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Panel on Welfare Services and Panel on Health Services

Report of Joint Subcommittee on Long-term Care Policy

Purpose

This paper reports on the deliberations of the Joint Subcommittee on Long-term Care Policy ("the Joint Subcommittee").

Background

2. The Joint Subcommittee was jointly appointed by the Panel on Welfare Services ("WS Panel") and Panel on Health Services ("HS Panel") in November 2012 to study the long-term care ("LTC") policy and services (including home-based, community based and residential care services for the elderly, people with disabilities and the chronically ill), discuss the policy concerned with the Administration and make timely recommendations.

3. The terms of reference and membership of the Joint Subcommittee are set out in **Appendices I and II** respectively. The approval of the House Committee ("HC") was obtained on 15 November 2013 for the Joint Subcommittee to continue its work until 31 July 2014.

4. Under the chairmanship of Dr Hon Fernando CHEUNG Chiu-hung, the Joint Subcommittee held a total of 18 meetings. The Joint Subcommittee also received views from 176 deputations on various issues of concerns at 14 of these meetings. A list of the deputations which have given views to the Joint Subcommittee is in **Appendix III**.

Deliberations of Joint Subcommittee

Policy and planning

5. According to the Administration, its LTC policy for the elderly is underpinned by the following three principles: (a) promoting "ageing in place as the core, institutional care as back-up"; (b) promoting a continuum of care in subsidized residential care services ("RCS"); and (c) offering assistance to most needy elderly citizens.

6. As regards LTC policy for persons with disabilities, the Administration's policy objectives are –

(a) providing appropriate residential care and necessary training and support services for those persons with disabilities who cannot live independently and those who cannot be adequately cared for by their families, with a view to improving their quality of life and helping them develop independent living skills; and

(b) making available training and support to persons with disabilities in response to their needs, assisting them in developing their potential, enabling them to continue to live independently at home and preparing them for full integration into the community; and strengthening the carers' caring capacity and relieving their stress so as to provide a better quality of life for persons with disabilities and themselves.

7. Members consider that the existing provision of LTC services is fragmented with unnecessary categorization under "elderly" and "persons with disabilities", which is against the international trend of no distinct age limit. The Administration is urged to conduct a comprehensive review of its LTC policy with a view to offering services according to the needs of recipients, instead of their age. Given that the Chief Executive, as announced in his 2014 Policy Address, has tasked the Elderly Commission to prepare the Elderly Services Programme Plan within two years, members consider that the Elderly Services Programme Plan should be prepared in tandem with the Rehabilitation Programme Plan, so that the Administration can map out holistically the direction of LTC policy according to the needs of recipients.

8. Members are gravely concerned about the inadequate provision of

RCS and community care services ("CCS") for the elderly and persons with disabilities. Members consider that the inadequacy arises from the lack of good planning to address the huge demand. They call on the Administration to have long-term planning, in terms of manpower and training, as well as funding for provision of RCS and CCS, with scientific data and analyses from the information collected under the Standardized Care Needs Assessment for Elderly Services ("SCNAMES") and the central referral system for rehabilitation services, with a view to making a projection of LTC needs of the elderly and persons with disabilities in the next 10 to 20 years. The Administration is also requested to provide members with relevant data and information, and allow academics and the welfare sector to have access to such data and information.

Residential care services

Provision of RCS places

9. Members note with grave concern that the inadequate provision of subsidized places in residential care homes for the elderly ("RCHEs") and for persons with disabilities ("RCHDs") has resulted in a long waiting time (e.g. nearly nine years for hostels for severely mentally handicapped persons and over 2.5 years for nursing home places) for admission to these residential care homes. The Joint Subcommittee strongly urges the Administration to set target admission time for both RCHEs and RCHDs. In this connection, members call on the Administration to expeditiously increase the number of subsidized places in RCHEs and RCHDs. The Administration is also requested to reserve lower floors of the building blocks in its public housing projects for provision of RCHEs.

10. The Administration has advised that the waiting time for subsidized RCHEs is affected by a number of factors such as the special preference of applicants in terms of the location, diet and religious background of the elderly homes, whether the applicant has requested joining family members and/or relatives in a particular home, and the turn-over rate of individual homes, etc. In the Administration's view, it is very difficult to set target time for admission to RCHEs. In the case of RCHDs, the waiting time also hinges on a number of factors such as the location preference of applicants and the turn-over rate of individual homes, etc. It is difficult to estimate the extent to which the waiting time will be shortened by the provision of additional places. Regarding the supply of RCHE places in public housing estates, the Administration has advised that the inclusion of RCHE places in public housing estates would be subject to the overall planning and development of individual districts.

