
state 'living place'	-3.123	150	.002	.88	1.31
state 'region'	-3.398	150	.001	1.01	1.50
state 'day'	-1.526	150	.129	1.31	1.53
state 'month'	-1.120	150	.265	1.24	1.40
state 'year'	-.643	150	.521	1.50	1.58
counting	-.373	150	.710	.56	.61
toileting	-.581	150	.562	.75	.83
dressing	-.562	150	.575	.75	.83
feeding	-.504	150	.615	.42	.49
washing	-1.718	150	.088	.48	.71
bathing	.949	150	.344	1.38	1.24
shopping	-1.883	150	.062	1.48	1.69
managing money	-2.923	150	.004	1.10	1.49
grooming	-.420	150	.675	.52	.58
bed making	-4.472	150	.000	1.41	1.89
wandering	.048	150	.962	.21	.21
day disturbance	-.925	150	.356	.15	.22
night disturbance	.214	150	.831	.12	.11
accusing	.253	150	.800	.20	.18
sleep pattern	2.905	150	.004	.94	.60
age	-1.055	150	.293	85.36	86.69

Table 7.38 Residents' changes across the two Care Homes: 1990 and 2006

Items	Residents' changes between 1990 and 2006					
	Both Care Homes		Chak On		Lai Yiu	
	t	Sig. (2-tailed)	t	Sig. (2-tailed)	t	Sig. (2-tailed)
sex	-.135	.893	-.586	.559	.385	.701
walking aid	-4.526	.000	-3.329	.001	-3.188	.002
mobility	-3.114	.002	-2.562	.011	-2.087	.039
urine incontinence	-5.881	.000	-5.107	.000	-3.204	.002
faeces incontinence	-5.095	.000	-3.373	.001	-3.832	.000
expressiveness	-2.345	.020	-3.881	.000	.628	.531
comprehension	-4.094	.000	-4.079	.000	-1.645	.102
vision	.006	.995	-.056	.955	.035	.972
hearing	-4.370	.000	-2.422	.017	-3.769	.000
hearing aid	-1.780	.076	-1.295	.197	-1.355	.178
state 'name'	-2.528	.012	-1.982	.050	-1.526	.129
state 'age'	-6.250	.000	-3.568	.000	-5.475	.000
state 'date of birth'	-13.914	.000	-8.517	.000	-11.360	.000
state 'living place'	-3.393	.001	.378	.706	-5.669	.000
state 'region'	-2.518	.012	.955	.341	-4.986	.000
state 'day'	-2.855	.005	-.704	.483	-3.466	.001
state 'month'	-2.982	.003	-.956	.341	-3.299	.001
state 'year'	-3.743	.000	-.686	.494	-4.578	.000
counting	-2.479	.014	-.447	.656	-3.243	.001
toileting	-4.006	.000	-3.159	.002	-2.564	.011
dressing	-2.106	.036	-1.405	.162	-1.593	.113
feeding	-3.199	.002	-1.854	.066	-2.699	.008
washing	.388	.699	.959	.339	-.444	.658
bathing	-3.683	.000	-3.743	.000	-1.514	.132
shopping	-4.382	.000	-2.439	.016	-3.865	.000
managing money	-4.575	.000	-1.803	.074	-4.968	.000
grooming	1.375	.170	1.497	.137	.438	.662
bed making	-4.909	.000	-2.389	.018	-5.271	.000
wandering	.409	.683	.738	.462	-.160	.873
day disturbance	1.989	.048	3.008	.003	-.316	.752
night disturbance	2.412	.017	3.216	.002	-.221	.826
accusing	-.504	.614	-.210	.834	-.497	.620
sleep pattern	-.544	.587	-2.392	.018	1.748	.083
age	-5.824	.000	-3.318	.001	-5.034	.000

Table 7.39 Chak On: 1990 and 2006

Items	Chak On		t	Sig. (2-tailed)
	Mean (1990)	Mean (2006)		
sex	1.27	1.31	-.586	.559
walking aid	1.78	2.66	-3.329	.001
mobility	.90	1.28	-2.562	.011
urine incontinence	.30	1.26	-5.107	.000
faeces incontinence	.23	.80	-3.373	.001
expressiveness	.33	.78	-3.881	.000
comprehension	.25	.69	-4.079	.000
vision	.77	.78	-.056	.955
hearing	.30	.55	-2.422	.017
hearing aid	.10	.20	-1.295	.197
state ‘name’	.10	.30	-1.982	.050
state ‘age’	.67	1.21	-3.568	.000
state ‘date of birth’	.65	1.74	-8.517	.000
state ‘living place’	.93	.88	.378	.706
state ‘region’	1.17	1.01	.955	.341
state ‘day’	1.20	1.31	-.704	.483
state ‘month’	1.08	1.24	-.956	.341
state ‘year’	1.40	1.50	-.686	.494
counting	.50	.56	-.447	.656
toileting	.33	.75	-3.159	.002
dressing	.55	.75	-1.405	.162
feeding	.22	.42	-1.854	.066
washing	.60	.48	.959	.339
bathing	.83	1.38	-3.743	.000
shopping	1.13	1.48	-2.439	.016
managing money	.83	1.10	-1.803	.074
grooming	.73	.52	1.497	.137
bed making	1.07	1.41	-2.389	.018
wandering	.28	.21	.738	.462
day disturbance	.45	.15	3.008	.003
night disturbance	.43	.12	3.216	.002
accusing	.18	.20	-.210	.834
sleep pattern	.65	.94	-2.392	.018
age	80.67	85.36	-3.318	.001

