

**For discussion
on 11 January 2010**

**Legislative Council Panel on Welfare Services
Consultancy Study on Residential Care Services for the Elderly
Initiated by the Elderly Commission**

Purpose

This paper outlines the key findings and recommendations of a consultancy study initiated by the Elderly Commission (EC) on Hong Kong's residential care services for the elderly.

Background

2. Against the backdrop of a rapidly ageing population, increasing the supply of subsidised residential care places alone will not be sufficient to meet the ever-growing long-term care (LTC) needs of the elderly. To address this problem, EC has commissioned the University of Hong Kong to examine the following :

- (a) how to target subsidised residential care services at elders most in need;
- (b) how to promote further development of quality self-financing / private residential care services; and
- (c) how to encourage shared responsibilities among individuals, their families and society in meeting the LTC needs of the elderly.

Study methodology and findings

3. The consultant team has reviewed international experiences and trends in the provision of LTC services, conducted a survey covering

about 4 000 elders and carers, interviewed local stakeholders including non-governmental organisations (NGOs) providing elderly services, operators of private residential care homes for the elderly (RCHEs), and relevant government bureaux and departments. The study report is at **Annex** for Members' reference. The key findings are summarised below :

- (a) it is a global trend to promote “ageing in place” and provide support services or subsidy to enable elders to age at home rather than in RCHEs;
- (b) in places where the tax rates are relatively low, LTC services are usually provided on a selective basis and, in many cases, through means test or financial assessment;
- (c) elders' institutionalisation rate (i.e. percentage of elders staying in RCHEs) in Hong Kong is relatively high compared to that in other countries, whereas the utilisation of community care services is very low. There is thus room for enhancing and promoting such services; and
- (d) implementing a voucher scheme for residential care services is likely to induce substantial demand for residential care places, resulting in premature or unnecessary institutionalisation.

Recommendations

4. Having considered carefully the policy options, the consultant team has made three recommendations.

(a) *Devising a viable and sustainable LTC financing model*

5. At present, elders who pass the standard care need assessment¹

¹ Under the Social Welfare Department's Standardised Care Need Assessment Mechanism for Elderly Services (SCNAMES), an internationally recognised assessment tool is used to ascertain the care needs of elders and match them with appropriate services. The assessment covers the elders' abilities in activities of daily living, physical functioning, memory, communication, behaviour and emotion, as well as their health problem, environmental risk and coping problem, etc.

(i.e. the frailty test) can, irrespective of their financial means, apply for heavily subsidised LTC services. With a rapidly ageing population, growing life expectancy and low-tax environment in Hong Kong, the current financing model will not be sustainable in the long run. The consultant therefore recommends that the Government should direct limited public resources to elders most in need by introducing a selection mechanism, such as a means test, for the provision of subsidised LTC services. This idea was supported by the majority of elders interviewed by the consultant, also for the reason that limited public resources should be allocated to people most in need.

(b) Re-considering the service matching mechanism

6. At present, elders assessed to be eligible for subsidised LTC services will be given a service recommendation, denoting the type of services they can receive. There are three types of service recommendation, namely, residential care services only, community care services only, and “dual option” (i.e. either residential or community care services). Over 50% of the eligible elders are given the “dual option”. However, for various reasons, over 90% of them choose residential care.

7. The predominant preference for residential care places goes against the global trend and HKSAR Government’s policy of promoting “ageing in place”. To ensure that the very limited subsidised residential care places will be allocated to elders most in need, the consultant recommends adjusting the existing service matching mechanism such that “dual option” holders will be encouraged, or even required, to use community care services² before choosing residential care services. Such an approach will not only help promote the use of community care services, but also shorten the waiting time for residential care places. Nevertheless, considering that the existing community care services are still under-developed, and that the private market for providing such services is far from mature, the consultant considers that the recommendation should not be taken forward until the community care services are enhanced to such an extent that they become a viable alternative to residential care.

² Subsidised community care services are designed to support frail elders who age at home. Services include meal delivery, personal and nursing care, rehabilitation exercises and housekeeping, etc.

(c) Further development of community care services

8. In the survey conducted during the study, most respondents agreed that community care services could help elders stay at home. Nevertheless, there are concerns that the existing community care services are not comprehensive enough to address the needs of elders. The consultant therefore recommends expanding the service scope and adopting a more flexible mode of service delivery so that, apart from conventional welfare NGOs, social enterprises and private operators can also be service providers. Also, better synergy can be achieved in the provision of social and medical services, and a holistic and integrated approach should be adopted in serving elders in need.

9. As carers (including family members and domestic helpers) play a key role in looking after elders at home, support services for carers should also be strengthened.

Way forward

10. In view of the consultant's recommendation to further develop community care services, EC has decided to conduct a more in-depth study on possible service enhancement, including a more flexible and diverse mode of service delivery, e.g. by involving private or social enterprises as service providers, with a view to further encouraging elders to age in place and thus avoid premature and unnecessary institutionalisation.

Advice sought

11. Members are invited to give their views on the consultant's findings and recommendations.

**Labour and Welfare Bureau
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Elderly Commission's Study
on
Residential Care Services for the Elderly

Final Report

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CHAPTER 1

Executive Summary

Residential Care Services for the Elderly in Hong Kong

At present, there is a mix of public and private provision of residential care services (RCS) for the elderly in Hong Kong. As RCS are not provided within the administrative structure, subsidised services are provided by non-governmental organisations (NGOs) or private operators with funding from the Government while elders may also choose to take up RCS offered by private or self-financing operators. The ageing population and the consequential growing demand for RCS have called into question the sustainability of the current system.

The Study

2. Arising from the recommendations of the former Commission on Poverty regarding the waitlisting situation of subsidised RCS, the Elderly Commission (EC) has looked into the key issues involved and has engaged our Team to conduct a consultancy study to explore the following aspects-

- (a) how to target subsidised RCS at elders most in need; and
- (b) how to promote further development of quality self-financing / private RCS and encourage shared responsibilities among individuals, their families and the society in meeting the long-term care (LTC) needs of the elderly.

3. In conducting the consultancy study, we have reviewed relevant local and overseas literature and conducted face-to-face and telephone interviews with stakeholders including elders (aged 65 or above), soon-to-be-old (those aged 45 – 64), NGOs, private operators of residential care homes for the elderly (RCHEs), Government officials and the public at large. In total, over 3 500 elders and soon-to-be-old were interviewed. 15 NGOs and 2 associations representing private RCHEs

also contributed to the study. Please see Chapter 2 for details of the research methodology.

International Trend

Ageing in place

4. In Chapter 3 of the report, we have examined in detail the overseas experiences in the provision and financing of LTC services. In particular, we observe that it is the common objective of governments worldwide to promote “ageing in place” with a range of policy tools such as the provision of cash and in-kind subsidies. The policy direction is consistent with the wishes of the majority of elders who would prefer to age at home rather than being institutionalised. Recognising that the Hong Kong Government and the Elderly Commission share similar vision in promoting “ageing in place”, we note with caution that the institutionalisation rate in Hong Kong is relatively high as compared with other developed countries.

Selective provision of publicly-funded LTC service

5. At present, Hong Kong adopts a publicly funded and non-selective model in the provision of subsidised RCS to its population. We note that countries which adopt a publicly funded model such as the United Kingdom have commonly put in place means-test mechanisms to target their resources at the most in need. Given the ageing population and the increasing morbidity of our elderly population, we have grave concern on the sustainability of universal provision. It is also worth noting that our respondents were generally supportive of a selective mechanism to ensure the efficient allocation of limited public resources.

Policy Options

6. To meet the LTC needs of our ageing society in a sustainable manner, we have formulated a number of policy options and assessed their pros and cons. These options may be adopted in combination as they are not mutually exclusive.

(1) Status quo - increasing the provision of subsidised residential care places at the current pace

7. Should subsidised residential care places be increased at the current pace, it is likely that the waiting time for subsidised RCS can be kept at a certain level in the short to medium term. But as the population keeps on ageing, it is inevitable that the new supply would not be able to catch up with the ever growing demand.

(2) Adjusting the “dual option” arrangement

8. Since 2000, the Government has implemented the Standardised Care Need Assessment Mechanism for Elderly Services (SCNAMES) to assess the care need of applicants for subsidised LTC services and to ascertain their eligibility. Under the mechanism, an internationally recognised assessment tool is adopted to ascertain the care needs of elders and match them with appropriate services including “RCS only”, “CCS only” or “dual option” (i.e. either RCS or CCS). When presented with the “dual option”, we note that over 90% of the applicants would choose RCS although the overwhelming majority of our elders had expressed their preference to stay at home¹. To allow elders and their carers better understanding of CCS, a mandatory trial period for CCS could be introduced before those with a “dual option” would be offered RCS. This option can help reduce substantially the waiting time for subsidised RCS, and ensure that the subsidised residential care places are allocated to elders most in need.

(3) Introduction of a means-test mechanism

9. The introduction of a means-test mechanism would help the Government focus its limited resources to those who are most in need and shorten the waiting list for subsidised residential care places in the longer term. The idea was also supported by the majority of the survey respondents. We have attempted to assess the impact of a means-test mechanism on the waiting time for subsidised RCS. If we make reference to the income limit adopted by the Hospital Authority under the

¹ According to the Thematic Household Survey Report No. 40 on Socio-demographic Profile, Health Status and Self-care Capability of Older Persons, only 3.6% of the older persons residing in domestic households had an intention to move into a local RCHE.

Medical Fee Waiving Mechanism of Public Hospitals, the waiting list for subsidised RCS would only be shortened slightly, although its effect would become more significant in the longer term.

(4) A mean-tested voucher scheme for RCS

10. With a view to promoting further development of quality self-financing/private RCS and encouraging shared responsibilities among individuals, their families and society in meeting the LTC needs of the elderly, we have explored the feasibility of introducing a voucher scheme for RCS. From our research, we note that there are various examples of voucher schemes for CCS in other developed countries, in order to encourage their elders to age in place or care-givers to take care of the elders in their own homes. However, we note that cash subsidy for RCS is extremely rare worldwide.

11. Given the inherent nature of voucher in inducing demand, we have reservations, as with other developed countries, on a voucher scheme covering only RCS as this could inadvertently encourage pre-mature or unnecessary institutionalisation, thus seriously undermining our policy objective of promoting “ageing in place” and creating additional burden on public resources. This view is generally shared by the NGOs that have been interviewed.

12. Please see Chapter 4 for details of the policy options and assessment.

Recommended Directions

13. Having reviewed the international experience, the information collected from the surveys and interviews, and assessed the impact of various possible policy options, we recommend the following directions for EC’s consideration -

- (a) to consider putting in place a proper means-test mechanism to target subsidised RCS at elders who have genuine financial need;
- (b) to consider the introduction of a mandatory trial period for CCS

for those who are offered a “dual option” under SCNAMES; and

- (c) to consider expanding the scope and coverage of CCS with the participation of social enterprises and the private sector which should be the pre-requisite for the introduction of any voucher scheme for LTC services.

Please see Chapter 5 for details of the above recommendations.

Other Issues

14. In this study, we have also identified a number of pertinent issues which would have a significant bearing on the provision of RCS. These issues include the manpower provision of medical, para-medical and care professionals, the quality assurance of RCHEs (especially, private RCHEs), and the provision of nursing home places. Please see Chapter 5 for details.

CHAPTER 2

BACKGROUND OF THE STUDY

THE NEED FOR REVIEW

Ageing population and rising long-term care (LTC) needs

15. Like other advanced countries, Hong Kong is being gradually confronted with the challenges posed by an ageing population, against a background of decreased fertility and of increased longevity brought about by advances in medical technology. The proportion of people in the population aged 65 and above increased from 7.6% in 1986 to 12.4% in 2006; that is to say that by 2006, they constituted 853 000 of the territory's 6.8 million people; while those aged over 60 comprised as much as 16.2% (Census and Statistics Department (C&SD)), the Hong Kong Special Administrative Region Government ((HKSARG), 2007b). In the same report, the population aged over 60 in 2026 was estimated to be 2.4 million which would constitute 29.5% of the total population. In the same year, proportion of people aged 65 and above was projected to be 21.9% of the whole population which amounted to about 1.8 million people. The 'elderly dependency ratio' rose from 124 in 1991 to 168 in 2006, and is expected to reach 425 by the year 2036 (C&SD, HKSARG, 2007a). Hong Kong now has the second highest proportion of older people in the population in Asia, after Japan.

16. Similar to other ageing societies, apart from the increased number and proportion of older people in the population, an ageing population also implies longer life expectancy. In 2006, the life expectancy at birth in Hong Kong was 79.4 years for male and 85.5 years for female (C&SD, HKSARG, 2007a).

17. In a study on the international comparison of well-being of seniors conducted in 2008 by CADENZA, Hong Kong seniors were compared with their counterparts of some developed countries including Japan, Singapore, Australia, the United States (US) and the United Kingdom (UK). Comparison had been done on three main aspects, namely nutrition and health-related lifestyle; social network and

engagement; and health status. The study revealed that Hong Kong seniors generally live a healthy and active life.

18. The CADENZA study (2008) also revealed that the prevalence of hypertension and diabetes in Hong Kong seniors was similar of that of other countries, which was around 40% and 16% respectively. As regards the prevalence of heart diseases and their mortality rates, the level was comparatively lower in our seniors. The same case also applies to mortality rates due to cancer.

19. The CADENZA study (2008) further showed that Hong Kong seniors appeared to have less limitations in “Activities of Daily Living” (ADL) and Instrumental ADL (IADL) than their counterparts in some of the countries studied, meaning that their physical conditions were comparatively good. The situation in Hong Kong seemed to be better than in some countries when multi-morbidity was concerned. Regarding seniors’ views towards their own health status, those of Hong Kong were positive, which was consistent with elders in other economies studied in the report.

20. The generally satisfactory health condition of Hong Kong seniors could be explained by the readily accessible public health services and the overall improvement in living standard in society at large.