The Social Welfare Department ("SWD") has been closely liaising with the Housing Department and the Planning Department for the development plan of welfare facilities in new development projects. According to the Administration, a foremost criterion should be accessibility for provision of elderly care service facilities.

Quality and monitoring of private RCHEs and RCHDs

11. According to the Administration, SWD introduced an Enhanced Bought Place Scheme ("EBPS") in 1998 to upgrade the service quality of private RCHEs by enhancing staffing ratio and per capita space standards. In addition to statutory requirements under the Residential Care Homes (Elderly Persons) Ordinance ("RCHE Ordinance") (Cap. 459), private RCHEs participating in EBPS are required to fulfill requirements in respect of management as stipulated in the Service Quality Standards and Criteria drawn up by SWD, which cover aspects such as service quality, protection of the rights of service users, retention and provision of service information, as well as human resources and financial management in the operation of RCHEs.

12. Members point out that a huge portion of income of private RCHEs is from the meagre Comprehensive Social Security Assistance ("CSSA") payments received by their residents. Most private RCHEs therefore lack funding to improve their services. Members call on the Administration to provide an additional allowance, on top of the standard CSSA payments, for needy elderly persons residing in private RCHEs, so as to subsidize their expenditure on accommodation fee. More support should also be provided for private RCHEs to upgrade their services. In this connection, the Administration is requested to increase the number of purchased places in private RCHEs, explore ways to attract people to work in private RCHEs, develop service yardsticks and encourage private RCHEs to participate in accreditation programmes.

13. Regarding monitoring of private RCHEs, the Administration has advised that, to ensure that RCHEs comply with the licensing requirements, the Licensing Office of Residential Care Homes for the Elderly ("LORCHE") of SWD inspects RCHEs pursuant to section 18 of the RCHE Ordinance. The inspections are very comprehensive, covering aspects such as drug management, personal care services, infection control, handling of accidents, environmental hygiene, meals and staffing. At present, LORCHE conducts on average seven surprise inspections of each private RCHE per year, and will adjust the frequency of inspection based on the risk level of individual RCHEs. RCHEs are

required by LORCHE to rectify irregularities detected during inspections. Advisory or warning letters will be issued to non-compliant RCHEs, and prosecution actions will be taken if needed. Operational experience shows that most RCHEs are receptive to LORCHE's advice and will rectify irregularities promptly.

14. Notwithstanding the Administration's monitoring work, members consider that the quality of service provided by private RCHEs is far from satisfactory and their services fail to live up to public expectation. Members urge the Administration to review the RCHE Ordinance as well as revise and raise the service standards of private RCHEs to live up to public expectation. They also stress the need for the Administration to step up its monitoring measures against elderly abuse cases, non-compliance of staffing requirements and other irregularities in private residential care homes. The Administration should also address the problem of non-admission of elderly persons with human immunodeficiency virus ("HIV") to RCHEs, so as to ensure that elderly persons receive the same level of care without unlawful discrimination.

15. Members consider that the quality of service provided by private RCHDs is unacceptable. Members point out that since the implementation of the Residential Care Homes (Persons with Disabilities) Ordinance ("RCHD Ordinance") (Cap. 613) in 2011, only a small number of private RCHDs have been issued with licences, while the others have been issued with certificates of exemption to allow reasonable time for the operators concerned to carry out improvement works for meeting the licensing requirements and standards. Members take the view that, like private RCHEs, the monitoring measures for private RCHDs should also be stepped up by strengthening enforcement against irregularities (including abuse of people with disabilities), reviewing the relevant legislation and upgrading the service qualities to live up to public expectation.

Community care services

CCS for the elderly

16. In the light of the international trend that most elderly people wish to live independently in a familiar community rather than living in an institution, the Administration is urged to strengthen the provision of home care and community care services to facilitate the elderly to age in place.

17. According to the Administration, it has all along been promoting "ageing in place" as the core of its elderly care services. It has taken forward the recommendations of the Elderly Commission to enhance CCS for the elderly and rolled out new initiatives such as the Pilot Scheme on CCS Voucher for the Elderly ("CCS Voucher Scheme") to provide more service options.