Table 7.40 Lai Yiu: 1990 and 2006

Items	Lai Yiu			
	Mean 1990	Mean 2006	t	Sig. (2-tailed)
sex	1.32	1.29	.385	.701
walking aid	2.16	3.04	-3.188	.002
mobility	1.29	1.61	-2.087	.039
urine incontinence	.47	1.10	-3.204	.002
faeces incontinence	.24	.93	-3.832	.000
expressiveness	.52	.44	.628	.531
comprehension	.34	.51	-1.645	.102
vision	.84	.83	.035	.972
hearing	.23	.61	-3.769	.000
hearing aid	.21	.36	-1.355	.178
state ‘name’	.05	.14	-1.526	.129
state ‘age’	.42	1.11	-5.475	.000
state ‘date of birth’	.42	1.74	-11.360	.000
state ‘living place’	.50	1.31	-5.669	.000
state ‘region’	.76	1.50	-4.986	.000
state ‘day’	1.00	1.53	-3.466	.001
state ‘month’	.87	1.40	-3.299	.001
state ‘year’	.89	1.58	-4.578	.000
counting	.21	.61	-3.243	.001
toileting	.47	.83	-2.564	.011
dressing	.60	.83	-1.593	.113
feeding	.19	.49	-2.699	.008
washing	.65	.71	-.444	.658
bathing	1.00	1.24	-1.514	.132
shopping	1.16	1.69	-3.865	.000
managing money	.79	1.49	-4.968	.000
grooming	.65	.58	.438	.662
bed making	1.26	1.89	-5.271	.000
wandering	.19	.21	-.160	.873
day disturbance	.19	.22	-.316	.752
night disturbance	.10	.11	-.221	.826
accusing	.15	.18	-.497	.620
sleep pattern	.81	.60	1.748	.083
age	80.11	86.69	-5.034	.000

Table 7.41 Residents' health conditions - Chak On

Year	Arthritis	Cataract	Diabetes mellitus	Hip fracture	Heart disease	Hyper-tension	Osteo-porosis	Parkin-son's disease	Respira-tory tract disorder	Demen-tia	Stroke
1991	7.6%	21.5%	13.9%	16.5%	7.6%	50.6%	0%	3.8%	12.7%	15.2%	29.1%
1992	7.5%	25%	12.5%	15%	10%	51.3%	1.3%	3.8%	13.8%	15%	28.8%
1993	6.3%	32.9%	13.9%	21.5%	16.5%	54.4%	2.5%	5.1%	15.2%	13.9%	32.9%
1994	11%	31.7%	13.4%	24.4%	22.2%	47.6%	4.9%	8.5%	13.4%	20.7%	34.1%
1995	25.6%	42.7%	11%	28%	31.7%	37.8%	3.7%	3.7%	19.5%	22%	31.7%
1996	28.2%	25.9%	14.1%	29.4%	35.3%	40%	3.5%	7.1%	28.2%	21.2%	32.9%
1997	14.5%	21.7%	13.3%	12.1%	20.5%	18.1%	15.7%	10.8%	15.7%	7.2%	31.3%
1998	39.3%	19%	23.8%	22.6%	17.9%	33.3%	20.2%	13.1%	19%	14.3%	14.3%
1999	42.4%	14.1%	17.6%	9.4%	17.6%	47.1%	21.2%	2.4%	15.3%	27.1%	17.6%
2000	41.9%	25.6%	23.3%	19.8%	31.4%	58.1%	41.9%	10.5%	24.4%	22.1%	20.9%
2001	16.5%	51.8%	17.6%	28.2%	34.1%	56.5%	4.8%	15.3%	28.2%	20%	20%
2002	24.1%	55.4%	20.5%	16.9%	33.7%	52.2%	4.8%	6%	10.8%	25.3%	25.3%
2003	20.9%	55.8%	19.8%	31.4%	32.6%	57%	3.5%	8.1%	22.1%	11.6%	29.1%
2004	27.1%	51.8%	15.3%	22.4%	34.1%	55.3%	2.4%	7.1%	8.2%	36.5%	34.1%
2005	15.3%	55.3%	18.8%	34.1%	35.3%	57.6%	2.4%	8.2%	21.2%	32.9%	32.9%
2006	21.5%	53%	20%	22%	26%	63%	3.5%	1%	10%	38%	35%

Source: Helping Hand (1991-2006).

