

A Response to the Healthcare Reform Consultation Document

“Your Health, Your Life”

Brain Health United

June 11, 2008

To further advance research and services related to the diagnosis, management and care of Alzheimer's disease, the Faculty of Health and Social Sciences of The Hong Kong Polytechnic University (PolyU) and the Hong Kong Alzheimer's Disease Association (HKADA) joined hands in June 2005. Through this collaboration, we seek to improve the community's awareness of Alzheimer's disease and provide better service for the local community. We call ourselves Brain Health United (BHU; Appendix 1). This response document (hereafter called as the Response) is prepared based on this background.

BHU applauds the vision of the Food and Health Bureau to achieve a healthcare system that improves the state of health and quality of life of the people of Hong Kong. We agree with the Bureau that it is essential to develop better primary care for the local community in order to realize its vision. We support in principle the Bureau's proposal that the community of Hong Kong needs to formulate some kind of supplementary financing arrangements in order to render our healthcare system sustainable, albeit at this stage we do not have sufficient information to indicate our preference for a particular financing model.

However, there are a few concerns that BHU would like to advocate on behalf of those unfortunate enough to be suffering from cognitive impairment and their families, and to bring to the attention of the Bureau as it maps out the future of our healthcare system. We observe from the Consultation Document (hereafter referred to as the Document) that there is:

1. a lack of appreciation of the different nature of needs among local populations;
2. an emphasis on choosing a financing model; but a lack of appreciation for those who may not be able to look after their own business;
3. an emphasis on primary care, but primary care is mainly defined as medical or clinic services rendered to the public;
4. in terms of services – a lack of due recognition and support of the contribution made by family carers in long-term care; and
5. in terms of policy – a lack of consideration of the financing model for long-term care.

The discussion below details our views and position.

1. The lacking of appreciation of the different nature of needs among local populations

1.1 Dementia is not on Hong Kong's health and social policy agenda

Scientific reports inform us that dementia is quickly becoming the new epidemic in the years ahead, simply because of the sheer number of people who may develop dementia in view of global ageing.¹ Many advanced countries have already put dementia on the health policy agenda: to name a few, France, the United States (US), and Australia. Yet, the impact of global ageing and dementia has not been recognized by the Hong Kong SAR government. Dementia is not on our health and social policy agenda. There is limited awareness of the challenges that we are going to face in the near future. Based on their study in 2006, which observed a rate of 9.3% or dementia prevalence in those aged 70 and over, the Department of Health, Hong Kong, projects that 240,000 persons who are 70 years old and above will be afflicted in Hong Kong in 2036.² Ferri et al. (2005) report that by 2040, the global prevalence of dementia will become 81.1 million.³ The rate of increase from 2001 to 2040 is estimated as 234%, and this will be three to four times higher in developing countries, e.g., many Asian countries.

1.2 Integrative versus specific care

Over the years, local health and social policy has adopted a “one-size-fits-all” approach. All elderly people in need are treated similarly in various types of service provision, for instance, criteria for eligibility of services. In terms of services for elderly people, there is limited, if any, differentiation among those with special needs, such as those with cognitive impairment. Those who may require special care are expected to be covered under the general provisions for elderly people.

However, we do need specific care for the people with dementia and their families, for the following reasons:

- 1.2.1 Their impaired cognition but relatively well preserved social and activities of daily living (ADL) skills renders it difficult for people without training or experience to notice the problems. The Minimum Data Set-Home Care is used for the Standardised Care Need Assessment Mechanism for Elderly Services

(SCNAMO), but it is unable to identify relevant problems in those with dementia, thus leading to erroneous conclusions about placement needs, rendering those with dementia and their families unable to obtain timely support. The SCNAMO may be good at identifying general problems, but is not suitable for assessing dementia care needs.

1.2.2 An impaired cognitive status calls for 24-hour supervision. Impaired cognition renders a person unsafe to live alone without supervision and support. A stove may be forgotten and left on, giving rise to fire hazards. Other sick or disabled individuals with intact cognition do not need such intensive supervision. As such, the needs of those with dementia and their families must be duly considered.