Pilot Scheme on CCS Voucher for the Elderly

18. The Joint Subcommittee has examined the CCS Voucher Scheme before its implementation in September 2013. According to the Administration, in the first phase of the CCS Voucher Scheme, a maximum of 1 200 vouchers will be issued to elderly applicants in eight selected districts who are moderately impaired. The services provided under the CCS Voucher Scheme will remain subsidized. A sliding scale of co-payment will be put in place with five levels of government subsidy, so that the less the user can afford, the more the Government will pay. SWD will conduct means test to assess the household income of the voucher holder to determine his/her level of co-payment. The asset value of the voucher holder and his/her household is, however, not subject to such means test. There will be a total of 62 eligible recognized service providers ("RSPs") to be operated by 29 non-governmental organizations ("NGOs") and two social enterprises ("SEs").

19. Members and deputations consider that the service capacity of NGOs and SEs to operate as RSPs is questionable, given that the resources of these NGOs and SEs, such as manpower and space, have been stretched to the limit by providing services for existing service users. Members and deputations consider that the introduction of the CCS Voucher Scheme will adversely affect the provision of subsidized CCS and RCS places for those elderly people who are on the Central Waiting List ("CWL") for such places, as the Scheme will draw manpower resource from subsidized CCS and RCS.

20. Members note that each elderly person on CWL is being taken care of by a responsible worker ("RW") regarding his/her LTC services application. Eligible elderly persons are invited to join the CCS Voucher Scheme via their RWs. Members are concerned about the impartiality of RWs in helping these elderly persons to select CCS given the employment relationship between RWs and RSPs. Members suggest that independent social workers, rather than RWs employed by NGOs and SEs, should be assigned to draw up care plans for these elderly persons.

Integrated Home Care Services for the Elderly

21. According to the Administration, its subsidized CCS for the elderly include home-based services and centre-based services. The subsidized home-based services include the Integrated Home Care Services (Ordinary Cases) ("IHCS(OCs)"), IHCS (Frail Cases) ("IHCS(FCs)") and Enhanced Home and Community Care Services ("EHCCS"). With effect from 1 April 2003, the Administration has re-engineered and enhanced home and community based services for elderly persons and their families by upgrading the 138 subvented Home Help Teams to 60 agency and district-based IHCS Teams to provide a continuum of care and support services to frail and non-frail elderly persons living at home.

22. Members share deputations' concerns that NGOs running IHCS face operational difficulties in terms of budget control and manpower management. The demand for IHCS(OCs) is huge because of its low threshold and the need of the elderly for basic home-based support such as personal care, meal delivery and escort services. To address the problem of service mismatch and duplication, the Administration should reintegrate the existing services under IHCS(OCs), IHCS(FCs) and EHCCS with a view to alleviating the heavy workload of the service teams for IHCS(OCs). In this connection, members call on the Administration to provide a concrete timetable for a comprehensive review of IHCS (including its service content, operating costs, and coordination among service providers). Different stakeholders, in particular service users, should be invited to give views on the way forward.

CCS for persons with disabilities

23. According to the Administration, a day activity centre ("DAC") provides training in daily living skills and simple work skills for persons aged 15 and above with severe intellectual disabilities who are unable to benefit from vocational training or sheltered workshop service. They are trained to become more independent in their daily life, thereby facilitating their integration into the community. As at December 2012, there were more than 3 700 persons with disabilities on the waiting lists for the training places in DACs and sheltered workshops. The Administration is committed to increasing the day training places by collaborating with various government departments to identify suitable premises and facilitating NGOs to redevelop their existing premises/sites.

24. Members share deputations' concern about the long waiting time (six to seven years) for training places in DACs and sheltered workshops. They consider it important for the Administration to set specific targets to reduce such waiting time.

25. Members note that the Pilot Scheme on Home Care Service for Persons with Severe Disabilities ("the HCS Scheme") has provided a package of home-based personal care, rehabilitation training and nursing care services for persons with severe disabilities who are living in four districts and on the waiting list for subvented residential care service.