Table 7.42 Residents' health conditions - Lai Yiu

Year	Arthritis	Cataract	Diabetes mellitus	Hip fracture	Heart disease	Hyper-tension	Osteo-porosis	Parkin-son's disease	Respira-tory tract disorder	Demen-tia	Stroke
1991	6.3%	26.6%	6.3%	26.6%	18.8%	28.1%	7.8%	4.7%	42.2%	17.2%	42.2%
1992	11.8%	30.9%	8.8%	27.9%	19.1%	23.5%	7.4%	2.9%	42.6%	14.7%	38.2%
1993	10.1%	26.1%	11.6%	5.8%	30.4%	27.5%	7.2%	1.4%	30.4%	14.5%	42%
1994	4.4%	23.5%	19.1%	5.9%	27.9%	22.1%	2.9%	1.5%	29.4%	11.8%	44.1%
1995	4.6%	25.8%	16.7%	10.6%	22.7%	21.2%	3%	1.5%	30.3%	10.6%	40.9%
1996	5.9%	29.4%	20.6%	13.2%	23.5%	17.6%	2.9%	2.9%	27.9%	8.8%	44.1%
1997	7.4%	35.3%	20.6%	13.2%	19.1%	29.4%	2.9%	4.4%	25%	7.4%	42.7%
1998	23.6%	52.7%	21.8%	23.6%	27.3%	36.4%	1.8%	9.1%	21.8%	32.7%	42%
1999	11.9%	38.8%	16.4%	23.9%	31.3%	41.8%	3.1%	3%	16.4%	10.4%	31.3%
2000	10.7%	44%	14.7%	22.7%	26.7%	44%	2.7%	5.3%	14.7%	12%	33.3%
2001	16%	53.3%	13.3%	12%	30.7%	45.3%	4%	9.3%	10.7%	9.3%	33.3%
2002	11.8%	52.6%	9.2%	10.5%	36.8%	42.1%	5.3%	3.9%	17.1%	6.6%	34.2%
2003	11.8%	50%	10.5%	9.2%	32.9%	44.7%	5.3%	3.9%	15.8%	32.9%	31.6%
2004	19.2%	61.6%	12.3%	30.1%	31.5%	54.8%	5.5%	5.5%	9.6%	32.9%	32.9%
2005	18.9%	51.4%	20.3%	24.3%	21.6%	54.1%	14.9%	5.4%	17.6%	24.3%	31.1%
2006	19.1%	47.9%	17.8%	26%	21.9%	53.4%	12.3%	2.7%	16.4%	27.3%	28.7%

Source: Helping Hand (1991-2006).

Table 8.1 Total income of the two Care Homes

(HK$)

Year	Chak On			Lai Yiu		
	Total income	Income per capita	No. of residents	Total income	Income per capita	No. of residents
1991	$2,436,059	$30,836	79	$2,373,033	$37,079	64
1992	$3,834,566	$47,932	80	$3,290,496	$48,390	68
1993	$5,454,251	$69,041	79	$4,820,561	$69,863	69
1994	$6,326,462	$77,152	82	$5,491,596	$80,759	68
1995	$6,279,448	$76,579	82	$5,525,901	$83,726	66
1996	$7,176,580	$84,430	85	$6,335,023	$93,162	68
1997	$8,470,180	$102,050	83	$7,041,866	$103,557	68
1998	$9,507,844	$113,189	84	$7,719,822	$111,882	69
1999	$10,102,974	$120,274	84	$8,569,173	$124,191	69
2000	$11,171,068	$129,896	86	$9,010,203	$120,136	75
2001	$11,513,578	$135,454	85	$9,738,061	$129,841	75
2002	$11,774,726	$141,864	83	$9,578,496	$126,033	76
2003	$11,555,864	$134,371	86	$9,515,576	$125,205	76
2004	$11,125,841	$130,892	85	$9,900,677	$135,626	73
2005	$10,794,918	$126,999	85	$9,907,846	$133,890	74
2006	$10,541,571	$122,576	86	$9,950,139	$136,303	73

Source: Helping Hand (1991-2006).

Table 8.2 Rental income

(HK$)

Year	Chak On		Lai Yiu	
	Rental fees	Income per capita	Rental fees	Income per capita
1991	$439,484	$5,563	$407,747	$6,371
1992	$549,358	$6,867	$424,245	$6,239
1993	$687,021	$8,697	$618,550	$8,965
1994	$1,028,249	$12,540	$877,421	$12,903
1995	$1,084,008	$13,220	$936,240	$14,186
1996	$1,113,582	$13,101	$906,348	$13,329
1997	$1,324,645	$15,960	$1,103,074	$16,222
1998	$1,446,247	$17,217	$1,190,440	$17,253
1999	$1,498,255	$17,836	$1,375,443	$19,934
2000	$1,559,375	$18,132	$1,293,833	$17,251
2001	$1,535,852	$18,069	$1,350,737	$18,010
2002	$1,534,348	$18,486	$1,346,223	$17,714
2003	$1,642,750	$19,102	$1,252,160	$16,476
2004	$1,423,932	$16,752	$1,239,867	$16,985
2005	$1,403,298	$16,509	$1,216,875	$16,444
2006	$1,406,337	$16,353	$1,216,587	$16,666

Source: Helping Hand (1991-2006).

Table 8.3 Rate of change of income and expenditure: 1991-2006

Items	Rate of change between 1991 and 2006 Chak On	Lai Yiu
Total income	+333%	+319%
Meals and other charges	+207%	+172%
Rental fees	+220%	+198%
Government subsidy	+345%	+356%
Community Chest donation	+80%	+75%
Self-generated donation	+956%	+443%
Total expenditure	+113%	+110%
Staff salaries	+121%	+107%
Provident funds	+423%	+334%
Food	+17%	+22%
Rent and rates	+81%	+119%
Water and electricity	+126%	+118%

Source: Helping Hand (1991-2006).