21. However, even the advances in medical and health technology cannot entirely halt the natural physiological deterioration of the human body. With increased longevity, there will inevitably be a more profound morbidity among the elderly population. Various local studies over the years have revealed that a considerable portion of the present elderly is still having problems in general health (both physical and mental) (Chi and Lee, 1989; Chi and Boey, 1994; C&SD, HKSARG, 2004). The 2009 Thematic Household Survey (THS) on socio-demographic profile, health status and self-care capability of older persons revealed that there is a high incidence of chronic illness among older people: amongst those aged 60 or above staying in the community, 70% suffered from one or more chronic diseases; amongst them, 63% had hypertension and 20% had rheumatism (THS Report No. 40, C&SD, HKSARG, 2009). About 77 800 older people in the community had

difficulty in carrying out activities of daily living (THS Report No. 40, C&SD, HKSARG, 2009).

22. Physical frailty and chronic illness contribute to frequent medical consultations of older people. Thus, as revealed by statistics of the Hospital Authority (HA), while the elderly population (aged 60 or over) constituted some 15% of the total population (as at 2004), their utilisation of hospital services (in terms of bed days) constituted more than 50% of the overall utilisation (HA, 2005).

23. The prevalence of dementia, a disease that reduces the capacity of elderly patients to care for themselves, among Hong Kong Chinese older people is worth noting. A local study revealed a prevalence rate of 4% in older people aged 65 or above and 6% among those aged 70 or above. The prevalence doubles every five years from the age of 65 (Chiu et al., 1998). More recently, a research conducted by the Department of Health (DH) and the Chinese University of Hong Kong in 2006 revealed that the prevalence was 1.2% for the 60-65 age group and 32% for the 85-and-above age group; and the study projected that some 70 000 community-dwelling older people suffered from dementia in 2006 (Lam et al., 2007).

High institutionalisation rate in Hong Kong

24. With their increasing frailty and inability to care for themselves, some older people have to receive LTC services either subsidised by the Government or on a self-financing basis. It is most Hong Kong elders' wish to age in a familiar environment, and to continue to enjoy the support of their family members, friends and neighbours. Various studies have revealed that across the world, there has been a general preference amongst elderly people and their family members to remain living in their own home, instead of entering an institution (Allen, Hogg and Peace, 1992). A recent study, in which 435 older people who started receiving LTC services in Hong Kong were surveyed, revealed that 73.5% of the respondents agreed or strongly agreed that "receiving care at home is better than that at residential facilities" (Lou et al., 2009).

25. It is also the Government's policy to promote community care

and “ageing in place”. The Government has provided subsidy to local NGOs to operate various kinds of community care services (CCS), which include Enhanced Home and Community Care Services (EHCCS), Integrated Home Care Services (IHCS) and Day Care Services.

26. Nonetheless, Hong Kong records a higher institutionalisation rate (nearly 7% of elders aged 65 or above) when compared with other countries which lies roughly in the range of 1% to 5%. The ratio of residential care beds to elderly population of Hong Kong is also relatively high among the countries under comparison in Table 2.1.

Table 2.1 Institutionalisation rate and Ratio of “residential care beds to elderly population”^{Note 1}		
	Institutionalisation rate	Residential care beds to elderly population
Hong Kong	6.8% (2009)	1:15 (2009) [@]
China	1.0% (2008)	1:119 (2007) ^{# Note 2}
Taiwan	2.0% (2009)	1:37 (2009) [@]
Japan	3.0% (2006)	1:38 (2007) [#]
Singapore	2.3% (2006)	1:35 (2006) [@]
Australia	5.4% (2006)	1:17 (2007) [@]
UK	4.2% (2004)	1:55 (2005) [*]
USA	3.9% (2004)	1:23 (2007) [@]
Canada	4.2% (2003)	1:10 (2002) ^{#Note3}

Note1: Elderly population refers to people aged 65 or above unless otherwise specified.
Note2: Elderly population refers to people aged 60 or above.
Note3: Elderly population refers to people aged 75 or above.
@ Residential care beds of both subsidised and non-subsidised elderly homes are included
There is no specification on the nature of residential care beds.
* Only those residential care beds included in the UK’s National Health Service.
Sources: Some figures were compiled from various sources. Data from the Internet were retrieved on June 30, 2009.
Hong Kong - (*Inst. rate*) SWD; (*ratio*) SWD (2009) and C&SD (2009)
China - (*Inst. rate*) 中華人民共和國民政部 (2008); (*ratio*) 中華人民共和國民政部 (2008)
Taiwan - (*Inst. rate*) 內政部統計處 (2009); (*ratio*) 內政部統計處 (2009)
Australia - (*Inst. rate*) OECD (2009) ; (*ratio*) OECD (2009)
UK - (*Inst. rate*) OECD (2009); (*ratio*) OECD (2009)
USA - (*Inst. rate*) OECD (2009); (*ratio*) OECD (2009).
Canada - (*Inst. rate*) OECD (2009); (*ratio*) RJ Currie (2002).
Japan - (*Inst. rate*) OECD (2009) ; (*ratio*) OECD (2009).
Singapore - (*Inst. rate*) Integrated Health Services Division and Healthcare Finance Division (2006); (*ratio*) Integrated Health Services Division and Healthcare Finance Division (2006)

27. The high institutionalisation rate in Hong Kong may be attributable to a number of factors, including the decreasing ability of the family in shouldering the care responsibility due to reduced family size, the decreasing trend of co-residence between adult children and their

elderly parents, and the limited space available in Hong Kong's residential flats. Particularly, it is observed that there are some critical factors that would trigger institutionalisation of elderly people, including sudden deterioration in the health conditions of elders due to stroke, dementia, bone fracture; and/or the lack of transitional support after being discharged from hospitals.

28. On the other hand, viable community care services can help delay or even prevent pre-mature or unnecessary institutionalisation. If provided with sufficient rehabilitation support after hospital discharge, some elders can return to community living with some assistance. In these cases, clinical input together with social support will be able to meet the particular care needs of the elders discharged from hospitals. Thus, a more dynamic integration of CCS and RCS where clients may be cared for in a bi-directional manner according to their physical and family needs could be a solution to early or unnecessary institutionalisation after hospital discharge.

HONG KONG'S MODEL OF LTC FINANCING AND SERVICE DELIVERY

LTC services – overview

29. LTC services comprise a wide range of services to enable frail elderly people to live with dignity, and maintain an optimal level of quality of life. Such services usually include, 1) community care services, 2) institutional services, which are the two major types; and other ancillary services that include 3) access services (e.g. transportation, case management, information and referral, and income maintenance; 4) housing options (e.g. assisted living, retirement communities, universal design and tele-health/care services and facilities); and 5) protective services (e.g. guardianship, representative payee) (Wilber, Schneider & Thorstenson, 1997:21). In the context of the present paper, LTC will be confined to 1) CCS (including home-based and centre-based services) and 2) institutional or residential care services.

30. The Hong Kong Government, before and after 1997, has persistently upheld the principle of “ageing in place” in the development of LTC services for elderly people. Such a principle emphasises that elderly people should live with their families or in a familiar environment as they age. This policy orientation has been the basis of the Government’s social welfare policy for the elderly since 1977 and was reiterated in the 1991 White Paper on social welfare, entitled “Social Welfare into the 1990s and Beyond”.

31. To ensure that subsidised LTC services are targeted at elders with genuine needs, the Government has since 2000 introduced the Standardised Care Need Assessment Mechanism for Elderly Services (SCNAMES) to assess the care need of applicants for subsidised LTC services and to ascertain their eligibility.

32. Similar to other advanced countries, LTC services in Hong Kong include CCS (home-based and centre-based services) and residential care services (RCS). As the Government does not provide LTC services directly within its administrative structure, it provides funding to service operators/providers in both the CCS and RCS domains with service quality ensured through monitoring by the Social Welfare Department (SWD). The private market also plays an important role in the provision of LTC services. The following paragraphs set out the provision of LTC services in Hong Kong, and the related problems.

Residential care services (RCS)

33. In the RCS domain, there exists a mix of public and private modes. So far as NGOs are concerned, the Government provides them with an array of support for the provision of subsidised RCS, including 1) provision of premises charged at a highly subsidised rate; 2) capital costs (for construction, fitting-out, furniture and equipment); and 3) operating cost (staff remuneration and program expenses, etc.). The Government also encourages NGOs to operate self-financing residential care homes or places in their subvented residential care homes for the elderly (RCHEs) to cater for the needs of elders who are financially more capable. In 2001, the Government introduced competitive bidding as a new mode of selecting operators for subsidised RCHEs developed by the Government,

with a view to enhancing the quality of service, encouraging innovative and value-added services, and achieving cost effectiveness. Both NGOs and private operators can bid the contracts for the operation of these subsidised RCHEs (i.e. contract RCHEs). On the other hand, to shorten the waiting time for places in subsidised RCHEs and at the same time enhance the quality of private RCHEs, the Government increased the supply of subsidised places for the elderly by ‘purchasing’ places from private RCHEs through the Enhanced Bought Place Scheme (EBPS). In all cases, upon allocation of a subsidised place, elderly users only have to pay about 20% of the service fee and the remaining of which will be subsidised by the Government.

34. In the history of evolution of elderly services, the NGOs have developed two different types of RCHEs catering for the need of elderly people of different levels of frailty (Leung, 2001), i.e. ‘care and attention homes’ (C&A homes) and nursing homes (NHs). In line with the direction of providing a continuum of care in RCHEs, the Government embarked on a conversion programme in 2005 with a view to converting places without LTC element to places providing continuum of care so that elderly residents can continue living in their original RCHEs without the need to move to NHs as their health conditions deteriorate. The Government also provides RCHEs operating subsidised places with special supplements for providing better care for demented and infirm elders.

35. As for the private sector, there were (as at 2008) over 570 privately operated RCHEs throughout the territory, providing some 70% of the total number of residential care places (including EBPS places). They cover all levels of care and have adopted a continuum of care model, admitting residents at varying levels of frailty (Leung, 2001). Some are located in areas supported by comprehensive transport networks that facilitate the elderly residents and their family members to maintain close contacts, while others are located in more remote areas. All RCHEs have to meet the licensing requirements of SWD in providing an acceptable standard of care, despite that there is a wide disparity of size, quality of services and level of fees charged among private RCHEs. Reasons of such disparity are multi-faceted but circumstantial constraints appear to be the key factors. There is an acute shortage of land in Hong

Kong for the development of RCHEs and while subvented RCHEs are set up in areas located in public housing estates or purpose-built complex provided by the Government, private RCHEs are mostly located in commercial or residential buildings which are relatively less spacious but more expensive in rental cost. There appears to be a need to enhance the service quality of private RCHEs by instituting measures such as professional codes and ethics of care, better education and training for practitioners at various levels.

Long waiting time for subsidised RCS

36. A review of the current situation of the ‘supply’ of RCS in Hong Kong reveals the following (Table 2.2): a majority of RCHE places are provided in the ‘private’ sector, amounting to 62%, the second major proportion (23%) is constituted by subsidised RCS provided in NGO-run subvented RCHEs and contract RCHEs run by NGOs or private operators; another 9% is the ‘bought places’ which are provided by private RCHEs participating in EBPS that receive government subsidy for the provision of subsidised places; and finally the remaining 6% of places is constituted by the self-financing homes operated by NGOs or self-financing places in contract RCHEs.

Table 2.2 Number of places in various types of RCHE² in Hong Kong (as at May 2009)

<i>Type of RCHE</i>	<i>Self-financing & contract homes (non-subsidised places)</i>	<i>Subvented & contract homes (subsidised places)</i>	<i>Subsidised Places under Enhanced Bought Place Scheme (EBPS)</i>	<i>Private RCHEs</i>	Total
Number of places	4 755	16 477	6 614	45 109	72 955
%	6	23	9	62	100

37. Currently, there is considerable number of vacancies in private/self-financing RCHEs (estimated to be around 32%), indicating an under-utilisation of existing RCS resources in the community. There

² There are another 656 subsidised residential care places with no LTC element which are not included in the table as issues relating to these places fall outside the scope of this study.

should be strengthened efforts to tap on existing, under-utilised resources in the private residential care market. More specifically, there could be better ‘market segmentation’ where people who can afford higher service fees could be diverted to the higher-end private market.

38. On the other hand, there is a substantial waiting list for subsidised RCS: as at August 2009, there were about 25 000 applicants registered under SWD’s Central Waiting List (CWL) for Subsidised Long Term Care Services. This could be attributed to a number of factors: firstly, it might reflect the actual growing size of the frail elderly population; secondly, it might indicate that the elderly (and probably their family members) have better confidence in the quality of subsidised RCS; thirdly, as there is no means-test for subsidised RCS, elders of all financial status are eligible to apply if they pass the care need assessment under SCNAMES; lastly, and most importantly, the elderly and their family members only need to pay a very low service fee for the subsidised places.

39. As revealed from Table 2.3, the waiting time for subsidised C&A and NH places as at end of August 2009 is about 22 and 40 months respectively.

Table 2.3 Waiting time (in months) for subsidised C&A/NH places^{Note}	
C&A places	
Subvented homes and contract homes	32
Private RCHEs participating in EBPS	8
Average	22
NH places	
40	
Source: SWD website (retrieved on Sept 16, 2009)	
Note: Including normal and priority cases.	

Table 2.4 CSSA recipients in various types of RCHE and on CWL (as at March 2009)					
	Self-financing/ contract homes	Subvented/ contract homes	EBPS homes	Private homes	Waitlisted Note
CSSA recipients aged 60 or above	NA	13 574	3 602	25 375	9 076
Total no. of places	4 778	17 157	6 621	44 967	N.A.
Note: The number in the “waitlisted column” may overlap with the numbers in other columns as some waitlisted elders are residing in non-subsidised places of self-financing/contract homes or private homes.					