1.2.3 People with impaired cognition have poor judgment. Their words and actions often alienate those around them who do not understand dementia as an illness. Even if others do understand, it is a tremendous undertaking to tolerate the sometimes bizarre behaviour of those with dementia. So-called integrative care (such as putting demented and non-demented people in the same day care centre or nursing home) can easily lead to discrimination and the isolation of those suffering from the disease. Upholding the equity principle in providing care does not necessarily mean treating everybody in an equal manner (i.e., same nursing home with same provisions). Providing the same kinds of services to those who are physically and cognitively impaired can not be said to be in tune with their healthcare needs.

In summary, integrating the care of those with dementia with those who suffer from other problems is not optimal care, which the Bureau intends to achieve in the future. While acknowledging a certain level of integration is desirable, BHU advocates for specific care for those with dementia. Their specific needs must be recognized and catered for.

2. An emphasis on choosing a financing model, but a lack of appreciation for those who may not be able to look after their own business.

The Document discusses how we should develop quality services for Hong Kong society. On this principle we can easily identify with the Bureau. Yet the focus of discussion

for the Document is about healthcare financing, rather than a holistic model of health and healthcare services. Six different financing models are proposed for discussion by the general public. Presently, BHU supports the principle of developing a new financing model to enable our present system to stay viable in the long run. We need more details of these six financing models for further deliberation amongst ourselves and those we serve.

We observe that the Document presents itself as if everyone in our society can make rational decisions in our society. Not everyone among us has the capacity to make “rational” decisions, for instance, those who are cognitively impaired.

An individual with cognitive impairment to the extent that affects his or her mental capacity will not be able to make use of, for instance, their Medical Savings account (or whatever account or policy they have opted for, for that matter). Nowhere in the Document is there a discussion of mental incompetence, and the protection that will be available for this individual. We would like future discussions on local healthcare reform to include discussions on the provisions for and protection of those who may be mentally challenged or incompetent.

3. An emphasis on primary care – but primary care is mainly defined as medical or clinic services rendered to the public

The Document has rightly identified that there is insufficient emphasis on holistic primary care, and has devoted an entire chapter (Chapter 2) in the discussion of how to enhance primary care. Disappointingly, primary care, as depicted in the Document, is mostly refers to services, and mainly clinic services, provided by doctors. Primary care health professionals other than physicians, such as nurses, optometrists, and other health care disciplines, need to be better recognized and utilized. In fact, they are well utilized in advanced countries such as Canada. Nurses are valued by the WHO as the largest asset in primary care. In America, the cost-effectiveness of utilizing nurse practitioners has been repeatedly evidenced by research findings.

Regardless of what type of financing model is used or we structure our primary care services in the future, we would like to point out that it is often those who are marginal (old and with multiple chronic illnesses) or disadvantaged (e.g., the less educated) who suffer

most. Not that the safety net or primary care services mentioned in the Document do not include them, but that their problem-solving ability may be compromised and they may not know how to seek help. According to the Census and Statistics Department, 39% among those aged 60 and above had only primary education while 30% had no education.⁴ When reforming our health care system, the needs of these groups need to be attended to, so that they too can enjoy the better quality of health envisioned for all by the Bureau.

BHU stresses that primary care should be considered more fully than just as the accessibility of services, or the provision of clinics, or the electronic networking and liaison between the public and private sectors. To effectuate a more cost-effective primary care model, the input of health disciplines other than medical doctors must be solicited.

4. In terms of services – a lacking of due recognition and support of the contribution made by family carers in long-term care

The burden of family caregiving in chronic illness is well recognized by researchers as well as clinicians. Regrettably, Government recognition of family carers' contribution in supporting their loved ones is very limited.⁵

The odyssey that families have to go through in caring for someone with dementia is unlike for those who are caring for relatives with physically disabling disorders. Studies have found dementia carers to be more involved in terms of caregiving hours per week than carers of those who are non-demented. They were also noted to experience greater strain and stress,⁶⁻⁹ and of poorer mental and physical health.⁹⁻¹¹ Local studies report a similar phenomenon.¹² Providing care to people with dementia is widely known as having a “36-hour” day.¹³

Many of those suffering from Alzheimer's disease or dementia live for about seven to eight years after the appearance of early symptoms. Some may live for up to twenty years. Family support is crucial to the cost-effective long-term support of afflicted individuals. Binstock reports an Italian study which found that unpaid care by family members accounts for 60% of long-term care costs.¹⁴ By supporting their families such as by providing carer allowance, in-home care, subsidy of the cost of drugs (or to be reimbursed by future insurance), and more day care places, we can allow people with dementia to age in place (at least as long as they

possibly can), families can look after their loved ones (of whom many only resort to institutionalization as a final measure), and our society can cut down on the cost of financing long-term care. It is a triple-win situation that must be considered. Developed countries such as Ireland and Australia provide a carer's allowance, while US family carers can apply for tax exemption. These are some of the measures that the Bureau can consider in support of family caregiving.