Table 8.4 Income from meals and other charges

(HK$)

Year	Chak On		Lai Yiu	
	Meals & other charges	Charges per capita	Meals & other charges	Charges per capita
1991	$596,453	$7,550	$567,441	$8,866
1992	$726,675	$9,083	$547,218	$8,047
1993	$766,258	$9,700	$683,368	$9,904
1994	$879,713	$10,728	$747,783	$10,997
1995	$931,820	$11,364	$809,781	$12,269
1996	$1,034,319	$12,169	$873,312	$12,843
1997	$1,129,145	$13,604	$941,429	$13,845
1998	$1,359,223	$16,181	$1,127,505	$16,341
1999	$1,390,650	$16,555	$1,262,720	$18,300
2000	$1,468,765	$17,079	$1,226,225	$16,350
2001	$1,470,920	$17,305	$1,285,525	$17,140
2002	$1,750,690	$21,093	$1,523,340	$20,044
2003	$1,898,390	$22,074	$1,429,270	$18,806
2004	$1,776,150	$20,896	$1,529,910	$20,958
2005	$1,798,198	$21,155	$1,539,410	$20,803
2006	$1,828,515	$21,262	$1,545,335	$21,169

Source: Helping Hand (1991-2006).

Table 8.5 Government subsidy

(HK$)

Year	Chak On	Payment per capita (CO)	Lai Yiu	Payment per capita (LY)
1991	$1,265,152	$16,015	$1,146,544	$17,915
1992	$2,503,168	$31,290	$2,268,496	$33,360
1993	$2,818,560	$35,678	$2,554,320	$37,019
1994	$3,103,488	$37,847	$2,812,536	$41,361
1995	$3,393,024	$41,378	$3,074,928	$46,590
1996	$3,785,537	$44,536	$3,432,355	$50,476
1997	$4,089,465	$49,271	$3,706,129	$54,502
1998	$4,677,372	$55,683	$3,999,492	$57,964
1999	$5,101,308	$60,730	$4,361,988	$63,217
2000	$5,135,660	$59,717	$4,609,260	$61,457
2001	$5,512,446	$64,852	$4,930,323	$65,738
2002	$5,748,251	$69,256	$5,365,422	$70,598
2003	$5,823,647	$67,717	$5,443,177	$71,621
2004	$6,140,653	$72,243	$5,614,418	$76,910
2005	$5,826,148	$68,543	$5,421,984	$73,270
2006	$5,633,011	$65,500	$5,222,162	$71,537

Source: Helping Hand (1991-2006).

Table 8.6 Income structure - Chak On

Year	Rental fees	Other payment	SWD subsidy	Community Chest donation	Self-generated donation
1991	18%	24%	52%	0%	5%
1993	13%	14%	52%	20%	1%
2006	13%	17%	53%	2%	13%

Source: Helping Hand (1991-2006).

Table 8.7 Income structure - Lai Yiu

Year	Rental fees	Other payment	SWD subsidy	Community Chest donation	Self-generated donation
1991	17%	24%	48%	0%	11%
1993	13%	14%	53%	19%	1%
2006	12%	16%	52%	2%	14%

Source: Helping Hand (1991-2006).

Table 8.8 Donations by the Community Chest

(HK$)

Year	Chak On	Donation per capita (CO)	Lai Yiu	Donation per capita (LY)
1991	Nil	Nil	Nil	Nil
1992	Nil	Nil	Nil	Nil
1993	$1,118,000	$14,152	$900,000	$13,044
1994	$1,268,004	$15,464	$1,028,004	$15,118
1995	$811,334	$9,894	$681,334	$10,323
1996	$1,106,852	$13,022	$985,199	$14,488
1997	$647,954	$7,807	$477,839	$7,027
1998	$675,022	$8,036	$553,041	$8,015
1999	$746,682	$8,889	$610,815	$8,852
2000	$669,451	$7,784	$541,527	$7,220
2001	$670,074	$7,883	$525,819	$7,011
2002	$712,582	$8,585	$441,382	$5,808
2003	$702,016	$8,163	$455,470	$5,993
2004	$454,582	$5,348	$419,558	$5,747
2005	$454,588	$5,348	$419,564	$5,670
2006	$225,312	$2,620	$225,312	$3,086

Source: Helping Hand (1991-2006).

Table 8.9 Agency's self-generated income

(HK$)

Year	Chak On	Income per capita (CO)	Lai Yiu	Income per capita (LY)
1991	$129,001	$1,633	$249,901	$3,905
1992	$50,500	$631	$48,879	$719
1993	$63,250	$801	$61,350	$889
1994	$46,134	$563	$42,046	$618
1995	$58,856	$718	$23,544	$357
1996	$135,627	$1,596	$137,708	$2,025
1997	$1,278,801	$15,407	$813,395	$11,962
1998	$1,315,745	$15,664	$844,082	$12,233
1999	$1,264,354	$15,052	$944,524	$13,689
2000	$2,174,716	$25,287	$1,333,663	$17,782
2001	$2,090,672	$24,596	$1,562,659	$20,836
2002	$1,887,618	$22,742	$733,139	$9,647
2003	$1,395,543	$16,227	$861,788	$11,339
2004	$1,233,440	$14,511	$1,030,991	$14,123
2005	$1,218,920	$14,340	$1,041,801	$14,078
2006	$1,362,567	$15,844	$1,357,856	$18,601

Source: Helping Hand (1991-2006).