40. In 2008-09, the Government has devoted about \$1.8 billion in providing subvention to NGOs for providing subsidised places through subvented/contract RCHEs, and another \$450 million in purchasing services from private RCHEs through EBPS. In addition, there are substantial portions of elders living in subvented or private RCHEs who are receiving CSSA (Table 2.4), which practically constitutes an indirect subsidy by the Government on RCS. As at May 2009, 43 607 elderly residents in RCHEs (or 75% of all elderly RCHE residents) were receiving CSSA. However, not all elders on CSSA residing in non-subsidised places have LTC needs as care need assessment under SCNAMES is not mandatory for non-subsidised RCS (except those provided by the contract RCHEs), despite the fact that they are receiving an “indirect subsidy” through CSSA.

Community care services (CCS)

41. “Ageing in place” is a preference of most elderly in Hong Kong. A recent study reveals that depression level of elders living in RCHEs was higher than community-living elders and that elders inclined to use CCS more (Lou, et al. 2009). The present study also reveals that some 54.8% to 70.0% of different categories of respondents commented that CCS could facilitate them to live at home at ease. Such a preference by

elderly people to community living rather than institutional living can be revealed in the international scene. A study showed that the majority of older adults in the US prefer to age in place (Callahan, 1992). Another US survey in 1999 revealed that home-delivered care and assisted living could fill the gap left by declining nursing home use (Bishop, 1999) among persons aged 65 and above. In the UK, a study identified that older people saw 'home' as an ideal place to be cared for at the end of life (Gott, et al., 2004).

42. In the CCS domain, with the virtual absence of private market, its provision is essentially a 'public' model where services are provided by NGOs which receive funding from the Government (Table 2.5). The funding mode is basically tax-based supplemented by a very minor portion of user fees.

Table 2.5 Statistics of Community Care Services (as at March 2009)

	EHCCS	IHCS (Frail Cases) and (Ordinary Cases)*	Day Care
Service capacity	3 466	1 120 for frail cases and no service capacity for ordinary cases	2 234
Total no. of users	2 758	1099 for frail cases and 19 764 for ordinary cases	2 895
Cost per case served per month	\$3,062	\$1,330 (Average of frail cases and ordinary cases)	\$6,100
Annual Expenditure	\$88.5 M	\$453.3 M	\$156.6 M

* For ordinary cases, the applicants are not required to pass the care need assessment under SCNAMES.

43. The waiting time for subsidised CCS, as compared to

subsidised RCS, is a lot shorter, with an average of about 7 months for day care services and about 2 months for home based services (frail cases). There is also higher flexibility in the provision of CCS (especially home based services) as it is less prone to physical constraints such as accommodation.

44. With an ageing population, there is a growing demand for CCS. At present, CCS is mainly provided by NGOs operating with government subsidies. Private sector involvement in the CCS market is minimal. The Senior Citizens Home Safety Association is a notable exception which has developed a social enterprise named “Easyhome” (管家易) for providing in-home services to different target groups including elderly. The elderly and their family members may choose from a variety of service packages such as house cleaning, meal, nursing care, personal care, escort service, cognitive training, physical exercise with coaching, carer training, etc., which are all delivered at home. Users can choose any combination of service according to their unique needs and affordability.

45. We also note that the capacity of families in taking care of frail elderly members at home is decreasing, and although the Government has launched transitional services such as the Integrated Discharge Support Trial Programme for Elderly Patients in 2008 to cater for the needs of elderly hospital discharges, their provision is still fairly limited. There is a worrying trend that frail elders are inclined to seek RCS even though they can age at home if adequate support is given.

46. There is a need to address the bias towards residential care and the underdevelopment of community care and rehabilitation services. More comprehensive and accessible community care options should be developed, and the financing model should be revisited so as to devise a more sustainable and equitable provision of services.

47. On the other hand, as prevalent in other countries practising community care, the burden of care rests very much on family members, especially the women in the family. In the light of this, District Elderly Community Centres (DECC) developed paid carer services after launching the “District-based Trial Scheme on Carer Training” (the Trial

Scheme) with the one-off seed money of \$50,000 from the Government between October 2007 to late 2008. About 66% of the Trial Scheme participants completing the training programme have joined the pool of carer-helpers to provide services including temporary care, accompanying elders for outdoor or leisure activities and medical appointments, emotional support through home visits, and escort service, etc. These services are fee-charging which aim at supplementing the existing CCS for elders, and providing another personalised form of care to elders and their carers.

Financing of LTC services

48. With the combined effect of an ageing population and increasing longevity, it could be anticipated that the demand for LTC services, both CCS and RCS, would continue to increase for a prolonged period. Thus, it would be wise to better utilise the existing vacant residential care places in the private/self-financing market to meet the LTC needs of elders.

49. If the current mode of financing LTC services i.e. largely funded by the Government through a tax-based regime, was to be maintained, it definitely would pose a tremendous fiscal burden on public finance. In addition, the lack of a mechanism to screen out those elders who can afford to contribute also exerts great pressure on the existing service delivery system as the population ages. The waiting list will continue to grow and the waiting time will correspondingly increase.

50. In view of the situation, there were suggestions to adopting alternative modes in the provision and financing of LTC services. The proposals range from introduction of means-test in the allocation of subsidised LTC services (Chou, Chow & Chi, 2005); promoting the private sector in taking up a more active role in service provision, catering for the need of those who can afford the private market price; to the implementation of a 'voucher' system (Chi, Lam, & Chan, 1998; Leung, 2001; Chi, 2001; Chou, Chow & Chi, 2005) that provides wider consumer choice to the elderly and their family members in accessing and using LTC services; and the establishment of LTC insurance (Chi, 2001).

51. It is in this context that there arises the need to explore the possible alternative modes in the provision and financing of LTC services in Hong Kong, which forms the background of the present study.

OBJECTIVES OF STUDY

52. This consultancy study aims at exploring:

- i. how to target subsidised RCS at elderly people most in need; and
- ii. how to promote further development of quality self-financing/private RCS and to encourage shared responsibilities among individuals, their families and the society in meeting the LTC needs of the elderly.

53. Along with the above-mentioned objectives, this study also attempts to examine the impact of introducing a means-tested financial assistance scheme i.e. voucher for subsidised residential care places for the elderly and examines complementary measures (e.g. co-payment or topping-up) which may help achieve the above objectives.

54. In order to actualise the policy direction and respond to the elderly's preference to ageing in the community, this study also explores the issue of how best to enhance the provision of CCS, in conjunction with that of RCS.

METHODOLOGY

55. Given that the study covers a wide range of issues and has to collect a broad spectrum of data (both quantitative and qualitative), it has adopted multiple methods as detailed below.

Literature review

56. The research team had reviewed relevant previous and ongoing studies, both local and overseas, to provide reference for the present study.

57. The research team also collected a huge amount of information about the LTC policy and practices, including the financing mode and the service scope and variations, in 19 member countries of the Organisation for Economic Co-operation and Development (OECD) and Asian countries / economies, which provided a framework of comparison with the situation in Hong Kong.

58. A review of existing means-test mechanisms in Hong Kong was conducted to provide reference for the factors that have to be taken into account if a means-test were to be implemented along with the financial assistance (voucher) scheme for subsidised RCS.

Interviews

(a) Face-to-face interviews

59. A total of 2 183 elderly people aged 65 and above, and 1 144 ‘soon-to-be-old’ aged 45-64 were interviewed face-to-face in the study period.³ In order to include potential users of RCS with different backgrounds, six sampling categories were adopted and they were (Table 2.6):

- a) Those on SWD’s CWL waiting for subsidised RCS but not using subsidised CCS nor subsidised RCS of a lower care level (to solicit their views on shifting to non-subsidised RCS under a voucher system);
- b) Those on CWL waiting for subsidised RCS and using subsidised CCS (to solicit their views of shifting to non-subsidised RCS under a voucher system and what would help them stay in the community);
- c) Those receiving subsidised CCS only but not on CWL (to find out what helped them stay in the community and their views about a voucher system as they are potential users of RCS);
- d) Those living in private/self-financing RCHEs but not on CWL (to find

³ There were another nine cases whose age was unidentified. Therefore, a total of 3 336 face-to-face interviews were completed.

out their views about the voucher system as they are potential users of the voucher);

- e) Carers of those selected in the above categories and existing social service users (they were interviewed because they were familiar with LTC services, and thus their views on a voucher system and the factors influencing their decision to keep their elders “ageing in place”);
- f) The community samples of different economic statuses.

(b) Telephone interviews

60. In addition to the face-to-face interviews of the elderly people and the ‘soon-to-be-old’ from the various categories mentioned above, it would also be desirable to solicit the views of a group of people who are living in the community and are conscious of personal health and home safety by using a tele-health system. This group of people is using a personal emergency link service (PE Link) which is a 24-hour advanced communication system operated by the Senior Citizen Home Safety Association. Its users can speak to the operator through the main unit at home by pressing a button and the operator is thus able to identify the needs of the caller and provide the necessary support services.

61. A total of 400 users aged 45 or above and cognitively fit were randomly sampled from the membership of the PE Link (category 7 in Table 2.6). Checking was conducted to avoid selecting users who had been interviewed in the face-to-face interviews.

Table 2.6 Sampling framework for the face-to-face interview					
	Age^{Note}	45 - 64	65 or above	Un-identified	Sampling method
	Sample category				
1	Those on CWL but without using subsidised CCS/ subsidised RCS of a lower care level	8	495	2	Random sampling from CWL Convenient sampling from DECCs and Neighbourhood Elderly Centres (NECs)
2	Those on CWL and using subsidised CCS	9	423	1	Random sampling from CWL Convenient sampling from CCS, DECCs and NECs
3	Those receiving subsidised CCS only but not on CWL	17	416	1	Random sampling from CCS via SWD Convenient sampling from CCS
4	Those living in private/ self-financing RCHEs but not on CWL	8	103	2	Convenient sampling
5	Carers of	531	273	2	Convenient

	those selected in the categories 1-4 above and existing social service users				sampling
6	Community samples (including samples of different economic statuses)	571	473	1	Random sampling (community survey)
	Total=3 336	1 144	2 183	9	
7	PE Link users	17	382	1	Random sampling
<p><i>Note :</i> Subsidised RCS and CCS (except for DE /DCU for frail elders aged 60 or above) are provided for frail elders aged 65 or above, while the eligibility of those aged 60-64 will be considered if there is a proven need.</p>					

Informant interviews

(a) Government officials

62. As the Government has been administering means-test in the CSSA Scheme, public rental housing allocation and medical fee waiver scheme, reference had been made to the experiences of relevant government departments/HA in terms of the actual implementation of means-test mechanisms, manpower requirement and administrative expenses. Thus, officers from SWD, the Housing Department and HA were interviewed.

63. More recently, the Government also introduced the Pre-primary Education Voucher Scheme (PEVS) and the Elderly Health Care Voucher

Pilot Scheme. Thus, an interview had been conducted with officers from the Education Bureau and a written response had been obtained from DH to solicit data and experience related to administering a voucher system.

(b) Operators of Residential Care Homes for the Elderly (RCHE) and CCS

64. It is imperative to interview operators of private RCHEs to explore the mechanism in setting entry requirements for RCHEs to be eligible under a voucher scheme. To this end, representatives from the two associations of the private RCS sector were interviewed.

65. As about 30% of existing RCHE places are operated by subvented NGOs, it is also necessary to solicit views from representatives of NGOs about the impact of the possible changes in policy on their operation and finance. Apart from the RCHE operators, views from CCS operators about the possible impact of implementing a voucher system for subsidised RCS on their operation were also solicited. A total of 15 NGO operators of subvented RCHE and/or CCS were interviewed for this Study.

Focus group discussions

66. Focus groups were held with CCS users, CWL applicants, private home residents and carers. Such discussions were useful for the collection of qualitative data from relevant stakeholders in providing a more comprehensive appraisal of the relevant issues involved, which contributed to the formulation of the questionnaire and overall analysis.

Secondary analysis of existing data

67. In order to capture the widest possible range of data relevant to the study, it is necessary for the research team to analyse data archive provided by relevant government departments, including the following:

(a) Social Welfare Department

68. SWD maintains data archive of subsidised and private RCHEs. The following data were retrieved for further projection analysis:

- i. Aggregated data of the SCNAMES from 2004-2008;
- ii. Subsidy/public expenditure on RCS and CCS;
- iii. Expenditure on CSSA and its caseload;
- iv. Percentage of CSSA recipients in RCS users.

(b) Census & Statistics Department

69. The following data were retrieved from C&SD:

- iii. 2006 Population By-census
- iv. Data of the 2004 and 2008 THSs on socio-demographic profile, health status and long-term care needs of older persons

Policy options and impact analysis

70. Based upon the results of the review of international practices, findings of the various surveys conducted in this study, analysis of secondary data, as well as information collected from the informant interviews with operators of LTC services and concerned government officials, etc., the research team will examine various policy options for meeting the LTC needs of the ageing population, including the pros and cons of these options.

CHAPTER 3

OVERSEAS EXPERIENCES IN LTC PROVISION AND FINANCING

THE INTERNATIONAL SCENE – PUBLIC OR PRIVATE MODEL

71. In the international scene, there can be different approaches to social service delivery, ranging from 1) state-oriented, 2) traditional mixed economy, 3) contemporary mixed economy to 4) market-oriented (Johnson, 1999). As revealed in Table 3.1, the four approaches lie in a continuum between state and market approach of provision, while there can be mixed approaches where the state, the non-profit NGO sector and the market play varying roles in the provision.

72. In terms of the degree of centralisation, health care models can also be depicted by another typology, namely, 1) centralised planning and management, 2) mixed public-private national health service, 3) mixed public-private social insurance, and 4) decentralised pluralistic model (Lassey, Lassey & Jinks, 1997).