5. In terms of policy – a lack of consideration of the financing model for long-term care

The Document states that “After finalizing the reform and supplementary financing proposals to be taken forward, the Bureau will further examine the necessary policies and measures to develop and enhance specific areas of healthcare services, ...” (p.107). Long-term medical care is one of specific areas mentioned. We would like to point out that long-term medical care does not equate long-term care. Long-term care is much broader in scope than just long-term medical care, just as primary care is much more than clinic services.

Long-term care costs can rise at a rate much faster than inflation.¹⁴ These costs will quickly use up the savings of elderly people needing such care, except for those who are wealthy. Moreover, these costs often place substantial financial burdens on their adult children.¹⁴ We also consider it important for the Government to consider insurance for long-term care at home, in nursing homes, or in other residential care settings. When considering different models for financing our health system, the reality of the magnitude of long-term care cost needs to be adequately spelled out. This is not explicitly discussed in the document.

A summary of our proposal

BHU supports in principle that supplementary financing arrangements will be essential to render our healthcare system sustainable. Presently, we do not have sufficient information about these financing models to deliberate among our group or with those who suffer from dementia and their families.

BHU observes that the Document lacks an appreciation of the magnitude of the problems associated with the prevalence of dementia in an ageing population. Dementia needs to be put on Hong Kong's health and social policy agenda now. There is no time to

lose as globally there is one new case every seven second.¹⁵ The people with dementia have specific needs and provisions must be made for specialized rather than integrative care, although some level of integration would be beneficial. Families of people with dementia must be duly recognized and supported, so that in turn they can support their loved ones as long as they can in the community.

We also observe that the healthcare model described in the Document has a narrow definition of primary care and the accessibility of services. Health professionals other than family physicians (e.g., nurses, social workers, optometrists) must be structured as an integral part of the primary care team. Their professional expertise must be put to good use. We would like to see more details of the six financing models proposed, other than discussion of the pros and cons of each model. Long-term care costs (costs incurred for in-home, in nursing homes, or in other residential settings) for an ageing population must be taken into consideration when contemplating a new financial model for health care.

We are attaching a summary of concerns raised by the participants of a seminar on April 21, 2008 - "Let's put dementia on the agenda," of which BHU was a co-host (Appendix II). The participants were professionals working in the long-term care field, including nurses, social workers, occupational therapists, and the like. There were also quite a number of family carers voicing their plea and plight. Their suggestions were therefore highly relevant and practical. We believe this appendix could be of importance to the Bureau when considering the delivery of quality services, which is another dimension emphasized in the Document.

Concluding our response

Stephen Post, a prominent American bioethicist, emphasized that "dementia is a problem of the highest order for all those who reflect on the human condition and the future".¹⁶ We earnestly and sincerely hope that the Bureau, now reflecting on the future, and on the condition of the people of Hong Kong, will incorporate dementia as an item of top priority on its agenda. We can only move in the right direction when we know where we should be heading.

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Portable Multi-sensory Stimulation System 手提多感官刺激系統

This project resulted in the development of a portable, integrated, multi-sensory stimulation apparatus for elderly people suffering from dementia. It provides users with a variety of stimuli including cognitive, visual, olfactory, tactile and auditory stimuli by making use of memory games, optical fibres, a projector, an aroma diffuser, magic tactile boards and an audio delivery system. Dr Raymond Tong and his students have won the Diamond Award of Innovation Winner (the highest honour) in the PolyU-IDT Innovative Entrepreneur Contest in 2006.