Table 8.10 Total expenditure of the two Care Homes

(HK$)

Year	Chak On	Per capita costs (CO)	Lai Yiu	Per capita costs (LY)
1991	$4,752,896	$60,163	$3,901,589	$60,962
1992	$5,403,595	$67,545	$4,336,673	$63,775
1993	$6,312,479	$79,905	$5,079,040	$73,609
1994	$7,200,583	$87,812	$5,709,320	$83,961
1995	$8,359,229	$101,942	$6,819,600	$103,327
1996	$9,301,726	$109,432	$7,771,829	$114,292
1997	$10,030,644	$120,851	$8,483,594	$124,759
1998	$10,642,316	$126,694	$9,096,684	$131,836
1999	$11,365,260	$135,301	$10,045,539	$145,588
2000	$11,670,988	$135,709	$9,987,218	$133,163
2001	$11,984,826	$140,998	$10,049,859	$133,998
2002	$11,728,007	$141,301	$9,579,467	$126,046
2003	$11,256,115	$130,885	$9,093,122	$119,646
2004	$10,984,993	$129,235	$9,090,271	$124,524
2005	$10,493,199	$123,449	$8,664,509	$117,088
2006	$10,135,574	$117,856	$8,195,127	$112,262

Source: Helping Hand (1991-2006).

Table 8.11 Staff salaries

(HK$)

Year	Chak On	Per capita costs (CO)	Lai Yiu	Per capita costs (LY)
1991	$3,381,135	$42,799	$2,708,495	$42,320
1992	$3,986,385	$49,830	$3,041,193	$44,723
1993	$4,766,927	$60,341	$3,635,760	$52,692
1994	$5,508,526	$67,177	$4,141,584	$60,906
1995	$6,267,086	$76,428	$4,935,869	$74,786
1996	$7,074,079	$83,225	$5,564,579	$81,832
1997	$7,641,254	$92,063	$6,172,560	$90,773
1998	$8,124,063	$96,715	$6,680,586	$96,820
1999	$8,849,541	$105,352	$7,309,266	$105,931
2000	$9,085,289	$105,643	$7,214,740	$96,197
2001	$9,342,504	$109,912	$7,142,658	$95,235
2002	$9,116,094	$109,833	$6,848,621	$90,113
2003	$8,679,544	$100,925	$6,454,402	$84,926
2004	$8,412,084	$98,966	$6,463,575	$88,542
2005	$7,838,416	$92,217	$6,010,072	$81,217
2006	$7,482,866	$87,010	$5,600,928	$76,725

Source: Helping Hand (1991-2006).

Table 8.12 Expenditure on rent and rates

(HK$)

Year	Chak On	Expenditure per capita (CO)	Lai Yiu	Expenditure per capita (LY)	Inflation rate (CCPI)
1991	$319,404	$4,043	$347,124	$5,424	
1992	$339,804	$4,248	$314,897	$4,631	12.8%
1993	$387,744	$4,908	$439,500	$6,370	13.1%
1994	$416,844	$5,084	$439,500	$6,463	12.5%
1995	$461,784	$5,632	$447,420	$6,779	13%
1996	$493,884	$5,810	$579,348	$8,520	10.2%
1997	$543,360	$6,547	$579,348	$8,520	9.3%
1998	$578,700	$6,889	$584,268	$8,468	4.7%
1999	$558,855	$6,653	$757,890	$10,984	-5.1%
2000	$569,250	$6,619	$764,445	$10,193	-8.3%
2001	$578,700	$6,808	$768,420	$10,246	-3.1%
2002	$571,665	$6,888	$766,420	$10,084	-5.7%
2003	$566,811	$6,591	$761,820	$10,024	-4.8%
2004	$564,199	$6,638	$755,620	$10,351	-5.2%
2005	$578,700	$6,808	$758,820	$10,254	0.07%
2006	$578,700	$6,729	$760,020	$10,411	4.7%

Source: Helping Hand (1991-2006).

Table 8.13 Composite Consumer Price Index: 1991-2006

CCPI (1991=100)

Year	Food	Water & Electricity & Gas	Rent & Rates
1991	100	100	100
1992	110 (10%)	105.4 (5.4%)	112.8 (12.8%)
1993	122.2 (11.1%)	110.5 (4.8%)	127.6 (13.1%)
1994	127.6 (4.4%)	115.1 (4.2%)	143.6 (12.5%)
1995	137.4 (7.7%)	125.7 (9.2%)	162.3 (13%)
1996	142.9 (4%)	132 (5%)	178.8 (10.2%)
1997	148.3 (3.8%)	138.8 (5.2%)	195.5 (9.3%)
1998	151 (1.8%)	140.8 (1.4%)	204.7 (4.7%)
1999	148.3 (-1.8%)	139.9 (-0.6%)	194.2 (-5.1%)
2000	145 (-2.2%)	145 (3.6%)	178.1(-8.3%)
2001	143.9 (-0.8%)	142.2 (-1.9%)	172.6 (-3.1%)
2002	140.8 (-2.2%)	132.4 (-6.9%)	162.8 (-5.7%)
2003	138.6 (-1.6%)	134.2 (1.4%)	155 (-4.8%)
2004	140.1 (1.1%)	149.5 (11.4%)	146.9 (-5.2%)
2005	142.6 (1.8%)	155.6 (4.1%)	147 (0.07%)
2006	145 (1.7%)	158.9 (2.1%)	153.9 (4.7%)

Source: Hong Kong Annual Digest of Statistics (2001, 2002, 2004 and 2007 Editions). Hong Kong Monthly Digest of Statistics (November 2004).