Table 3.1 Approaches to social service delivery

Approach	State-oriented	Traditional mixed economy	Contemporary mixed economy	Market oriented
Provision	Government	<ul style="list-style-type: none"> ● Government ● Volunteer agencies 	<ul style="list-style-type: none"> ● Government ● Voluntary agencies ● Commercial suppliers 	<ul style="list-style-type: none"> ● Commercial suppliers
Finance	Government	<ul style="list-style-type: none"> ● Government ● Private sources 	<ul style="list-style-type: none"> ● Government ● Private sources ● Fees and charges 	<ul style="list-style-type: none"> ● Fees and charges
Regulation	Government	<ul style="list-style-type: none"> ● Government ● Self-regulated association 	<ul style="list-style-type: none"> ● Government ● Self-regulated association ● Markets 	<ul style="list-style-type: none"> ● Markets

Source: Johnson, N. (1999). *Mixed economies of welfare: a comparative perspective*. New York: Prentice Hall. P. 24.

73. With specific reference to medical/health and LTC services in the economically advanced and developed countries, such services may be provided either on a universal or selective (means-tested) basis. In the UK, Australia and Canada where a universal National Health Service (NHS) system is provided, people can have access to free medical services. However, in the LTC domain, even in these countries where universal accessibility to health services is provided, ‘care’ services (instead of ‘cure’ services) are not universally provided, but are administered on a selective basis. Such selective provision of LTC services is usually based upon three eligibility criteria: 1) age, 2) functional disability and 3) financial means (asset and income) (Wilber, Schneider & Thorstenson, 1997:19).

74. Internationally, LTC has ‘historically received far fewer resources than acute care’, that is attributable to its ‘low tech / high touch’ nature that involves personal care services delivered by low-skilled and poorly paid workers (Wilber, Schneider & Thorstenson, 1997:17). In addition, the evolution of LTC financing is also subsequent to that of health financing. As all countries reviewed developed their LTC financing and service delivery models based upon the foundation of their respective health care provision, such a typology of health care financing can also shed light on the evolution of different models of LTC financing in these advanced countries.

75. A review of global practices in health care financing mechanisms reveal that there can be a public-private continuum, in which the responsibility of provision and financing of health care services lies respectively in the ‘collective’ versus the ‘individual’ dimensions. The specific financing mechanisms can be categorised along this continuum into five different major types. They are, respectively, 1) tax-based, 2) social insurance, 3) community-based insurance, 4) private insurance, and 5) user fees (OECD, 2000; Bennett & Gilson, 2001). Singapore presents a rather unique case of health care financing – that of ‘personal savings account’, that diverges from the five major prototypes mentioned here. As mentioned above, the LTC financing models in the developed countries are very much based on and derived from the health care financing models of those countries. Table 3.2 presents a typology of the six

possible types of health / LTC financing mechanisms in the world.

Table 3.2: A typology of major health / LTC financing mechanisms						
Nature	Public			Private		
Responsibility	Collectivist			Individualistic / atomistic		
Mechanisms	1	2	3	4	5	6
Mechanisms	Tax-based financing	Social insurance financing	Community-based health insurance	Private saving account	Private insurance	User fees
Source of fund	Government revenue	Mandatory contributions / premium from employers and employees in society as a whole	Voluntary contributions / premium from members of specific community (e.g. an industry)	Mandatory contributions from individuals	Voluntary contributions/ premium from individuals	Direct (out of pocket) payment
Sources: modified from OECD (2000). <i>A System of Health Accounts</i> . Retrieved on August 12, 2008, from http://www.oecd.org/dataoecd/41/4/1841456.pdf ; Bennett, S., & and Gilson, L. (2001). <i>Health financing: designing and implementing pro-poor policies</i> . DFID Health Systems Resource Centre. Retrieved on August 12, 2008, from http://www.wemos.nl/Documents/dfid_pro_poor_health_financing.pdf						

76. If categorised based on the degree of centralisation, health care and LTC provision and funding models in the world can be displayed along a continuum as shown in Table 3.3.

Table 3.3: Health Care and LTC models based on the level of centralisation				
Types	Centralised planning and management	Mixed public-private (national health service model)	Mixed public-private (social insurance model)	Decentralised / pluralistic model
Countries / Regions	(pre-1980s) China	Australia, Canada, UK, (post-1980s) China, Korea, Hong Kong (@)	Germany, Japan, Netherlands, Luxemburg, Singapore (#)	USA, Taiwan
Degree of centralisation	Centralised government control, funding and management	←————→		Decentralised and private control, funding and management
Feature	<ul style="list-style-type: none"> ● All major decisions and financing are derived from the central governments; ● Services are owned and managed by governments of various levels; ● Services are provided universally to all citizens 	<ul style="list-style-type: none"> ● Plans and managements are from the central governments; ● Specific functions are decentralised to lower levels of governments; ● Service providers are independent but closely supervised by the governments 	<ul style="list-style-type: none"> ● Planning and supervisions from governments of various levels; ● Services are funded by social insurance and provided by independent practitioners and voluntary organisations 	<ul style="list-style-type: none"> ● Minimal government responsibilities; ● Government service only selectively provided for special social groups; ● Planning, management financing and provision are largely from the private sector
<p>Adopted and modified from: Lassey, M.L., Lassey, W. R. & Jinks, M.J. (1997). Health care systems around the world: characteristics, issues, reforms (p317-319). N.J.: Prentice Hall.</p> <p>@ In Hong Kong, RCS is largely subsidised by the Government through subsidised places operated by NGOs/private operators, or finance assistance (in the form of CSSA) for payment of elderly home fees.</p> <p># Singapore adopts a ‘saving account’ approach which can be regarded as a special variant of the ‘social insurance’ scheme.</p>				

77. The Hong Kong Government has also developed a multitude of health care financing models as proposed in the Healthcare Reform Consultative Document (Food and Health Bureau, 2008). The various models are briefly enlisted in Table 3.4 below.

Table 3.4 Six options for providing supplementary financing for healthcare (extracted from the Healthcare Reform Consultation Document, Food and Health Bureau, HKSARG March 2008)

- (a) **Social health insurance:** to require the workforce to contribute a certain percentage of their income to fund healthcare for the whole population.
- (b) **Out-of-pocket payments (user fees):** to increase user fees for public healthcare services.
- (c) **Medical savings accounts:** to require a specified group of the population to save to a personal account for accruing savings (with the option to invest) to meet their own future healthcare expenses, including insurance premium if they take out private health insurance.
- (d) **Voluntary private health insurance:** to encourage more individuals to take out private health insurance in the market voluntarily.
- (e) **Mandatory private health insurance:** to require a specified group of the population to subscribe to a regulated private health insurance scheme for their own healthcare protection.
- (f) **Personal healthcare reserve:** to require a specified group of the population to deposit part of their income into a personal account, both for subscribing to a mandatory regulated medical insurance before and after retirement, and for accruing savings (with the option to invest) to meet their own healthcare expenses including insurance premium after retirement.

78. The following paragraphs describe the main features of the various mechanisms or models, which will provide the context for a critical appraisal of the relative merits and limitations of the models, and will provide reference for Hong Kong in the development of a viable and sustainable LTC financing model.

79. In those countries that practice a ‘tax-based’ or publicly funded mode of financing LTC service, it would normally adopt a ‘selective’ basis of services provision, and concomitantly there is usually a mechanism of means-test on the recipients’ assets and incomes. The administration of a means-test mechanism is to ensure the services are

targeted to some specific groups of beneficiaries, with consideration of the latter's financial conditions and thus affordability to LTC services. It is also designed in consideration of the possible heavy fiscal burden posed upon a government if LTC services are provided universally, especially in view of an increasingly aged population with high morbidity and thereby escalating demand for services.

Universal or selective provision – tax-based and social insurance models

80. Of the 19 OECD countries examined in the OECD report (OECD, 2005), seven of them (i.e. Austria, Germany, Japan, Luxemburg, the Netherlands, Norway and Sweden) provide comprehensive coverage of LTC services to their people. This arrangement is in line with their provision of health-related services that are also well integrated with their social protection systems. In these countries that provide universal and comprehensive LTC services, the expenditure on LTC constituted 0.8% to 2.9% of their respective Gross Domestic Product (GDP).

81. However, there is also a significant difference among these seven countries that provide a comprehensive coverage of LTC services: while the Nordic countries (i.e. Norway and Sweden) and Austria opt for a tax-based system, the Netherlands, Germany, Japan and Luxembourg resort to establishing universal LTC social insurance. It should be noted that the tax rates in the Nordic countries and Austria are high in order to provide a comprehensive coverage of LTC services; for instance, individual tax rates could be as high as 48% in Norway, 50% in Austria and 57% in Sweden (www.worldwide-tax.com 2009). Thus, it presents a very different tax regime from that of Hong Kong where the tax system is simple and the tax rates are low in international standard.

82. The other 12 countries (i.e. Australia, Canada, Korea, Hungary, Ireland, Mexico, New Zealand, Poland, Spain, Switzerland, the UK and the US) provide LTC services based on some mechanisms of means-test on the user's income and/or assets. In these countries, the share of LTC expenditure in GDP ranges from about 0.2% to 1.5%.

83. In countries with social insurance schemes (i.e. Germany,

Japan, Luxembourg and the Netherlands), their pensioners are also required to contribute premium in the form of deductions from their pensions or out-of-pocket contributions. Deduction from pension serves as a structural guarantee to ensure the payment of premium to such insurance schemes.

84. However, in the implementation of mandatory social LTC insurance (LTCI), there could be lessons to be learnt in ensuring a proper functioning of the system. Firstly, the mechanism of ‘co-payment’ (as practiced in Japan, Germany) would help reduce abuse – or over-usage of LTCI. Secondly, the assessment of service need (as usually determined by the level of frailty of the elderly people) should be objective and impartial. This would avoid the problem of ‘suppressing’ the actual LTC need of the elderly, as revealed in the case of Japan where some users / family members request for re-assessment to reduce the care level, so as to reduce the amount of co-payment required. Thirdly, it should avoid the problem of ‘budgetary flight’, especially with the interface between medical (cure) and LTC (care) domains. Normally, medical services are more expensive than community LTC services; there would be a tendency for the insurance company/agent to avoid users going into hospitals, so as to reduce the payment to the users. Such a problem of ‘budgetary flight’ may also happen in such countries or systems where there is a division between central (or federal) and local sources of financing, since governments at different levels would try to avoid taking up the fiscal burden of providing the more costly services.

85. Notwithstanding the differences in adopting a tax-based or insurance mechanism, a universal or selective provision of LTC services, all these developed countries have viable pension system in place that provides financial security for their retired elderly people. Thus, in most cases, their pensioners are normally required to contribute to funding LTC; in the form of paying insurance premium (e.g. German, Japan) or out-of-pocket ‘top-up’ to LTC services to achieve cost-sharing.

Private insurance

86. Although there exists a continuum of different mechanisms of provision ranging from the ‘public’ to the ‘private’, it appears that,

amongst the OECD countries, private LTC insurance has not been a significant mode of financing LTC services. Having said that, private insurance or out-of-pocket payment is more prevalent in residential/institutional LTC than home care services. Private LTC insurance is either totally non-existent or rather limited in OECD countries with comprehensive public LTC benefits (such as in Scandinavia, the Netherlands, Japan and Luxembourg) and countries with a more 'private' LTC mode of provision. Private LTC insurance is more popular in France and the US than in other countries. But even in the US, private insurance only constitutes about 4% of the total expenses on LTC services (Congress of The United States Congressional Budget Office 2004). The low prevalence of private LTC insurance may be attributable to a combination of low demand and limited supply (Colombo and Tapay, 2004).

Personal saving account – the unique case of Singapore

87. Singapore presents a unique and exceptional case where there is neither a tax-based nor an insurance-based financing model, but a contributory saving account model (Phua 2001). The government-administered central provident fund (CPF), with contributions from both employers and employees, addresses the various needs of its citizens and their family dependents, including housing, education, health, and also LTC. The Singapore Government heralds the virtue of individual responsibility of welfare and thus devised the CPF as a fundamental financing model of provision for various social services, and plays a supplementary or residual role in providing financial support to NGOs in providing services and administering means-tested provisions to those who are destitute.

INTERNATIONAL TREND OF PROMOTING COMMUNITY CARE

88. In the international scene, there are quite a wide variety of subsidies, in the form of cash or voucher, provided by governments (at federal, provincial or municipal levels) to the service users and/or their family members to enable them to exercise choice in using LTC services, and to encourage elderly to age in place or their family caregivers to take

care of elderly in their own homes. These subsidies can be viewed as a kind of ‘consumer-directed care’ which empowers the users or their family members to exercise more choices in deciding on the package of home-care services. The US has the longest experience of developing consumer-directed care amongst the OECD countries, in which some programmes have been developed for over 20 years.

89. In countries that provide both in-kind (services) and cash support, the elderly may choose between the two alternatives, or in the case of Germany, can even choose a combination of both types of support. But in most cases the cash alternative is set at a lower level than the value of the services.

90. The international trend of preference to providing subsidy to enable elderly and their family members to live in a domestic setting is based upon the fact that community-based home care services have been demonstrated to play a significant and indispensable role for older people. Such services contribute to the avoidance of premature and unnecessary institutionalisation, and help to put “ageing in place” into effect. In the US, the Social Health Maintenance Organisation and the Program for All Inclusive Care for the Elderly (PACE) have demonstrated success in providing community-based in-home services for older people in general (Eleazer and Fretwell, 1999) and for those older people housed in marginal accommodation (Mai and Eng, 2007). In Australia, the Community Aged Care Packages (CACCP) has contributed to enabling older people to remain living in the community instead of being institutionalised. In Canada, Integrated System of Care for the Frail Elderly (SIPA) is a programme of integrated care for vulnerable community-dwelling older persons and has resulted in a 50% reduction in the number of patients awaiting nursing home placement after acute hospitalisation (Beland et al., 2006). In Italy, integrated social and medical care and case management provided by home care services has improved elderly service users’ physical functions and reduced the decline in cognitive status (Bemabei et al., 1998).