26. Having regard to the HCS Scheme's requirement of SWD's referral for use of services, members call on the Administration to enhance the flexibility in the provision of services, solicit the views of service users and conduct a review of the HCS Scheme. According to the Administration, the HCS Scheme was regularized in March 2014, and has extended to cover persons with severe disabilities in all districts, irrespective of whether they are on the waiting list.

Care services for people with dementia

27. Members share deputations' concerns about the inadequate provision of care services for people with dementia. The specific issues that they are concerned about include the lack of dedicated services for persons with dementia under the age of 60 or for elderly persons with dementia in subsidized day care centres/units for the elderly (DEs/DCUs) and RCHEs, the lack of early identification or early intervention, long waiting time for service provision and collaboration between the medical and welfare sectors.

28. According to the Administration, SWD has substantially increased the resources for enhancing the services for elderly persons with dementia in DEs/DCUs; in tandem, elderly service units can apply for the Dementia Supplement ("DS") to enhance care support and services for demented persons. The waiting time for referral for services by the psychiatric departments of the Hospital Authority ("HA") is about 40 weeks to one year; and for urgent cases, the patients will be referred to Memory Clinics. Noting the importance of early identification, HA recognizes the need to shorten the waiting time and will enhance follow-up therapy for patients suffering from dementia. SWD will continue to collaborate with the Department of Health, HA and universities to develop training programmes for demented persons, their carers, and service practitioners.

29. Notwithstanding the Administration's explanation, members consider the existing assessment and referral mechanism lagging much behind in respect of early identification of dementia symptoms and provision of proper medical intervention. They call on the Food and Health Bureau ("FHB")/HA and Labour and Welfare Bureau ("LWB") to enhance their collaboration regarding the planning of services, assessment, and service referrals for persons with dementia. A long-term policy on dementia should be developed with a view to addressing the special needs of persons with dementia. Given that SCNAMES mainly tests the physical functioning of elderly persons, it should be enhanced so that the mental and cognitive conditions of persons with dementia can also be assessed. The waiting time for training and community care services for persons with dementia should be shortened. Dedicated service units and DEs/DCUs should be set up. In addition, an allowance should be offered to carers of patients with dementia regardless of the patients' age.

Support services for carers

Respite service

30. According to the Administration, carers play a vital role in taking care of elderly persons who age at home. Apart from offering carer training, counselling and referral services to support carers, the Administration is providing respite services for the elderly with a view to offering temporary relief to the carers when needs arise. As regards support for carers of persons with disabilities, one of the strategic development directions set out in the Hong Kong Rehabilitation Programme Plan is to empower persons with disabilities and their carers to become valuable social capital. Towards this direction, the Administration provides a series of support service for carers of persons with disabilities, including respite services, with a view to relieving their stress in taking care of their family members with disabilities.

31. Members and deputations call on the Administration to set up a computerized central platform providing latest updates on the availability of respite places for elderly persons and persons with disabilities in different districts. The Administration should look into the lack of places for urgent institutionalization of elderly persons and persons with disabilities, especially for persons with severe disabilities.

32. To address the acute shortage of respite service for persons with

disabilities, members request the Education Bureau ("EDB") to utilize casually vacant places in special schools to meet the demand for short-term and/or urgent respite service for children with disabilities. According to EDB, if casually vacant boarding places are available, individual special schools have been trying their very best to provide residential respite service on a voluntary basis for their own students to meet their temporary or contingency needs. With their very limited physical capacity and manpower, special schools cannot operate a systematic, structured and open mechanism to provide residential respite service for outsiders, which is by nature a social service and not the core business of special schools. The majority of special schools have already had great difficulties in providing residential respite services for their own students. Hence, they have great reservation in providing residential respite service for outsiders as a matter of policy. Special schools are not able to cope with the caring needs of those outsiders whose medical/psychological/emotional conditions and unique support needs are unknown to them. Special schools would have great difficulty in the appropriate deployment of manpower and specialist staff to meet such needs, not to mention that some special schools have already been facing difficulties in recruiting sufficient paramedical staff to meet their operational needs. Special schools also have great concerns about the potential responsibility for mistreatment and the potential discontent and anxiety of the parents of the existing boarders of the schools over the impact on the safety of their children. EDB considers it inappropriate for special schools to provide residential respite services for students with disabilities on a regular basis and as a matter of policy.