這個項目是要為患癡呆症的長者研發一具手提、綜合和多感官刺激的儀器，通過運用記憶遊戲、光纖、投影器、氣味擴散器魔術觸板以及聲音傳遞系統，提供多種不同的刺激，包括知覺、視覺、嗅覺、觸覺和聽覺的刺激。湯啟宇博士及其學生更於二零零六年憑此系統勇奪「理大萬威科技創業擂台陣」的鑽石創意大獎。

Early Detection Programme for Probable Dementia 癡呆症的早期檢測計劃

The number of elderly people suffering from dementia is increasing, and there is thus a pressing need for early identification of probable dementia. This programme, coordinated by Dr Jenny Chung and team, aims to enable early identification of older people who are at risk of dementia or mild cognitive impairment (MCI) and promote awareness of brain health among the elderly and the general public. We provide neuropsychological tests examining the mental state, attention, memory, visual spatial ability, and functional assessments to at-risk adults. Educational seminars

are delivered to elderly service organizations. Exhibitions are also held to raise the public's awareness and understanding of cognitive aging and brain health.

老人患癡呆症的人數正在上升，因此迫切需要盡早鑒別出疑似患者。這項由鍾晶晶博士率領的小組所協調的計劃的目的是盡早識別有患上癡呆症潛在風險或輕度認知障礙的長者；並且向長者和公眾推廣對腦健康的認識。我們向有潛在風險的成年人提供精神心理測驗，檢查精神狀態、專注力、記憶、視覺空間能力和功能評估。向為長者服務的機構提供教育研討會，舉辦展覽，提高公眾對認知老化和腦健康的認識和了解等，也是此計劃的一部份。

Support for Patients with Mild Cognitive Impairment (MCI)

輕度認知障礙患者的支援

In view of the lack of services for people with MCI, as well as wanting to enhance our members' understanding of memory problems, MCI and dementia, Mrs Teresa Tsien and team set up an 8-session informational/support group to serve patients with MCI. This group will explore members' concerns, assist members in developing their own support systems, provide training in memory-enhancing strategies and related cognitive skills, and introduce community resources for resolving problems that may arise with a diagnosis of MCI. Recruitment of interested participants is underway.

鑑於輕度認知障礙患者缺乏服務、和希望加強成員對記憶問題之了解，錢黃碧君女士及其率領之團隊成立資訊/支援小組，為輕度認知障礙的患者提供為期八次的服務。小組會探求參加者的需要、協助他們訂定出個人的支援系統，在強化記憶策略及相關的知覺技巧上提供培訓，為診斷出輕度認知障礙患者解決可能出現的問題，為他們引進社區資源。招募有興趣參加人士的工作已經展開。



BRAIN
智 HEALTH
聯 UNITED



Background 背景

The Hong Kong Polytechnic University (PolyU) and Hong Kong Alzheimer's Disease Association (HKADA) share a common concern over the issue of elderly health in the local community. To further advance the research and services related to the diagnosis, management and care of elderly people with Alzheimer's disease, the Centre for Telehealth and Telecare of the Faculty of Health and Social Sciences of PolyU and HKADA joined hands and signed a collaboration agreement on 2 June 2005. Through this collaboration, we seek to improve the community's awareness of Alzheimer's disease and provide better service for these patients. We call ourselves Brain Health United.

香港理工大學和香港老年痴呆症協會對本地長者的健康問題均表示關注。為了進一步推動和改善與老人癡呆症的診斷、管理和護理相關的研究和服務，香港理工大學醫療及社會科學院遙距健康及護理中心與香港老年痴呆症協會攜手合作，在二零零五年六月二日簽定合作協議。通過合作，我們致力提升公眾對老人癡呆症的認知以及向患者提供更好的服務。我們將此稱為智聯。



Our Vision 我們的抱負

- To promote brain health for the people of Hong Kong and neighbouring areas
促進香港及鄰近地區居民的腦健康
- To develop a holistic model of care that is humanistic, scientific, and accessible to people with dementia and their families
為癡呆症患者及其家人，致力研發結合人性、科學和易使用特點的全面護理模式

Our Mission 我們的使命

- To promote brain health for the people of Hong Kong through interdisciplinary collaborative endeavours at all levels in research, service, product development, and education
通過各專業的共同努力，在研究、產品研發和教育所有層面上協作，促進港人的腦健康
- To promote and establish a stigma-free society for people with dementia and their caregivers through social, cultural, technological, and educational strategies
通過社會、文化、科技和教育各項策略，推動建立一個對癡呆症患者及其家人沒有歧視的社會
- To advance quality and appropriate care for people with dementia and their families in the community using state-of-the-art information and communications technology
利用尖端的資訊和通訊科技，在社區層面為癡呆症患者及其家人提供優質和適當的照顧
- To provide health care professionals with advanced training in state-of-the-art dementia care
為醫療衛生服務的專業人員在癡呆症患者及其家人的照顧上提供先進的培訓