Table 8.14 Expenditure on water and electricity

(HK$)

Year	Chak On	Expenditure per capita (CO)	Lai Yiu	Expenditure per capita (LY)	Inflation rate (CCPI)
1991	$125,860	$1,593	$136,769	$2,137	
1992	$151,529	$1,894	$152,767	$2,247	5.4%
1993	$153,634	$1,945	$155,463	$2,253	4.8%
1994	$204,641	$2,496	$178,759	$2,629	4.2%
1995	$225,296	$2,748	$233,463	$3,537	9.2%
1996	$238,888	$2,810	$249,725	$3,672	5%
1997	$255,783	$3,082	$273,420	$4,021	5.2%
1998	$263,118	$3,132	$288,645	$4,183	1.4%
1999	$263,547	$3,138	$319,223	$4,626	-0.6%
2000	$294,287	$3,422	$337,359	$4,498	3.6%
2001	$253,284	$2,980	$367,918	$4,906	-1.9%
2002	$260,004	$3,133	$386,170	$5,081	-6.9%
2003	$268,576	$3,123	$395,133	$5,199	1.4%
2004	$279,766	$3,291	$353,330	$4,840	11.4%
2005	$281,997	$3,318	$282,288	$3,815	4.1%
2006	$284,534	$3,309	$298,529	$4,089	2.1%

Source: Helping Hand (1991-2006).

Table 8.15 Expenditure on food

(HK$)

Year	Chak On	Expenditure per capita (CO)	Lai Yiu	Expenditure per capita (LY)	Inflation rate (CCPI)
1991	$486,379	$6,157	$360,895	$5,639	
1992	$417,986	$5,225	$387,293	$5,696	10%
1993	$424,575	$5,374	$410,001	$5,942	11.1%
1994	$409,438	$4,993	$412,800	$6,071	4.4%
1995	$513,296	$6,260	$429,178	$6,503	7.7%
1996	$483,549	$5,689	$469,253	$6,901	4%
1997	$523,061	$6,302	$472,999	$6,956	3.8%
1998	$546,858	$6,510	$509,025	$7,377	1.8%
1999	$523,141	$6,228	$509,332	$7,382	-1.8%
2000	$502,274	$5,840	$529,461	$7,060	-2.2%
2001	$510,679	$6,008	$536,165	$7,149	-0.8%
2002	$511,828	$6,167	$515,536	$6,783	-2.2%
2003	$490,614	$5,705	$476,381	$6,268	-1.6%
2004	$464,204	$5,461	$485,304	$6,648	1.1%
2005	$438,845	$5,163	$516,578	$6,981	1.8%
2006	$404,009	$4,698	$440,352	$6,032	1.7%

Source: Helping Hand (1991-2006).

Table 8.16 Monthly salary of an Enrolled Nurse

Year	Master Pay Scale	Monthly salary (HK$)
1991	Point 9	$7,850
1992	Point 10	$9,305
1993	Point 11	$10,930
1994	Point 12	$12,760
1995	Point 13	$14,905
1996	Point 14	$16,860
1997	Point 15	$18,915
1998	Point 16	$21,010
1999	Point 17	$22,075
2000	Point 18	$23,170
2001	Point 19	$24,900
2002	Point 20	25,715
2003	Point 21	$26,995
2004	Point 21	$26,168
2005	Point 21	$25,340

Source: Civil Service Bureau (2006).

Table 8.17 Monthly salary of a Personal Care Worker

Year	Master Pay Scale	Monthly Salary (HK$)
1991	Point 3	$5,370
1992	Point 4	$6,380
1993	Point 5	$7,535
1994	Point 6	$8,815
1995	Point 7	$10,350
1996	Point 8	$11,880
1997	Point 9	$13,515
1998	Point 9	$14,300
1999	Point 9	$14,300
2000	Point 9	$14,300
2001	Point 9	$14,645
2002	Point 9	$14,415
2003	Point 9	$14,415
2004	Point 9	$13,965
2005	Point 9	$13,515

Source: Civil Service Bureau (2006).

Table 8.18 Annual surplus of the two Care Homes

Year	Annual surplus (HK$)	
	Chak On	Lai Yiu
2002	$46,719	$999,029
2003	$299,749	$422,454
2004	$140,848	$810,406
2005	$301,719	$1,243,337
2006	$405,997	$1,755,012

Source: Helping Hand (2002-2006).