33. With the cessation of funding from the Lotteries Fund ("LF") for the provision of residential respite places for children with disabilities aged below 15, members call on the Administration to offer recurrent funding for the continuation of the service and in particular to increase the number of places for children with severe disabilities. Noting that the utilization rate of residential respite places in EBPS RCHEs is very low, members consider that stronger incentives should be offered to encourage private RCHEs to provide residential respite places.

Allowance for carers

34. The Joint Subcommittee has discussed, at its meeting in May 2013, the Administration's initial thinking on the introduction of a pilot scheme under the Community Care Fund ("CCF") on a carer allowance, which seeks to help families in need to further assist their elderly members to age at home. Members and deputations consider that the pilot scheme

should be extended to carers of persons with disabilities or with chronic illness. The granting of carer allowance should not preempt the continuous provision of CCS for the elderly. Members and deputations also call on the Administration to work out a timetable for launch of the pilot scheme and conduct public consultation to collect views of different stakeholders.

35. The Administration has advised that the pilot scheme is scheduled to be launched in the second quarter of 2014 for two years. For the elderly persons who are being taken care of by carers under the pilot scheme, they may apply or continue to apply for subsidized CCS. Service providers of subsidized CCS will make professional assessment on the service mix applicable to such elderly persons, taking into account the care-giving provided by the carers and having regard to the circumstances of individual cases. The Administration will consider the way forward on the provision of allowance for carers of persons with disabilities or with chronic illness, having regard to the experience gained from the pilot scheme.

Ageing of persons with intellectual disabilities

36. Members and deputations call on the Administration to examine the service needs of aged persons with intellectual disabilities. Members and deputations are concerned about the lack of RCHDs and DACs for persons with intellectual disabilities and the shortage of manpower, in particular psychiatric doctors and front-line care staff. The Administration is requested to restore the psychiatric outreach services provided before 2003 for persons with intellectual disabilities in moderate and mild levels.

37. According to the Administration, the Working Group on Ageing of Persons with Intellectual Disabilities, which is formed under the Rehabilitation Advisory Committee ("RAC") of LWB, has set up a Task Force on Rehabilitation Services to study in depth related issues and develop concrete proposals. The Task Force will conduct a survey on service users of rehabilitation services to obtain relevant data of aged persons with intellectual disabilities and their functional capacity etc., with a view to developing concrete proposals for service enhancement and a long and medium-term plan. The Task Force will also work with NGOs concerned to explore the development direction of providing day services for persons with intellectual disabilities having regard to the ageing trend of service users and, where appropriate, consider the feasibility of launching pilot projects with funding support from LF.

Places for short-term residential and day respite service will be increased and home-based support services will continue to be strengthened to address various needs of persons with intellectual disabilities. Due to manpower shortage, currently psychiatric outreach services are mainly provided for persons with severe intellectual disabilities. To enhance the psychiatric service for persons with intellectual disabilities, HA has assigned designated timeslots for psychiatric specialist out-patient services for persons with intellectual disabilities in the clusters of New Territories West, Kowloon West and Hong Kong West, and plans to extend such services to other clusters in 2014.

38. Notwithstanding the Administration's explanation, members call on the Administration to consider increasing funding to attract more psychiatric doctors from overseas to provide psychiatric outreach services in Hong Kong, so that it could cope with the manpower shortage of psychiatric doctors specialized in services for persons with intellectual disabilities. The Administration is also requested to extend the scope of the Pilot Project on Dental Services for Persons with Intellectual Disability to cover those with severe intellectual disabilities; and provide psychiatric outreach services for persons with intellectual disabilities in RCHDs.

Mental health case management

39. Members and deputations are concerned about the mechanism for referral between the Personalized Care Programme ("PCP") and the Integrated Community Centres for Mental Wellness ("ICCMWs"), role and caseload of case managers, as well as the problem of manpower shortage.

40. The Administration has advised that under the existing mechanism, case conference is an important platform for gathering inputs from different disciplines, including healthcare professionals and medical social workers. Patients will be referred by case managers of PCP to ICCMWs for follow-up according to the assessment conducted at case conferences; and there are referrals by ICCMWs to PCP as well. The Administration has developed guidelines on the referral procedures and will review the related guidelines as well as the operation of case conference for improvement as appropriate. The caseload of social workers servicing ICCMWs ranges from 36 to 43 cases, depending on complexity of the cases. As committed in the 2014 Policy Address, the Administration will strengthen the manpower of ICCMWs to dovetail with the service extension of the Case Management Programme. The

Administration acknowledges the manpower shortage of case managers. The recruitment exercise of an additional 60 case managers for the Programme will be completed by 2015-2016. The Administration has been collaborating with tertiary institutions on training programmes to increase the manpower supply of psychiatric nurses and other paramedical staff, and strengthen their professional skills. In the longer term, the Review Committee on Mental Health will review the existing mental health policy and map out future policy direction including manpower planning.