Our Values 我們的價值觀

- To grow and develop in the spirit of sharing and collaboration
以分擔和合作的精神成長和發展
- To move forward based on premises that are ethically-driven
以道德為據向前邁進
- To uncover knowledge out of a love of knowledge and to deliver service out of a passion to serve
愛學問以求知，熱誠服務社群
- To excel in our work out of an aspiration to learn and to apply our knowledge for the benefit of those suffering from dementia and their families
懷着學以致用、造福癡呆症患者及其家人的志向，不斷優化我們的工作

Current Projects 現有計劃

Dementia Patient Management in Acute Care Setting

癡呆症患者在急症服務的照顧

Besides enhancing continuity during transitional care and prioritizing special patient groups, the project on dementia patient management in acute care will provide guidelines for staff and improve their ability to recognize dementia and related elements. It will also advocate sufferers' rights to necessary treatment and emphasize early detection, as well as exploring patients' issues with dying. Complications and unnecessary hospital stays should be minimized as a result.

本計劃的重點在於促進癡呆症患者在急性醫療服務的過渡期照顧。除了按優先次序分配的特殊類別病人的服務外，本計劃強調服務的持續性，並為醫療服務人員提供服務指引，加強他們對癡呆症的認識。同時亦會提倡重視及早發現疾病和患者應得治療的權利及探求患者與死亡相關的問題。複雜和不必要的留院應盡量避免。

Care of Confused Patients 照顧精神紊亂病患者

Dr YM Wu and team are developing a delirium screening tool for early detection of acute confusional state (ACS) among patients in extended care hospitals. The project team also wants to advocate that alterations in mental state be treated as an additional "vital sign" to be routinely monitored by nursing staff and clinicians. A multi-component intervention strategy will be developed to improve the care of these patients. Last, the team will follow up the short- and long-term cognitive functioning and neuropsychiatric symptoms of patients, and identify factors affecting the outcome of ACS.

吳義銘醫生及其小組成員正在開發一個協助醫護人員盡早檢測急性精神紊亂的評估工具。小組提倡把精神狀態納為生命表徵(vital signs)的其中一項表徵，醫護人員需要當作常規評估。小組同時會研發一個從多方面介入的照顧模式，改善對這類病人的照顧。最後，小組會跟進病者的短期和長期認知功能及神經精神徵狀；並且識別影響急性精神紊亂後果的因素。

Appendix II (附錄 II):

「將老年痴呆症納入議程」社會政策研討會 - 與會者意見

日期 : 21 / 04 / 2008 (星期一)

地點 : 香港理工大學

參加人數 : 90 位。參加者包括患者家屬、醫生、護士、社工、職業治療師等專業人士，大學講師及學生、非牟利機構代表、志願工作者、公眾、和記者。

一直以來，本地的社會福利政策，把所有長者服務均一體化。老人痴呆症的患者及家屬所需，並沒有受到適切的照顧。本論壇建議設計服務及落實政策時，考慮老年痴呆症患者及其家人的特別需要。

1. 長期服務的社會服務政策

1.1 現有整合模式的缺點 (本文的「整合模式」指“Integrated service”而「痴呆症模式」指“Special care”。)

- 院友互不相讓
- 患者常被約束而引發暴力傾向
- 家人感無助不安
- 院方常接投訴，很難解決，沒完沒了；有此甚至放棄患有痴呆症長者。
- 職員疲於奔命，引致欠缺耐性，引起衝突。
- 患者初入住院舍不被允許陪伴過夜，使患者難以適應。

1.2 在院舍實施老人痴呆症模式的好處與會人士在討論過程中所發表的意見，綜合如下：

可獲三贏局面

- 痴呆症長者不被歧視：
 - 。 不被責罵，有自由的空間去活動，減少被約束的機會及時段;以合適的環境，設計，活動及人手配合。
- 家人：
 - 。 安心把家人安置在此院舍。家人與院舍職員互相、明白彼此的難處，互相支援及諒解。