Table 8.19 Provident funds

(HK$)

Year	Chak On	Per capita costs (CO)	Lai Yiu	Per capita costs (LY)
1991	$138,833	$1,757	$99,385	$1,553
1992	$199,670	$2,496	$182,134	$2,678
1993	$220,704	$2,794	$154,286	$2,236
1994	$251,524	$3,067	$185,363	$2,726
1995	$279,171	$3,405	$226,248	$3,428
1996	$329,770	$3,880	$250,642	$3,686
1997	$357,658	$4,309	$282,337	$4,152
1998	$391,355	$4,659	$308,512	$4,471
1999	$445,977	$5,309	$402,311	$5,831
2000	$547,074	$6,361	$420,839	$5,611
2001	$611,362	$7,193	$460,157	$6,135
2002	$608,295	$7,329	$422,145	$5,555
2003	$635,312	$7,387	$398,971	$5,250
2004	$644,994	$7,588	$425,025	$5,822
2005	$673,950	$7,929	$415,876	$5,620
2006	$725,452	$8,436	$431,148	$5,906

Source: Helping Hand (1991-2006).

Table 9.1 Residents' engagement in home activities

Engagement in home activities				
Year	0 (frequently)	1 (sometimes)	2 (rarely)	Total
1990	22 (18%)	68 (56%)	32 (26%)	122
2006	18 (11.8%)	65 (42.8%)	69 (45.4%)	152
Total	40 (14.6%)	133 (48.5%)	101 (36.9%)	274

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-square	10.868	2	.004

Table 9.2 Activities engagement and related factors

	Activities engagement	
	Pearson correlation (r)	Sig. (1-tailed)
sex	.102	.046
mobility	.277	.000
urine incontinence	.269	.000
faeces incontinence	.262	.000
expressiveness	.304	.001
vision	.116	.028
hearing	.185	.001
age	.086	.078
cognitive ability	.396	.000

Table 9.3 Different types of activities in the Care Homes

Year	Total frequency of home activities				
	social	recreational	rehabilitative	educational	developmental
1992	212 (3.2%)	861 (13%)	4534 (68.4%)	804 (12.1%)	213 (3.2%)
1993	264 (4.2%)	726 (11.7%)	3514 (56.5%)	1327 (21.3%)	391 (6.3%)
1994	385 (7.7%)	716 (14.3%)	2786 (55.7%)	646 (12.9%)	465 (9.3%)
1995	259 (5.8%)	520 (11.7%)	2559 (57.4%)	819 (18.4%)	302 (6.8%)
1996	305 (6.2%)	650 (13.2%)	2581 (52.4%)	1004 (20.4%)	382 (7.8%)
1997	511 (10%)	912 (17.8%)	1987 (38.8%)	1280 (25%)	429 (8.4%)
1998	377 (7.8%)	590 (12.1%)	2375 (48.8%)	1054 (21.7%)	467 (9.6%)
1999	326 (6.6%)	507 (10.3%)	2323 (47.3%)	1249 (25.4%)	510 (10.4%)
2000	394 (7.9%)	562 (11.2%)	2254 (45%)	1349 (26.9%)	448 (8.9%)
2001	367 (6.4%)	645 (11.3%)	2876 (50.5%)	981 (17.2%)	828 (14.5%)
2002	268 (6%)	688 (15.4%)	1992 (44.6%)	917 (20.5%)	600 (13.4%)
2003	509 (12.1%)	842 (20%)	1331 (31.7%)	890 (21.2%)	631 (15%)
2004	529 (10.7%)	838 (16.9%)	1854 (37.3%)	1094 (22%)	652 (13.1%)
2005	454 (8.6%)	929 (17.6%)	1400 (26.6%)	1732 (32.9%)	756 (14.3%)
2006	535 (8.5%)	952 (15.1%)	2189 (34.8%)	1780 (28.3%)	842 (13.4%)

Source: Helping Hand (1991-2006).

Table 9.4 Helping others

	Helping others			
Year	0 (frequently)	1 (sometimes)	2 (rarely)	Total
1990	17 (14%)	63 (51.6%)	42 (34.4%)	122
2006	9 (5.9%)	27 (17.8%)	116 (76.3%)	152
Total	26 (9.5%)	90 (32.8%)	158 (57.7%)	274

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-square	48.820	2	.000

Table 9.5 Helping others and related factors

	Helping others	
	Pearson correlation (r)	Sig. (1-tailed)
sex	.090	.068
mobility	.315	.000
urine incontinence	.362	.000
faeces incontinence	.309	.000
expressiveness	.273	.000
vision	.044	.234
hearing	.172	.002
age	.140	.010
cognitive ability	.481	.000

Table 9.6 Willingness to help others

Willingness to help others				
Year	0 (frequently)	1 (sometimes)	2 (rarely)	Total
1990	17 (13.9%)	84 (68.9%)	21 (17.2%)	122
2006	14 (9.2%)	31 (20.4%)	107 (70.4%)	152
Total	31 (11.3%)	115 (42%)	128 (46.7%)	274

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-square	80.174	2	.000

Table 9.7 Willingness to help others and related factors

	Willingness to help others	
	Pearson correlation (r)	Sig. (1-tailed)
sex	.035	.281
mobility	.339	.000
urine incontinence	.410	.000
faeces incontinence	.383	.000
expressiveness	.290	.000
vision	.050	.205
hearing	.137	.012
age	.200	.000
cognitive ability	.514	.000