91. Such a preference to promoting community living, rather than institutionalisation, may explain the trend that, amongst the countries reviewed, there is yet no ‘voucher’ or cash subsidy for residential service,

but only for home-care. In all the 19 OECD countries reviewed in the 2005 OECD report, only Austria provides universal cash payment at the federal and provincial levels to people for institutional services while the others only have in-kind provision in the form of RCS place arrangements. This could be interpreted as a means to encourage home-care by providing more flexibility, and monetary incentives for the elderly themselves and/or their family care-givers to prolong community living and avoid immature institutionalisation.

92. The provision of financial incentive to promote home care can take various forms. The *Personal Budgets* scheme in the Netherlands is the biggest of the schemes in this category (Lundsgaard, 2005). However, specific reference could be made to the ‘Cash & Counseling’ programme in the US. It provides a ‘budget’ to Medicaid recipients so that they could exercise their own choices about the personal assistance services they receive, to hire their own caregivers and even to purchase care equipments. The programme has a built-in ‘counseling’ element in which elders are provided with advice in managing their budget (Cash and Counseling homepage, 2009).

VOUCHER AS A FORM OF SUBSIDY AND ISSUES TO BE CONSIDERED

93. The idea of ‘voucher’ was first proposed by the Nobel Prize laureate Milton Friedman in the 1950s based upon his economic theory of markets. Friedman’s economic logic is grounded in a respect for diversity and a tolerance of individual values. Vouchers allow people to pursue their respective different interests. Later, Christopher Jencks, a professor of sociology from Harvard University proposed the ‘regulated voucher’ idea, in which choice and competition operate within a framework of government rules that are based upon some social values such as social equity. The idea of voucher was put into real practice under the Reagan administration in the 1980s (Moe, 2000).

94. There is a whole array of issues pertinent to the consideration of implementing a voucher system, ranging from equity, efficiency, reduction of cost, restriction of choice, replacement of other programs /services, increased competition, price control / manipulation by supplier

(inflationary trend due to voucher effect), knowledge and ability of users in making informed choice among suppliers, to quality enhancement and others (Steuerle, 2000a).

Voucher increases consumers' purchasing power

95. One of the potential benefits of a voucher system would be the 'side-effect' of releasing the household resources originally devoted to the service or goods subsidised by the voucher. This is regarded as a 'substitutability' effect brought about by vouchers that may improve household budgets. In this regard, a voucher can give purchasing power to an individual directly or indirectly.

Voucher enhances consumer choice

96. A voucher can provide consumer choice within boundaries, and can be both prescriptive and proscriptive, i.e. setting limits. On the one hand, the beneficiary of a voucher may have a choice of providers of goods or services, ranging from public to private, profit-making to non-profit-making organisations. On the other hand, a voucher system may restrict the scope of goods and services that can be purchased. Thus, a voucher system is a good policy tool in providing an 'intermediate' level of choice (Steuerle, 2000a:5). The scope of prescription and proscription allowable by a voucher should be designed by policymakers with due consideration and reference to goals and principles of a specific program.

Voucher may increase prices

97. Apart from bringing about some benefits, a voucher system also has its inherent problems. Due to the fact that vouchers may effectively increase the demand for those goods and services that are targeted, the prices of those goods and services may increase. This could be disadvantageous to the current and future users of those goods and services. A voucher system may thus benefit the providers more than the end-users.

Issue of ‘equity’

98. The issue of ‘equity’ touches upon whether the eligibility criteria are set reasonably and equitable to benefit the most in need. A universal application may appear to be equitable but may be problematic in being not target-specific and resources would be committed to those who can afford the cost of goods/services even without the government subsidy in the form of a voucher.

99. The ‘equity’ issue also boils down to whether there is a free and level playing field on the supply side, as well as free and available market information provided to the users in exercising their consumer choice. It is often the case that with limited number of suppliers or in a skewed market where some suppliers are in a better position than others, the vouchers may be used for services provided by a small number of better or stronger suppliers. Although it can be regarded as a market mechanism that helps to weed out under-performing suppliers, it may also result in limited consumer choice.

Co-payment as a principle

100. Topping-up by the consumers may enable them to choose services of better quality, thereby enhancing the quality of the private/self-financing market. This would also have the advantage of ensuring the sharing of responsibility by the consumers instead of merely relying upon public subsidy; and avoiding the problem of ‘moral hazard’ as manifested in some other systems that do not require co-payment.

The level of subsidy – by ‘proportion’ or ‘fixed amount’

101. There can be two possible ways of administering the subsidy or voucher – a) by proportion and b) by fixed amount. In the former case, as in the case of Germany, the user would be able to claim a certain percentage of the actual cost incurred. This would encourage those who could afford a higher fee to use better services available in the market. This would in turn stimulate improvement of services.

102. However, there are inherent problems to the ‘proportion’

approach. Firstly, the administration of a ‘proportion’ approach would incur higher costs in checking of variations in fees charged by different service providers. In addition, the Government would have difficulty in predicting and projecting the total expenditure as there could be variations in the fees chargeable by the service providers. Thirdly, this would likely induce the service providers to mark up their fee levels and that would in turn lead to the fourth problem, that of ‘moral hazard’ where the consumer would tend to use higher-end services though they need to share a corresponding higher cost.

103. The ‘fixed amount’ approach would adopt a flat rate that is payable to all eligible beneficiaries. This approach has the merits of administrative simplicity and cost-efficiency. This would also enable the Government to estimate the total expenditure involved based on the total number of beneficiaries.

104. On the other hand, a ‘fixed amount’ approach might be regarded as similar to a ‘regressive tax’ system that works as a disincentive to using higher-end services, as the amount of subsidy is the same irrespective of the service fee. Nonetheless, if provided with a topping-up arrangement, the availability of a voucher could still encourage the purchase of higher-end services.

A sliding scale of subsidy (voucher) provision

105. In formulating a viable mechanism for allocating subsidised services based on a selective means-test mechanism, there should be a balance between equity and efficiency.

106. As mentioned above, ‘equity’ refers to the characteristic of the allocation system which addresses the possible differences in the level of affordability, so that those who can afford a higher top-up fee would be provided with less subsidy; and those who have genuine need for a high level of subsidy could receive sufficient amount of subsidy. Thus, there should be a ‘sliding scale’ that adequately reflects the possible wide range of difference in affordability.

107. ‘Efficiency’ on the other hand, is concerned about minimising

administrative procedures in terms of checking the financial status of the applicant, as well as determining the level of subsidy. If a wide range of scale is designed, there could be cumbersome procedures in deciding upon the level of payment for the voucher.

Issue of regulation

108. Effective administration of a voucher system also hinges upon effective regulation to both consumers and service providers. The regulation on consumers should firstly address the issue of eligibility, and secondly on the scope and ways in which the voucher can be used. Service providers should also be subject to the eligibility requirement in terms of the quality of goods and services they can and should provide.

Availability of information to consumers

109. Besides, limited market information in terms of quality and pricing may also lead to mismatch of users' expectation and their actual consumption. The 'information divide' usually exists between those who are educated, knowledgeable and mobile and those who are disadvantaged in these aspects, thus constituting another facet of differences in socio-economic status.

Scope of application

110. If a voucher system were to be implemented, it would be desirable that it be launched to encompass the whole industry or scope of services / goods available in the market. If vouchers are only restrictively applicable to a particular and small segment, they may not have significant impact upon the overall demand and supply in the concerned market, which may in turn result in distortion of pricing mechanism and quantity of supply. For instance, with limited scope and application of vouchers, new suppliers may not be effectively attracted to enter into the market and the overall supply may not increase accordingly to offset the increased price induced by the introduction of a voucher system.

111. In the administration of vouchers, there should also be

considerations about problems related to individual variations in service needs. For instance, different users may need different treatments or intensity of care, and thus the value of the voucher may need to be adjusted to cater for individuals' varying needs. In view of such variation, vouchers are usually adjusted to reflect relative need and service delivery costs by means of some objective measures. For example, in the case of 'housing vouchers', the voucher value may need to be adjusted according to family size. In the experience of the US, such adjustments may need to be based upon variations in the nature of services, location (in view of different operating costs). The Centres for Medicare & Medicaid Services (CMS) devised the 'adjusted average per capita cost' (AAPCC) methodology based upon the Tax Equity and Fiscal Responsibility Act (TEFRA) to set Medicare voucher amounts that address the need for both geographic and individual cost variation (Reischauer, 2000: 420).

112. In the same vein, care services should vary according to the different degrees of frailty and thus the level of care needed, and so the value of a voucher may need to be adjusted accordingly.

Sustained implementation

113. Furthermore, if a voucher were to be implemented, it would also be desirable that the implementation period should cover a considerable period of time to induce sustained market impact in affecting demand and supply. If vouchers are only implemented for a short period of time, consumers may be hesitant to take up the benefit as they may worry about their affordability and inability in maintaining the level of consumption of goods or services should the voucher subsidy be withdrawn. On the supply side, the providers of goods and services may worry about the sustainability of the demand induced by the vouchers, and thus refrain from increasing supply or improving quality of service and goods.

Fiscal burden of government

114. The implementation of a voucher system may not necessarily reduce a government's fiscal burden of social service provision. The

introduction of vouchers may induce demand in the market, which in turn may increase the government's further provision of vouchers for a wider group of beneficiaries. The government may of course modify the eligibility to restrict or reduce the scope, but that would be politically risky if the public has already developed some vested interests and legitimate expectations in enjoying such a benefit.

LESSONS FOR HONG KONG

115. The review of international experiences in LTC provision and financing reveals that a publicly funded, non-contributory system of provision would usually be provided on a selective basis. This is premised on the fact that given limited public revenue, resources should be utilised in the most efficient way and thus service provision should be given to those most in need. This is to be reckoned in recognition of the low tax regime of Hong Kong which would probably render the current publicly funded, heavily subsidised LTC delivery model not sustainable in the long run. Internationally, this selective provision would normally be implemented by means of some mechanisms of means-test, so as to ascertain the inability of the publicly funded service recipients to afford the expenses of the services.

116. The provision of LTC services could be either in kind (services) or in cash (subsidies or voucher) or both, irrespective of the mode of financing. The device of cash subsidy (or voucher) provides higher flexibility and greater consumer choice, so that the end-users of the services could benefit most. Internationally, cash subsidies (or voucher) are usually provided only for CCS rather than for RCS.

117. The financial conditions of elderly people in Hong Kong have been a major concern in social policy formulation. As revealed in various local studies, the financial status of the current cohort of elderly people is, to a certain extent, found to be unfavourable. This is attributable to a host of factors, including, firstly that many of them have not been benefited by any retirement protection schemes, secondly, their low education and skills had restricted them to low-income jobs during their working age, thirdly, their low capacity for savings due to low incomes. However, with the implementation of the Mandatory Provident

Fund in 2000 and the changing socio-economic profile, it could be anticipated that the future cohort of elderly people could be better positioned financially to pursue a long-term retirement planning, including catering for the need for medical and LTC services.

118. In this light, the Government may have to continue its publicly funded mode of service provision for the present cohort of financially relatively disadvantaged elderly people; but plan ahead for devising some new modes of financing and provision for the future cohort of elderly people who may probably be in a better position for taking up contributory systems.

119. As regards the idea of using voucher as form of subsidy, having reviewed the issues to be considered, we see merits in adopting a “fixed amount with sliding scale” approach which would allow for differential subsidy to beneficiaries of different financial means. In determining the monetary value of the voucher, a number of factors such as the monthly rates of services in the private market, the waiting time for various types of subsidised places, the amount that the elders (and/or their family members) will be willing to pay (i.e. top-up amount), and the financial conditions of elders, etc., should also be considered.

120. International experience and trend reveal the preference to promoting “ageing in place”, rather than institutionalisation. The Hong Kong Government’s policy is also congruent with this overall direction and the preference of the elderly. Given that there is an apparent tendency to opt for RCS by the elderly people (and/or their family members) when offered the choice during care need assessment, there should be strengthened efforts and policy measures to reverse the inclination to premature or unnecessary institutionalisation. Thus, provision of incentives – in kind or in cash – to enable and encourage elders and their family members to opt for home care, could be seriously considered. Reference to the overseas experience of ‘personal budget’, ‘cash and counseling’ and the like could provide good examples for Hong Kong.

121. With specific consideration of the current provision of subsidised LTC services in Hong Kong administered through the

SCNAME, one option is the introduction of a mandatory trial period of using CCS before the elders can be admitted to subsidised RCS.

CHAPTER 4

POLICY OPTIONS FOR MEETING LTC NEEDS OF THE AGEING POPULATION

122. This chapter outlines the various options that can be considered to meet the LTC needs of the ageing Hong Kong society. Four options will be examined in the following paragraphs with their pros and cons, and the possible impacts in social, service and financial aspects. Specifically, such impacts include the change in the number of applicants on CWL for subsidised C&A places, the waiting time for subsidised C&A places, the operation of RCS and CCS in the subvented and private sectors, and public finance where appropriate. The four options include: 1) status quo (i.e. additional subsidised C&A places are provided annually at the same pace of previous years), 2) adjusting the “dual option” arrangement to proactively encourage elders to use CCS, 3) introduction of a means-test mechanism, and 4) introduction of a means-tested RCS voucher scheme.

123. In the discussion that follows, the word ‘elderly’ or ‘user’ refers to those frail elderly people who have passed the care need assessment of SWD’s SCNAMES in ascertaining their need for LTC services. CCS refers to services provided by DEs/DCUs, EHCCS and IHCS(Frail Cases).

PROVIDING MORE PLACES AS A PERSISTENT MEASURE

124. The current policy of the Government is to provide funding to NGOs or contract operators to provide RCS (in subvented and contract RCHEs), and to purchase private RCHE places under EBPS to meet the service needs of eligible elderly applicants on CWL. In July 2009, there are about 21 000 subsidised C&A places which are provided by subvented or contract RCHEs and private RCHEs under EBPS. Among these places, 14 391 are from subvented or contract RCHEs whereas 6 614 are under EBPS. The Government has also committed to increasing the number of subsidised RCS places to meet the rising demand. Taking the 2009/10 Budget as an example, the Government has earmarked

funding for the provision of an additional 500 subsidised RCS places through EBPS, and another 142 places through newly developed contract RCHEs.