- 院方：
 - 減少被投訴的情況，獨特設計，方便照顧如遊走徑，不同顏色的指示或引路徑等。
 - 集中招職及培訓「專業」之職業去護理長者，及為患者設計活動，不用分心，照顧正常長者。

1.3 政府資源或撥款應同時惠及私營安老院舍

- 家庭護老者，院舍，職員同樣在照顧上有一定的困難及需要。
- 家庭：撥款支助長者，讓長者可接受日間護理或兼職傭工之服務(NGO 及私營安老院均可)，可減低壓力。
- 鼓勵私營安老院開發多些服務，以補政府的不足。
- 增加老人精神科痴呆症之門診服務。
- 提高傷殘津貼金額。

1.4 應投入資源，建立新的服務模式。

- 特別是日間照顧、晚間照顧及增加日間照顧的彈性。
- 目前輪候時間長。
- 開設專為痴呆症患者而設的院舍或日間中心，不分私營或政府資助非牟利的機構。
- 長者只要證明患有此病症便可接受服務
- 應獲醫院提供外展醫護服務，因痴呆症較難外出診治及配藥時間較長，職員或家人很難控制患者。
- 可設添購治療設施補助金：向痴呆症院友提供治療活動，如音樂、懷緬等。

2. 現有的政策上不足之處提供特別服務，如提高補助金，加快獲得地區中心服務的時間

- 大部份長者服務，不適用於未滿 65 歲的患者。但早發性痴呆症的患者所需要的支援更多。
- 統一評估機制使用的評估工具，未能針對痴呆症患者的需要作出適切的評估，以致未能為患者配對合適切的服務及支援。社工、尤其是「安老服務統一機制」之評估員，勿把痴呆症患者勾出安老院候名單外，重檢評估工具，以配合適切的評估。
- 目前院舍申請 Dementia Supplement 的計算方法，只有少部份十分嚴重的患者才被計算在內，給予院舍補貼。

3. 患者家屬的支援

3.1. 經濟支援

- 為患者增加傷殘津貼及補貼金
- 設立照顧者津貼提供特別服務，如提高補助金，加快獲得地區中心服務的時間

3.2. 申請外地傭工需時 3 至 4 個月，能否縮減？

4. 醫療架構及政策

4.1 急症護理

- 先要整理及檢討現有醫管局的急症室流程，因各醫院可能有所分別
- 有些觀察期長達 5 小時，才獲安排送上病房或送回院舍或返家，期間醫院不負責看管，要由患者家人或院舍職員負責，不准離開(包括如廁及用膳)，否則被罵。
- 負責分流的護士，未必懂得分辨痴呆症病患，如有證明，可建議分流往快診之隊列及縮短觀察期。

4.2 留院安排

- 患者於住院期間，會因環境陌生而引起混亂及不安情緒，醫院有時為了防止患者遊走而進行約束，這更加深其不安 / 激動情緒。
- 當家人提議陪同患者留院以避免擾人情況，往往遭到拒絕。
- 為患者設彈性探訪時間。

4.3 老人精神科服務不足

4.4 多提供早期測檢服務、及早診治。

5. 專業 / 社區培訓

5.1 再培訓局可考慮增設有關痴呆症照顧之訓練課程，因當家人需人手協助時，一般家務助理未能足以勝任。

5.2 應加強各方前線同工對痴呆症的知識，家人面對的困難不只是金錢或資源，同時亦要面對服務機構有些不妥善的安排。

5.3 政府應透過傳媒增加宣傳，讓市民提高警覺，並與區議會合作宣傳，如派發單張，在全港推行評估日，簡介日。

5.4 教署應到學校作推廣

- 透過通識教育讓學生有初步認識
- 與家長教師會合辦研討會及分享會
- 跨部門組成專責小組，制定政策，研究及制定標準模式
- 設資源中心

6. 其他

- 交通服務十分重要，但這方面支援不夠。
- 很多研究撥款均集中於醫學方面，對照顧者的支援及撥款則不足。
- 獨居的病患者，特別需要支援。

總結:

加拿大在 12 年前已把痴呆症確立為特別的議題，與其他服務分開討論、策劃。對於痴呆症的普及和照顧等各方面的問題，政府、私營機構和社會大眾均有責任。現在很多家庭只生一個小孩，將來的患者會缺乏家人照顧，香港現在就要為將來籌謀。