Table 9.8 Conversation with fellow residents

Conversation with fellow residents				
Year	0 (frequently)	1 (sometimes)	2 (rarely)	Total
1990	24 (19.7%)	67 (54.9%)	31 (25.4%)	122
2006	20 (13.2%)	47 (30.9%)	85 (55.9%)	152
Total	44 (16.1%)	114 (41.6%)	116 (42.3%)	274

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-square	26.038	2	.000

Table 9.9 Conversation with fellow residents and related factors

Conversation with fellow residents		
	Pearson correlation (r)	Sig. (1-tailed)
sex	.216	.000
mobility	.263	.000
urine incontinence	.346	.000
faeces incontinence	.324	.000
expressiveness	.409	.000
vision	.018	.380
hearing	.269	.000
age	.095	.058
cognitive ability	.476	.000

Table 9.10 Conflict with residents

Conflict with residents				
Year	0 (frequently)	1 (sometimes)	2 (rarely)	Total
1990	81 (66.4%)	36 (29.5%)	5 (4.1%)	122
2006	5 (3.3%)	23 (15.1%)	124 (81.6%)	152
Total	86 (31.4%)	59 (21.5%)	129 (47.1%)	274

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-square	1.787	2	.000

Table 9.11 Conflict with residents and related factors

	Conflict with residents	
	Pearson correlation (r)	Sig. (1-tailed)
sex	.065	.141
mobility	.143	.009
urine incontinence	.299	.000
faeces incontinence	.259	.000
expressiveness	.105	.041
vision	-.064	.144
hearing	.226	.000
age	.235	.000
cognitive ability	.349	.000

Table 9.12 Sociability level of residents

	Sociability level			
Year	0 (good)	1 (average)	2 (seldom)	Total
1990	24 (19.7%)	64 (52.5%)	34 (27.8%)	122
2006	11 (7.2%)	66 (43.4%)	75 (49.4%)	152
Total	35 (12.8%)	130 (47.4%)	109 (39.8%)	274

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-square	17.203	2	.000

Table 9.13 Sociability level of residents and related factors

	Sociability level	
	Pearson correlation (r)	Sig. (1-tailed)
sex	.117	.027
mobility	.319	.000
urine incontinence	.398	.000
faeces incontinence	.350	.000
expressiveness	.372	.000
vision	.016	.396
hearing	.138	.011
age	.073	.113
cognitive ability	.556	.000

Table 9.14 Conversation with staff

	Conversation with staff			
Year	0 (rarely)	1 (sometimes)	2 (frequently)	Total
1990	25 (20.5%)	74 (60.6%)	23 (18.9%)	122
2006	92 (60.5%)	52 (34.2%)	8 (5.3%)	152
Total	117 (42.7%)	126 (46%)	31 (11.3%)	274

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-square	46.743	2	.000

Table 9.15 Conversation with staff and related factors

	Conversation with staff	
	Pearson correlation (r)	Sig. (1-tailed)
sex	.045	.230
mobility	-.040	.256
urine incontinence	-.087	.075
faeces incontinence	-.150	.006
expressiveness	-.034	.289
vision	-.093	.061
hearing	-.164	.003
age	-.152	.006
cognitive ability	-.130	.016

Table 9.16 Conflict with staff

	Conflict with staff			
Year	0 (rarely)	1 (sometimes)	2 (frequently)	Total
1990	87 (71%)	30 (25%)	5 (4%)	122
2006	138 (90.8%)	11 (7.2%)	3 (2%)	152
Total	225 (82%)	41 (15%)	8 (3%)	274

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-square	19.323	3	.000

Table 9.17 Conflict with staff and related factors

	Conflict with staff	
	Pearson correlation (r)	Sig. (1-tailed)
sex	.003	.482
mobility	.030	.312
urine incontinence	.010	.434
faeces incontinence	-.042	.246
expressiveness	-.001	.492
vision	.082	.088
hearing	.043	.241
age	-.021	.362
cognitive ability	.026	.335

Table 9.18 Visits by relatives

Visits by relatives					
Year	0 (rarely)	1 (sometimes)	2 (frequently)	3 (not applicable)	Total
1990	24 (20%)	59 (48%)	31 (25%)	8 (7%)	122
2006	56 (37%)	59 (39%)	37 (24%)	0 (0%)	152
Total	80 (29.2%)	118 (43.1%)	68 (24.8%)	8 (2.9%)	274

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-square	18.264	3	.000

Table 9.19 Visits by relatives and related factors

Visits by relatives		
	Pearson correlation (r)	Sig. (1-tailed)
sex	.037	.269
mobility	.100	.185
urine incontinence	.060	.162
faeces incontinence	-.006	.462
expressiveness	.079	.097
vision	-.129	.016
hearing	-.108	.037
age	-.122	.022
cognitive ability	-.007	.457

Table 9.20 Social participation of residents

			Mean	
	t	Sig. (2-tailed)	1990	2006
helping others			1.20	1.70
activity engagement	-3.101	.002	1.08	1.34
willingness to help others	-7.780	.000	1.03	1.61
conversation with residents	-4.376	.000	1.06	1.43
conflict with residents	-22.100	.000	.38	1.78
sociability level	-4.267	.000	1.08	1.42
conversation with staff	7.220	.000	.98	.45
conflict with staff	3.417	.001	.40	.11
visits by relatives	3.231	.001	1.19	.88