125. The problem with this option is, even if the Government can continue to increase the supply of subsidised places at the current pace, it is anticipated that the new supply may not be able to catch up with the increasing demand arising from the ageing population, meaning that there will continue to be a waiting list for subsidised places.

126. Besides, the addition of new residential places in the long run may convey a message to the society that the Government is in support of institutionalisation to meet the LTC needs of the frail elderly. It is contradictory to the policy direction of “ageing in place” that the Government has been holding. It is also not in line with the global trend of providing community-oriented LTC services for the elderly. An option to encourage “ageing in place” or maximize the utilization of CCS is to review the existing “dual option” arrangement for matching LTC services, which will be further discussed in the ensuing paragraphs.

ADJUSTING THE DUAL OPTION ARRANGEMENT

127. Apart from the annual addition of new places to absorb the increasing number of applicants on CWL, a change of the existing “dual option” arrangement can be another way to shorten the CWL. Dual option is one of the service recommendations generated for applicants who have undergone care need assessment under the SCNAMES. Applicants who are assigned with this recommendation are eligible for both RCS and CCS. If they so wish, they can receive CCS before a residential place can be offered to them because the waiting time for CCS is generally shorter than RCS. In some cases, they can be given CCS almost immediately after assessment.

128. As reflected by the concerned statistics of SWD, about 50% of elders having gone through the SCNAMES assessment at the time of application (i.e. eligibility screening assessment) are recommended with a dual option; and over 90% of elders having a dual option choose to apply for RCS (either as a sole RCS application or joint application for both

RCS and CCS) instead of CCS only. Hence, a change in the dual option arrangement will have significant impact on the waiting time for RCS. For instance, if 50% of the elderly applicants with dual option switch to CCS only, the waiting time for subsidised C&A place would be shortened to less than one month in 2020 and then the queue would vanish by 2023. If a more aggressive approach is adopted, which is doing away with the dual option altogether (meaning all dual option holders will use CCS only), the queue will completely vanish by 2013.

129. As far as social impact is concerned, if most of the dual option holders are required to use CCS, subsidised RCS places can be allocated to elders who are recommended with “RCS only”, i.e. elders whose care needs can only be met by using RCS because of their frailty, lack of family support and the existence of environmental risks. In other words, RCS places will be allocated to elders most in need and within a relatively short time.

130. Adjusting the percentage of dual option to receiving CCS may also have financial implications as the current unit cost of a subsidised C&A place is higher than a subsidised day care or home care service place. The financial implications may change if the Government decides to encourage the utilization of CCS by extending the service scope of CCS. It is therefore difficult to ascertain the financial implications of a change in the “dual option” arrangement.

131. Although the encouragement of or even mandatory requirement for CWL applicants with dual option to shift to CCS may help to maximize the usage of CCS and hence promote ageing in place, it may arouse public criticisms of depriving elders of their choice. Even if the existing dual option holders are grandfathered, new comers and their related interested parties might expect the same level of choice. To address such sentiments, concomitant measure to expand CCS to address the needs of the concerned applicants is required. The Government has to commit extra resources for enhancing CCS and allowing more flexibility in its service combination to attract more users.

INTRODUCING A MEANS-TEST MECHANISM IN THE ALLOCATION OF RCS

132. As revealed in Chapter 2, the Government has committed considerable amount of resources in the provision of subsidised RCS, both directly through providing subsidised residential care places and indirectly through financial assistance (i.e. CSSA) to a majority of private RCHE users. Only a minority of RCHE residents are using private RCS under a user-pay mode. The provision of RCS could therefore be regarded as largely a public-funded mode. In view of the ageing population, this would incur substantial financial burden to the public revenue in the long run.

133. Moreover, the current mode of allocation of subsidised RCS places is basically ‘universal’ in nature, without any selection based on financial means, though the applicants have to be screened by the SCNAMES based on, among other factors, their physical frailty. This may result in inefficient allocation of limited public resources to those who do not necessarily need public subsidy. This may also lead to criticisms of inequity in allocation of public resources. There is thus a need to come up with a selection mechanism to ensure the most efficient and equitable allocation of public resources to those most needy of RCS.

Pros and cons of means-test

134. Although international experiences (revealed in Chapter 3) reveal that publicly-funded services are usually provided on a selective basis through a means-test, there are still possible controversies in the introduction of a means-test in the local context. By means of focus groups and informant interviews conducted in this study, as well as the survey on a wide variety of respondents, including elderly service users, family members of elderly people, operators of RCS (from NGO and private sectors), diverse views were collected and analysed.

135. A majority of respondents in various focus groups and interviews supported the implementation of a means-test for RCS, based on the consideration that limited public resources should be allocated to the most needy and on a fair basis. Means-test may also give the

Government greater control on the expenditure on subsidised LTC services. This positive stance towards adopting means-test in RCS allocation is also shared by the majority of survey respondents.

136. More than 45% of all categories disagreed to allocate the resources of RCHE equally to all elders regardless of their financial ability which would result in relatively lower subsidy for everyone. Rather, over 60% of respondents from all categories thought that the resources of RCHE should be allocated to those with genuine financial need. Amongst those who supported a RCS “Voucher Scheme” or had no comment on the scheme, more than half of the respondents opined that the provision of the voucher should be based on a means-test mechanism in order to target resources at those elders who have genuine financial needs. This shows that there is general support amongst the survey respondents for the selective basis of provision of subsidised RCS.

137. That said, a few respondents in the focus groups and informant interviews, especially those from NGOs, opined that LTC services should be regarded as one of the means through which society reciprocates the contributions of our senior members, and therefore should be provided on a universal (i.e. non-means-tested) basis.

138. Some other respondents had reservations about means-test, as elderly people (and their family members) might not be willing to disclose their families’ financial conditions. From their direct experiences in working with elders, many respondents opined that most elders would opt for assessing their own financial conditions only, rather than including their family members in the means-test.

139. On the other hand, implementing a means-test would incur administrative costs. Government officials who have been involved in administering means-tested public services/subsidy schemes (e.g. public rental housing and social security) opined that it would require the setting up of a sizeable staff establishment and devising a detailed mechanism to verify the information provided by applicants. There are difficulties in administering means-tests especially on information verification.

140. Currently, all means-tested systems administered by the

Government (e.g. the Housing Authority and SWD) require the clients/applicants to declare their financial conditions with supporting documents. Applicants are also warned of possible prosecution for deception and/or provision of false information. The relevant authorities have also instituted appropriate mechanisms of cross checking and investigation to ascertain the applicants' eligibility.

141. Nonetheless, given the formidable challenge of an increasingly ageing population, coupled with ascending morbidity due to increased longevity, it is imperative for the Government to devise a sustainable model of RCS provision and financing. The current model of non-contributory, nearly universal provision of subsidised RCS may need to give way to one that is premised on selective provision through a means-test.

The choice of an appropriate means-test mechanism

(a) Reference to the Medical Fee Waiving Mechanism of Public Hospitals

142. Currently, there are means-test mechanisms operating in the provision of CSSA and housing service. If a means-test mechanism is adopted in the allocation of RCS on a selective basis, the ultimate aim is not to use it as a 'poverty-alleviation' policy device. It is different from CSSA in the sense that CSSA provides financial support covering a basket of essential goods and services for its recipients while the allocation of RCS is service specific and in-kind. Thus, the CSSA means-test mechanism may not be a suitable reference. Similarly, though subsidised RCS can be regarded as some kind of subsidised accommodation for the elderly, it is different from ordinary subsidised housing because RCS also involves special personal care elements to meet the LTC needs of end-users. Hence, it would not be appropriate to make reference to the Housing Authority's means-tested mechanism for the allocation of subsidised public rental housing units which does not take into account the care needs of its applicants.

143. On the other hand, both the CCS and RCS could be regarded as a kind of 'health care' service provided for the frail elderly people who need personal care of various degrees in a domestic or institutional setting.

The frailty and the need for personal care are ascertained by the SCNAMES. Given the similarity in nature, it is recommended that reference could be made to the **Medical Fee Waiving Mechanism of Public Hospitals** administered by HA.

144. HA's Medical Fee Waiving Mechanism makes reference to the Median Monthly Domestic Household Income (MMDHI). According to HA, eligible patients should fulfil two financial eligibility criteria in order to obtain the fee waiver: i) their monthly household income should not exceed 75% of the MMDHI applicable to their household size (at the reference time/year), and ii) the household asset value is within a certain limit based on their household size. (Table 4.1) Similar to other means-tested mechanisms adopted in Hong Kong, the residential property owned and occupied by the patient's household will not be taken into account in the assessment of assets. In addition, higher asset limit is given to households with elderly members.

145. Other non-financial factors would also be taken into consideration for those patients not fulfilling the financial criteria. Such 'other factors' usually relate to medical and/or social grounds e.g. single parent families, nature and severity of illness. Based on the above, partial waiver of medical fees is provided for eligible patients with household income not exceeding 75% of the MMDHI that is applicable to the appropriate household size, and full waiver will be given to those whose income only constitutes 50% of the MMDHI.

Household Size	MMDHI*	75% of the MMDHI	50% of the MMDHI	Asset Limit (with no elderly member)	Asset Limit (with 1 elderly member)	Asset Limit (with 2 elderly members)
1	\$6,600	\$4,950	\$3,300	\$30,000	\$150,000	-
2	\$14,000	\$10,500	\$7,000	\$60,000	\$180,000	\$300,000
3	\$18,000	\$13,500	\$9,000	\$90,000	\$210,000	\$330,000
4	\$23,800	\$17,850	\$11,900	\$120,000	\$240,000	\$360,000
5	\$29,600	\$22,200	\$14,800	\$150,000	\$270,000	\$390,000
6 or above	\$32,000	\$24,000	\$16,000	/	/	/

Note: The asset limit is raised by \$120,000 for each elderly member (i.e. age >65) in the patient's family.

*MMDHI by household size- 2nd quarter 2009, General Household Survey, Census and Statistics Department

146. A full-fledged means-test mechanism should normally assess both the applicant's assets and recurrent (monthly) income. However, due to the unavailability of data on respondents' asset in both the Census and Statistics Department's THS and the survey of the present study, the aspect of asset would be omitted in the subsequent projections of this study. It is worth pointing out that as most elders have retired and thus may not have much regular income, there might be a sizable portion of elders who could meet the means-test if asset is not counted.

(b) Household / family or individual as the unit for means-test

147. In the administration of a means-test mechanism, either the applicant of a particular service or benefit or the whole family/household could be taken into account in assessing the financial means. There are both pros and cons for each of these two approaches.

148. With respect to the approach of assessing only the elderly applicant, there could be several merits. Firstly, it could be viewed as taking the elderly as an independent entity in his/her application for social benefits, instead of subsuming individual elderly under a family or household. Secondly, it might reduce the administrative time and cost in assessing a large number of individuals. Thirdly, it may avoid the controversy of requiring the elderly to disclose their family members' financial information.

149. As for assessing the household / family, except for the case of singleton elderly where there are no co-residing family members, the means-test should include assessing the income and assets of those co-residing family members of the elderly applicant. This is based on several considerations: firstly, supporting the elderly is a traditional Chinese virtue in Hong Kong. Secondly, research findings have revealed that there is considerable inter-generational transfer between elderly parents and their adult children, i.e. elderly people normally get financial support from their children. Thirdly, co-residence between elderly and their family members actually constitutes sharing of the household finance, thus making the household as a unit of production and consumption. Finally, as practiced in many other means-test

mechanisms in various social policy domains – the CSSA, public rental housing, and medical fee waiver and education – the household is usually taken as the unit for means-test.

150. However, as revealed from survey findings of the current study, there appears to be a slight majority view amongst the elderly respondents that financial assessment related to the application of any publicly funded services for the elderly, mainly RCS and CCS, should only be applied to the elderly applicant. This stance was also shared by many of the informants from both the NGO service providers and private RCHE operators.

Impact of introducing a means-test mechanism

(a) Assumptions

151. Under the existing mechanism, the application of subsidised RCS places is not means-tested and there is no information about the financial situation of past and existing applicants. Therefore, in this exercise, only the income of the respondents on CWL who are non-CSSA recipients are taken as a reference for assessing the impact of means-test.

152. For projection purpose, the income limit of the “Medical Wavier” Scheme operated by the HA will be taken as reference. Also, only the income of the elders will be assessed and the income items are those defined in the THS. For this exercise, CSSA recipients will not be means-tested for applying for subsidised RCS. All the determining factors are based on survey finding, SWD data and THS data.

153. By making reference to the single person household size in HA’s Medical Fee Waiving Mechanism, the analysis in the following paragraphs is based on two hypothetical income thresholds, i.e. \$3,500 and \$5,250, to compare the differences in the impact when different income thresholds are applied to define who are eligible for applying for the subsidised RCS. Elders with income below the threshold are eligible for subsidised RCS.

(b) Impact on number of applicants in Central Waiting List (CWL) and waiting time

154. If a means-test mechanism were introduced in 2010 with annual addition of new C&A places at the current pace, the CWL would only be shortened slightly irrespective of the income threshold set at \$3 500 or \$5,250, although its effect would become more significant in the longer term. The impact on the waiting time is also expected to be small.

INTRODUCING A MEANS-TESTED VOUCHER SCHEME

155. As revealed in the international scene, further supported by the local normative value, there should be a greater emphasis on promoting community care rather than institutionalisation. Thus, if a voucher scheme is to be considered, it should be flexible enough to allow users / beneficiaries to make use of the subsidy provided to purchase either CCS or RCS.

156. At present, the great majority of CCS is provided by NGOs subsidised by the government. The existing 24 EHCCS teams⁴, 60 IHCS teams and 58 DEs/DCUs have already taken up a nearly saturated workload and are therefore not likely to be able to meet additional demand from a new group of CCS users who may benefit from a voucher scheme.