41. Members call on HA, LWB and SWD to jointly initiate a review of the Case Management Programme. They also urge the Administration to improve the manpower supply of case managers, social workers and paramedical staff to meet future service needs. It should also review the case manager-to-patient ratio to strengthen support for people with severe mental illness, promote public awareness and understanding of mental health, and identify permanent sites for ICCMWs in all districts for the provision of full-fledged service as soon as possible. Noting that the Service Manual on Mental Health Case Management is being prepared by the Administration, members call on the Administration to collect views of different stakeholders and the public on the Manual and take them into account in finalizing the Manual by the end of 2014.

Guardianship system for mentally incapacitated persons

42. According to the Administration, the Guardianship Board ("GB") is an independent statutory body which performs the functions provided and exercises the powers conferred under Part IVB of the Mental Health Ordinance (Cap. 136). It aims to protect mentally incapacitated adults and promote their welfare and interests through making of guardianship orders. GB may appoint a private guardian (a family member or a friend) or the public guardian (Director of Social Welfare) and grant the following powers to him/her –

(i) to require the person concerned to reside at a specific place;
(ii) to bring the person concerned to a specific place and use reasonable force for the purpose;
(iii) to require the person concerned to attend at a place and time for medical or dental treatment, special treatment, occupation, education or training;
(iv) to consent to medical or dental treatment if the person concerned is incapable of understanding the general nature and effect of the treatment;

(v) to require access to the person concerned to be given to any registered medical practitioner, approved social worker or other person specified in the guardianship order; and

(vi) to hold, receive or pay a specified monthly sum for the maintenance or other benefit of the person concerned (currently the maximum amount is $13,000 per month).

43. Considering that the above guardian's powers are too limited, members and deputations call on the Administration and GB to review such powers. Specifically, they consider that the amount of money (i.e. $13,000 per month) a guardian is empowered to manage is too small. The Administration is requested to explore whether the guardian's financial power can be expanded to cover management of property and other financial affairs of a mentally incapacitated person, with a view to better protecting his/her rights.

44. Members share deputations' concern about the use of guardianship orders, which are applied for by doctors of public hospitals, to discharge patients who are in a vegetative state. The Administration is urged to review the eligibility of doctors for making guardianship application, with a view to safeguarding the best interest of mentally incapacitated person in relation to receiving medical treatment. SWD is requested to strengthen its support for mentally incapacitated person through a case management system to provide advice on the procedures of making guardianship applications and coordinate different parties (doctors, medical social workers, and mentally incapacitated persons' family members) for matters concerning medial treatments.

45. Members and deputations take the view that, in the longer term, the Administration and GB should appoint an independent public trustee (or public advocate) to protect the interest of mentally incapacitated persons. The Administration is also requested to replace the existing model of "substitute decision making" (where decisions are made on behalf of a mentally incapacitated person by someone else) by "supported decision making" (where a mentally incapacitated person is provided with whatever support is required in order to exercise his or her legal capacity to the greatest extent possible).

<u>Financial assistance on medications and medical/rehabilitation appliances</u>

46. According to the Administration's healthcare policy, no one is prevented from receiving adequate medical treatment due to a lack of means. The Samaritan Fund ("SF") administered by HA aims to provide

financial assistance for HA patients, who meet the specified clinical criteria and pass the means test, to meet expenses on self-financed drugs or privately purchased medical items. Such drugs or medical items are needed in the course of medical treatment but are not covered by the standard fees and charges in public hospitals and clinics. Under the SF mechanism, financial assistance will be granted if the estimated cost of the drug is above the patients' maximum annual contribution payable, the calculation of which is based on the applicant's annual disposable financial resources, i.e. the sum of the patient's annual household disposable income and disposable capital. With the relaxation of the financial assessment criteria since 1 September 2012, a deductible allowance is also provided when calculating the value of disposable capital of the patient's household. The tiers of patients' contribution ratio for drug expenses are also simplified from the past 12 bandings to the present seven bandings.