157. It could be anticipated that, with the availability of a voucher that enables elderly and their family members to exercise greater choice and control of their utilisation of LTC services, the private market of both RCS and CCS could be stimulated. For instance, NGOs currently operating CCS may be encouraged to enlarge their scope of self-financing services.

158. In fact, there are already some initiatives taken by local NGOs to explore the possibility of launching self-financing CCS. For instance,

⁴ From December 2008 onwards, six new EHCCS teams have started operation, adding to the original 18 teams in the 18 District Council districts. These six new teams cater for the increasing demand in those designated districts. Thus, it could still be postulated that these new teams will shortly be saturated.

a total of nine NGOs participate in the joint study of the Hong Kong Council of Social Services on self-financing CCS. The Senior Citizen Home Safety Association is also providing some kinds of CCS on a self-financing mode.

159. Nonetheless, it should be reckoned that there is still a lack of a viable private CCS market in Hong Kong. Therefore, this study would be confined to the exploration of a RCS voucher amongst all other possible options that have been suggested in this chapter. It has to be emphasized that the provision of ‘voucher’ or cash subsidy for residential services is only very rare in the international regime (with the exception of Austria) while some countries provide cash subsidy for home-care only.

160. The general appraisal of a voucher system has been dealt with in Chapter 3 (international scene). The following paragraphs focus on the relevant issues to be considered in implementing a RCS voucher in Hong Kong’s context.

Why a RCS voucher scheme may be considered in Hong Kong?

161. In Chapter 2, a critical appraisal of the current situation of LTC financing and provision in Hong Kong has been outlined. It was identified that Hong Kong is essentially a public-funded system in which LTC services are largely funded by the Government directly (through subsidy to operators) or indirectly (through provision of CSSA to elderly residents in private RCHEs). However, in the allocation of subsidised residential care places, there is only the care need assessment under SCNAMES but no assessment on the financial conditions of the elderly applicants and/or their family members. While the SCNAMES can effectively assess the eligibility in terms of frailty and the need for LTC services, the lack of screening on financial means would practically imply a ‘universal’ provision of subsidised LTC services to elderly people of any financial ability.

162. In view of the ageing population and the rising cost of operating RCHE places as a result of increasing frailty level of elders admitted to RCHEs and the salary costs of para-medical staff, it would

pose a considerable financial burden to the publicly funded system of provision. It is therefore desirable to explore the possibility of introducing a mechanism which could effectively allocate limited public resources to those most in need of the highly subsidised service.

163. The Government has allocated considerable amount of resources on the provision of subsidised RCS. The overall supply of subsidised residential care places has increased from around 16 000 in 1997 to around 26 000 at present, representing a rise of about 60%. Due to the fact that subsidised RCHE places are virtually universally provided at present, it has induced elderly people (and/or their family members), regardless of their financial conditions, to apply for subsidised RCHE places by 'queuing up' under the CWL. As a result, there is a long waiting list. Currently, applicants on the CWL for subsidised residential care places in subvented or contract RCHEs would have to wait for a long time to be allocated a place (on average 32 and 40 months for C&A and NH places respectively, as at August 2009), while the waiting time for EBPS places (at C&A level) is relatively short (on average eight months, as at August 2009). However, even with the Government's commitment to increase subsidised RCHE places gradually in the long run, there are various hurdles limiting the immediate increase of such places in the short run. These constraints include critical aspects such as the shortage of nurses and lack of suitable sites for RCHEs (especially NHs). There is thus the need to explore means to enable applicants on the waiting list to be provided with alternatives in getting access to LTC services at appropriate level of service quality.

164. As revealed in international experiences, cash subsidy or voucher could serve as viable means to provide greater consumer choice and flexibility in getting access to needed services. If a RCS voucher was to be provided, some of the applicants on CWL would switch to purchase (with the voucher) RCHE places provided by private operators or NGO-run self-financing RCHEs. This could serve to speed up the access to RCHE places for those in urgent need, and thus shorten the waiting time for those remaining on the waiting list.

Impact of introducing a RCS voucher scheme – on users

165. Without the RCS voucher scheme, elders (and/or their family members) may not necessarily resort to RCS when they become frail. They may choose between RCS, CCS, or informal care support. Family members or professional advice may be influential to the elders' decision in making their choice. However, the existence of RCS voucher may affect the choice of elders, their family members, or even the professionals. Elders may be encouraged or decide by themselves to switch to RCS without any consideration of trying to stay in the community. In other words, the introduction of a RCS voucher scheme may induce demand for subsidised RCS, resulting in early or unnecessary institutionalization.

166. As revealed in the survey, more respondents in various categories supported a RCS "Voucher Scheme". Among all respondents, a considerable proportion from various categories would readily accept the voucher if such a scheme is launched. The survey of the study also explored the respondents' readiness to top up for the voucher. In the survey interview, respondents were briefed about the existing subsidy level of the subvented or contract RCHEs and the private RCHEs under the EBPS. With this background, respondents were asked about the amount of money they were willing to pay to top up the voucher provided by the government if they could choose a suitable residential place in the private sector immediately. The median amount of "willing to pay" ranged from \$750 for those currently living in private RCHE to \$1 750 for those either on the CWL or those residing in the community.

167. Under a RCS voucher scheme, it is more likely that CSSA recipients would not be able to top up the voucher to purchase residential care services in the private/self-financing market. As a result, they might stay in the CWL to wait for a subsidised place. On the other hand, those who are financially more capable and can pass the proposed means-test may choose the RCS voucher to purchase a place in the private market immediately.

168. As mentioned above, the introduction of a RCS voucher might result in shortening the CWL. However, it is anticipated that, with the

provision of this incentive, there may be ‘induced demand’, i.e. those who originally may not need RCS might be induced to apply for a RCS voucher. In other words, the total number of elders receiving subsidised RCS may increase substantially as a result of the introduction of a RCS voucher scheme.

Impact of introducing a RCS voucher scheme – on service provision

169. The present study interviewed 17 representatives of operators of NGO-run RCHEs (NGO operators) and operators of private RCHEs (private operators) to solicit their views on the possible impact of introducing a voucher scheme for RCS, in particular a means-tested one, on service provision and delivery.

170. First of all, respondents from both NGOs and private RCHEs agreed that the introduction of RCS voucher may motivate private homes to improve their quality in view of the increased demand, greater consumer choice and expectation, and more resources from the income of voucher.

171. If a RCS voucher scheme is to be implemented, some NGOs would adopt market-oriented strategies by developing more self-financing RCS services for those who can afford topping up to purchase higher quality services. Some even suggested affiliating their self-financing RCS with their existing subvented services to fully utilise the professional resources.

172. Some NGO respondents regarded the voucher scheme as an opportunity or incentive for them to provide more value-added or alternative services to the elders which would help fill up the existing service gap. A large scale NGO even indicated its readiness to provide self-financing CCS upon the implementation of a voucher scheme because it had already established self-financing home care services in various districts. It was proposed that intermediate agents would be required to counsel the elders on how to choose the proper services with the voucher; and to manage the use of the voucher to maximise the benefit to the care of the elders. This is similar to the ‘cash and counselling’ or ‘case management’ approach in the US and the UK

173. Having said the above, some NGO operators (mostly from large scale NGOs with long history) reflected they would not develop new or large scale self-financing RCS services as it was not their agency's vision or long-term strategy to start up market-oriented services. Their services would be need-driven and if the NGOs were to maintain the same high level of service quality as usual, it would be impossible for them to compete at a relatively low price. On the other hand, they are concerned about the shortage of health care personnel which was considered as a major hindrance to the expansion or development of either RCS or CCS. Furthermore, they worried that the implementation of voucher scheme may pose a drastic change to the current subvention mode and the funding source would become unstable which may affect the existing service quality.

Other considerations for introducing a means-tested voucher scheme in Hong Kong

174. Having regard to the international trend of promoting community care and support services and the Government's objective of encouraging ageing in place, the scope of coverage of the voucher could be as wide as possible with a view to facilitating "ageing in place" e.g. including CCS and even home modification services to improve the living environment of the elderly. This is supported by quite a number of NGO respondents interviewed in this study.

175. Although the present private CCS market is not mature enough compared with the subsidised market, with the introduction of a voucher scheme (should that be applicable for both RCS and CCS), there could possibly be an impact of encouraging both NGO and private operators to explore the development of self-financing CCS. Respondents from both sectors were optimistic about such positive impact in the provision of CCS. (ref. to Chapter 5) In particular, NGO respondents all agreed that the proposed voucher should be applied to both CCS and RCS, so as to avoid encouraging pre-mature or unnecessary institutionalisation, and to actualise the Government's policy objective of promoting ageing in the community. That said, some NGO operators opined that as subvented/contract RCHEs are popular among elders, they doubted

whether elders would be attracted by the CCS voucher and stop waiting for subvented/contract RCHEs.

176. As a matter of fact, some NGOs are already operating self-financing CCS and the introduction of CCS voucher would encourage these NGOs to further expand the existing scope of non-subvented services or to develop more comprehensive package of CCS to cater for the care need of the community elders. They strongly supported the idea of LTC voucher which covers both RCS and CCS, so that greater flexibility would be available for community elders to choose between RCS and CCS according to their physical condition which may change from time to time. Reference could be made to recent developments by some NGOs and DECCs, which will be discussed in Chapter 5.

177. The administration of the voucher should be as simple as possible so as to enable more effective utilisation by elderly users and service operators, and to reduce administrative and financial costs.

178. In cases where an elderly user and/or his/her family members can no longer afford to top up for the higher-end services they have been using for whatever reasons, service operators would need to have provisions in place for handling such unexpected circumstances and should refrain from evicting a client under duress.

179. Furthermore, the level of the means-test may have to be adjusted according to changing social circumstances, for instance, to be pegged with changes in composite consumer price index and/or median monthly household income.

180. To make the voucher scheme successful, the same means-test should be applied to the CWL for subsidised residential care places. Otherwise, those who fail the means-test for the voucher (i.e. the wealthier group) would simply join the waiting list for subsidised residential care places, which will defeat the fundamental objective of targeting resources at elders most in need.

181. Though NGOs are now operating under the Lump Sum Grant system, there could still be some ‘standard unit cost’ estimates for the provision of RCS and CCS, especially in view of the basic level of professional care provided. Thus, the value of the voucher could be benchmarked against this ‘standard unit cost’.

182. There had been concern raised by NGO representatives operating elderly services about the possible problem where private RCHEs raise their fees to the level of the voucher without corresponding enhancement in service quality. It was suggested that there may be a need to institute some measures to ensure that private RCHEs accepting vouchers would deliver quality services that would commensurate with their charges. Reference could be made to Education Bureau’s PEVS. The current Education Ordinance allows the Government to issue ‘fee certificate’ to kindergartens in approving their fee adjustments; so that the Government may practically set a price/fee ceiling as the eligibility criterion for using PEVS to avoid marking up of fees by kindergartens to absorb the PEVS. At present, SWD has set the amount of user fees chargeable by EBPS homes on elders occupying subsidised places through contractual agreements. Some key informants suggested that similar administrative measures could be explored for the voucher scheme to ensure a reasonable price level charged by private RCHE.

183. In order to actualize the merit of a voucher scheme, it would be desirable if there could be some mechanisms to promote the improvement of services, especially in private RCHEs. For instance, private RCHEs should be encouraged to participate in quality assurance or accreditation schemes, so that consumers (i.e. voucher holders) will have a better grasp of the service quality of different private RCHEs when using their vouchers.

184. In this connection, it is recognised that EBPS is successful in enhancing the quality of private RCHEs, and better utilising RCHE places in the private sector. It may therefore be desirable that EBPS be retained at the beginning of the implementation of the voucher in view of the need for the elderly and the EBPS home operators to adapt to policy changes. That said, some respondents opined that there is a need to review the relative merits of EBPS against the voucher in the long term.

185. Furthermore, there should be more transparency of the service information of private RCHEs in terms of location, physical environment, quality of service, fees, operating agents, and the like. Reference could be made to the Education Bureau's publication of a 'schools profile' that provides the basic information of the various operators. Currently, SWD also publishes basic information of RCHEs on its website. However, more detailed information could be provided. Only by providing easily accessible information can the user benefit most in exercising their choices and the utility of a voucher system be best achieved.

186. A complaint or feedback system could also be implemented for handling enquires about the standards of RCHE under the RCS voucher scheme. Such a system should be administered in a user-friendly manner, and should avoid incurring undue complaints and unnecessary administrative work. Issues related to accreditation, service quality assurance and information dissemination would be further examined in Chapter 5.

187. As a related matter, private operators are concerned about having a 'level playing field' in which both NGOs and private operators could compete on equal footings. For instance, some private operators opined that rental expense is a major operating cost of private RCHEs which, on the other hand, is not significant for subvented/contract RCHEs as they are usually located in subvented premises.

CHAPTER 5

RECOMMENDATIONS

188. In this chapter, we present our recommendations for the planning and development of LTC service.

DEVISING A VIABLE AND SUSTAINABLE LTC FINANCING MODEL

189. In meeting the challenges posed by an ageing population, Hong Kong should devise viable and sustainable policies and services to cater for the increasing demand for LTC services. As revealed in the international scene, further coupled by the general public's preference, which is also congruent with the government's policy direction, "ageing in place" and community care should be promoted. Efforts should be made to encourage elderly people to continue living in their familiar, domestic environment as long as possible, instead of having premature and unnecessary institutionalisation. There should be a need to explore how best to promote the development and provision of CCS either by the private sector or the NGOs by means of self-financing modes.

190. The present system of a publicly-funded mode of provision may not be sustainable and viable in the long run in view of the escalating demand given by an ageing population, especially in view of the absence of a screening mechanism to identify those who are in genuine need for government's financial subsidy.

191. As elaborated in Chapter 4, a majority of respondents in various focus groups and interviews supported the implementation of a means-test for RCS, based on the consideration that limited public resources should be allocated to the most needy and on a fair basis. This is also in line with the general trend of selective provision in places where LTC services are publicly funded.

RECONSIDERATION OF THE 'DUAL OPTION'

192. So far as subsidised services are concerned, the SCNAMES

would assess the care need of elderly applicants and make corresponding service recommendations, including “CCS only”, ”RCS only” and “dual option” i.e. suitable for receiving either CCS or RCS. Currently, over 90% of the applicants assessed to be suitable for both RCS and CCS (i.e. “dual option” applicants) choose to apply for RCS (either as sole RCS application or as joint application for both RCS and CCS), which goes against the global trend of promoting “ageing in place”. Though the provision of CCS can basically serve a considerable number of frail elders so that they can continue living in the community, there are still some factors leading to the tendency amongst elderly and their family members to opt for RCS.

193. Such factors may include the absence of a means-test mechanism in the allocation of RCS places; the impression that subvented RCHEs are better than private RCHEs and charge a lower fee, and that family members can be relieved of their care-giving burden once the elderly member is admitted to a subsidised RCHE; the under-development of support services immediately following elderly people’s discharge from hospitals; and the unavailability of family caregivers, among others.

194. The dual option arrangement should be reviewed in order to promote “ageing in place”. One option is to dispense with the “dual option” mode, i.e. only elders who have no support at home and cannot rely on CCS to stay in the community would be matched with RCS. Another option is to require “dual option” applicants to use CCS for a certain period of time before they can opt for RCS. This will give the elders an opportunity to stay in the community with the assistance of CCS before considering RCS. Such measure would also help alleviate the problem of early institutionalisation, and ensure that RCS places are allocated to elders most in need. After the trial period, if the need for RCS is substantiated, a RCS place could be arranged.

195. Subject to the availability of quality CCS services in the private or self-financing market, consideration may be given to providing subsidy for CCS in the form of a voucher in which CWL applicants may use the voucher to ‘purchase’ different combinations of CCS in the private/self-financing sector. For instance, if CWL applicants with “dual

option” are provided voucher to use CCS in the private sector during the mandatory trial period, there should be more incentive to use CCS.

FURTHER DEVELOPMENT OF CCS

196. As highlighted in Chapter 2, Hong Kong records a higher institutionalisation rate (nearly 7% of elders aged 65 or above) when compared with other countries which lies roughly in the range of 1% to 5%. The current situation where some elders and/or their family members opt for early and/or unnecessary institutionalisation should be seriously examined and tackled. In fact, the principle of ‘ageing in place’ has been persistently upheld both locally and internationally in the development of LTC for elderly people. Such a principle emphasises that elderly people should live with their families or in a familiar environment as they age. The promotion of CCS may encourage utilisation of CCS instead of RCS. Public education and publicity should be enhanced in this direction.

197. In addition, based upon the merits of cash subsidy as practiced in other OECD countries, further supported by the findings of this study that a voucher scheme would be welcomed, there is thus the need to explore introducing a voucher scheme for CCS. This is in line with the overall principle of promoting user-choice, flexibility and most of all, ageing in place. This may also avoid or reduce the possible problem of induced demand from a RCS voucher scheme if elders (and their family members) were provided with a further choice between RCS and CCS.

198. In fact, the provision of CCS voucher is supported by international experiences. Internationally, cash subsidies (or vouchers) are usually provided for CCS rather than for RCS (e.g. ‘Cash and Counseling’ in the US, Community Aged Care Packages CACP in Australia). The International trend of preference to providing cash subsidy to enable elderly and their family members to live in domestic setting is based upon the fact that community-based home care services have been demonstrated to play a significant and indispensable role for older people. Such services contribute to the avoidance of premature and unnecessary institutionalisation, and help to actualise “ageing in place”.

199. Such a preference to promoting community living, rather than institutionalisation, may explain the trend that, amongst the countries reviewed, there is only one (Austria) that provides ‘voucher’ or cash subsidy for residential service while others would provide cash subsidy for home-care only.

200. In the local context, the survey findings revealed that more respondents from various categories (ranging from 54.8% to 70.0%) agreed that CCS could facilitate them to live at home at ease. Findings also revealed that the following were favourable factors that would assist and encourage elders to stay at home instead of choosing elderly home: a) the enhancement of home care services; b) the enhancement of day care services; c) provision of direct subsidy for the elders to choose suitable service from the market; d) more skill training for caregivers; e) increasing caregivers’ knowledge of ageing; f) increasing caregivers’ knowledge of caring for the demented and elders’ knowledge of ageing; g) more promotion on CCS.

201. Both NGO and private operators interviewed in this study were optimistic about the positive impact of the introduction of voucher in the provision of CCS. In fact some NGOs / non-profit-making organisations are already developing self-financing CCS and some DECCs have already developed paid carer services as mentioned in Chapter 2.

202. Nevertheless, the present private CCS market is not mature enough while comparing with the RCS one. So, if a CCS voucher was to be introduced, there needs to be a well-developed private market, like that of RCS, so that elders holding the vouchers can freely choose the services that most suit their needs. In addition, the variety of services offered, and the flexibility of using such services (e.g. in terms of service hours and service mix) should be enhanced to cater for the needs of different elders and their carers. The issue of ensuring service quality would also need to be addressed to avoid any abuse of the voucher system. As mentioned above, there should be more publicity on CCS to encourage utilisation.

203. An attempt could also be made to achieve better synergy with other existing social, medical and related services, in promoting a holistic, integrated approach in serving the elderly in need. For example, there is a need to explore how best to provide timely support services to the elderly discharged from hospitals, so as to avoid institutionalisation of the elderly due to unavailability of family carers and/or relevant home-based services. Services provided by various service agencies/units such as the DH's Elderly Health Centres, the DECCs, NECs, and Integrated Family Service Centres could be better coordinated. Furthermore, resources could be tapped from developing social enterprises that provide "one-stop" and "personalised" services to enhance the support for elders in the community. This may also promote neighbourhood support and even generate potential employment opportunities for people who are committed to serving the elderly.

204. It is worth pointing out that carers also play an important role in supporting elders to "age in place". At present, support for carers is mainly provided through elderly centres, in the form of counselling and information provision, etc. In 2008, the Government launched the "District-based Trial Scheme on Carer Training" with a view to equipping carers with basic elderly care skills. With the ageing population and increasing frailty of elders, there is also a need to explore how to further enhance the support for carers of elders.

OTHER PERTINENT ISSUES TO BE CONSIDERED

Manpower problem

205. In the provision of a viable LTC service delivery system, the supply of sufficient, qualified and committed personnel is of prime importance.

206. Apart from the licensing requirements stipulated in the Residential Care Homes (Elderly Persons) Ordinance (Cap. 459) and its regulations which all RCHEs should comply with, subsidised RCHEs are also required to meet the essential / minimum manpower requirements set out in the Funding and Service Agreements or service contracts between the concerned operators and SWD. RCHEs providing NH places must

also obtain licences under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165) administered by DH.

207. However, there are concerns about the issues of manpower shortage and professional training in the field of elderly care services. Specifically, there is an acute shortage of Registered Nurses (RNs) and Enrolled Nurses (ENs) who play an important role in providing special nursing care for frail elders. The provision of NH places is even more closely tied to the availability of RNs as the Nursing Homes and Maternity Homes Registration Ordinance (Cap.165) has provisions requiring the attendance of RNs for the daily operation of NHs. The acute shortage of RNs hinders the service expansion of NH to a large extent.

208. In tackling the shortage of ENs, the Government has launched a two-year full time training programme to train ENs for the welfare sector since 2006. Four classes have been organised so far. Four more classes will be organised from now till 2011. These eight classes will provide a total of 930 training places. Tuition fees of the Programme are fully subsidised by the Government. Graduates have to undertake to work in the welfare sector for at least two consecutive years after graduation. Trainees of the first two classes graduated in April and October 2008, about 85% of the graduates of these graduates have joined the welfare sector. This will to a certain extent alleviate the shortage of ENs in the sector.

209. Apart from the shortage of nurses, NGO operators interviewed were concerned about the problem of shortage of health care workers. In this connection, the Elderly Commission has, in collaboration with the HA, implemented a pilot training programme for health workers to enhance their skills and competence in caring for frail elders in RCHEs. With the provision of more well-trained health workers in the long run, health workers may play increasingly important roles in providing care services in RCHEs, which may in turn attract the younger workforce to join the field.

210. In addition, many NGO operators interviewed in the present study commented that it might be desirable to stipulate higher staffing

requirements for RCHEs in the longer run, considering that elders admitted to RCHEs are frailer than before and they require higher level of care which is more labour-intensive. For subsidised RCHEs, this might be applied by means of reviewing the relevant service contracts or agreements. As for private RCHEs, a change in the staffing requirements will be hard to achieve for that would involve a change in the statutory licensing standards.

Quality Assurance and accreditation of private RCHEs

211. There have been concerns about the availability of quality RCS in the market. Given the disparity of service quality among private RCHEs, both NGO and private operators interviewed opined that quality control would be critical in the private market, particularly if a RCS voucher is to be considered in future.

212. At present, since a considerable portion of private RCHE users are on CSSA and that constitutes a readily available market for private RCHE places, there is a lack of incentive for private RCHEs to seek for accreditation in order to attract more customers. If a RCS voucher scheme was introduced, it might help induce private RCHEs to seek for accreditation and hence enhance service quality, so as to attract more customers looking for better quality service by means of topping up their vouchers.

213. SWD is now monitoring private RCHEs through licensing control administered by its Licensing Office of Residential Care Homes for the Elderly (LORCHE). While the licensing/monitoring mechanism is in place to ensure compliance of the private RCHEs with the statutory requirements, sub-standard services or malpractices are still found occasionally.

214. Currently, as there exists a gap in terms of image, quality and service fees between private and subvented RCHEs, some elderly (and their family members) may yet prefer remaining in the CWL to wait for subsidised RCHE places even if a RCS voucher system was introduced. The Government may need to consider how to narrow such gap with a view to fully utilising the residential care places in the

private/self-financing market.

215. To further ensure the service quality of private RCHEs, there should be better access to information such as location, physical environment, quality of service, manpower, fees, operating agents, etc. Currently, SWD only publishes basic information on RCHEs on its website. More comprehensive and user-friendly information could be provided through accessible channels to elders and their carers. A complaint or feedback system could also be implemented for handling enquires about the standards of RCHEs if a RCS voucher was introduced.

216. Reference can be made to OECD countries such as the UK and the US. The UK government has required all NHS organisations to produce an annual report that includes information on performance for public use. National standards, performance milestones and a timetable for improvement for services or types of health care were set under the UK's National Service Frameworks in 1998 to monitor the service quality. A mandatory national reporting system for adverse events in health-care delivery has also been created since 2001 to hold government-funded bodies accountable. In the US, public programmes have implemented systems of quality measurement and reporting focused on health-care providers, including nursing homes and home health care (Lundsgaard, 2005).

217. As mentioned above, the Government is using a licensing control system to ensure the basic service quality of private RCHEs. The introduction of EBPS in 1998 has provided some incentives for private RCHEs to enhance their service quality beyond the licensing requirements. One possible means of further enhancing service quality is to set up an accreditation system where operators could be accredited of attaining a particular level of service quality. The accreditation system should be independent from the Government's licensing control system in order to avoid any confusion with the statutory licensing requirements. Currently, there is a voluntary Accreditation Scheme for Residential Services for the Elders operated by the Hong Kong Association of Gerontology (HKAG). However, the number of accredited RCHEs has remained small since its inception in 2005. The Hong Kong Health Care Federation and the Hong Kong Productivity

Council launched another quality assurance scheme for elderly services entitled Quality Elderly Service Scheme in May 2009. The popularity of this scheme is yet to be seen.

218. The private RCHE operators interviewed raised a number of concerns about the current mechanism of voluntary accreditation. Firstly, there is so far no universally agreed or accepted quality assurance system; different operators resort to different systems, including the Hong Kong Association of Gerontology (HKAG)'s scheme, International Organisation of Standardisation (ISO), Hong Kong Management Association (HKMA)'s management audit, etc. Secondly, the cost of accreditation is considerable. Thirdly, it might take quite a long time to complete the accreditation for the whole private sector, especially in view of the need for training up a team of qualified accreditors and the vast number of RCHEs.

Provision of NH places

219. With increased frailty of elderly people, the level of care to be provided in residential care settings would have to be increased. Currently, there are C&A and NH places in the subsidised/private/self-financing market catering for the need of elderly of different degrees of frailty. With increased morbidity of an ageing population, it is anticipated that there would be increased demand for NH places.

220. The supply of subsidised NH places is determined by a number of factors. Firstly, it is the Government's policy direction and availability of resources. Secondly, it relates to the availability of land. Thirdly, it depends upon the availability of manpower, especially RNs, as Cap. 165 stipulates that there should be a round-the-clock RN in NHs.

221. From the land perspective, NHs are regarded as 'hospitals' under Cap. 165 and have to be located in areas zoned for 'Government, Institution or Community' (GIC) facilities which are in keen demand. On the other hand, C&A homes can be located in areas zoned for both 'Residential' and 'GIC uses'. Permission from the Town Planning

Board (TPB) must be sought if a NH is to be operated in a non-GIC site.

222. However, the current situation is that most of the private RCHEs are not located in GIC sites. It is quite unlikely for private organisations to acquire GIC sites for setting up profit-making NHs, nor is it a simple task to get permission from TPB for setting up one in non-GIC sites. Thus, the supply of private NH places would continue to be constrained by land supply in the foreseeable future.

223. Having said that, we note that the Chief Executive has recently announced a novel and multi-pronged approach to increase the number of subsidised NH places in the 2009-10 Policy Address. In view of the longer waiting time of NH places and their limited supply in the private market, we tend to agree with the focussed effort of the Government in increasing subsidised NH places and look forward to seeing the implementation details.

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