47. Members share deputations' view that in order to take forward its aforesaid healthcare policy, the Administration should further relax the financial assessment criteria for SF to benefit more needy patients and allow patients living with their family members to apply for assistance from SF on an individual basis.

48. Members note that SF provides needy patients with partial or full subsidy for drugs which are proven to be of significant benefits but extremely expensive for HA to provide as part of its subsidized service under the Drug Formulary. The drug list in the Drug Formulary is regularly reviewed by the HA Drug Advisory Committee and the HA Drug Management Committee. The former will systematically appraise new drugs every three months while the latter will conduct periodic reviews on existing drugs in the Formulary. The committees will give regard to the principles of efficacy, safety and cost-effectiveness when reviewing individual drugs. Members and deputations call on the Administration to invite representatives of patient groups to sit on relevant drug committees of HA to enhance operational transparency of drug formulary management.

49. According to the Administration, the Disability Allowance ("DA") under the Social Security Allowance Scheme, which is non-means-tested, helps persons with severe disabilities to meet their special needs. Recipients of Normal DA receive a monthly allowance of $1,510. Persons meeting the eligibility criteria for Normal DA and assessed by doctors to be in need of constant attendance from others in their daily life and not receiving care in government or residential institutions subsidized

by the Government (including subsidised places in subvented / contract homes and residential care homes under various bought place schemes), or all public hospitals and institutions under HA, or boarding in special schools under EDB can receive Higher DA at a rate of $3,020 a month. Members consider that there should be different levels of subsidies under DA for the purchase of drugs and medical equipment/appliances. The amount of DA received by a person with disabilities should be in accordance with his/her degree of disabilities.

Hospice care services

50. Members note that FHB, LWB, HA, SWD and other relevant parties are providing, through a multi-disciplinary approach, various hospice care services in medical and welfare settings. Members share deputations' view that the provision of the existing hospice care services is fragmented due to the lack of a hospice care policy. Having regard to the wide spectrum of policy issues involved, members call on the Administration to set up, under the purview of the Chief Secretary for Administration, an inter-departmental committee dedicated to formulate a comprehensive hospice care policy and coordinate the work of different bureaux/departments to improve hospice care services. Specifically, the Administration is requested to allocate more resources to enhance and broaden its existing hospice care services to cover palliative care (including home visits), RCS and CCS for the elderly, bereavement care, life and death education, monitoring of funeral and columbaria services as well as guardianship orders for mentally incapacitated persons. Members are also concerned about legal issues relating to decision making by medical personnel on attempting resuscitation for terminally ill patients on ambulance and provision of funeral and burial services for mentally incapacitated persons after the death of their parents.

51. The Administration has advised that comprehensive hospice care services involve a wide range of policy issues. These issues fall within the spheres of responsibilities of various bureaux and their departments. The Chief Secretary for Administration has asked the relevant bureaux and departments to continue with their work and to explore enhancing and broadening the services as appropriate. She will convene meetings to resolve any cross-bureau issues if deemed necessary.

52. As regards resuscitation for terminally ill patients on ambulance, the Administration has advised that at this stage, the Fire Service Department ("FSD") does not plan to instruct ambulance personnel to follow the HA's Do-Not-Attempt Cardiopulmonary Resuscitation

("DNACPR") Guidelines in making decision on resuscitation or other emergency aids for terminally ill patients in the course of discharging its statutory duties. According to legal advice obtained by the Administration, there appears to be a conflict between the implementation of DNACPR, which is a form of Advance Directive ("AD"), and the statutory obligations of the FSD officers under section 7(d) of the Fire Services Ordinance (Cap. 95) which mandates initiation of life-sustaining measures. Under section 7(d) of Cap. 95, FSD has the statutory duty to assist any person who appears to need prompt or immediate medical attention by resuscitating or sustaining his life. The primary objective of an AD is however for advance refusal of life-sustaining treatments to minimize stress or indignity when the patient faces a serious irreversible illness. It is a medical decision to be determined by medical professional as to whether or not giving life-sustaining treatment to the patient will reduce his suffering and distress, or what alternative on-the-spot treatment can be given to the patient. It may therefore be necessary to ascertain the validity of the AD/DNACPR Form with HA, to seek necessary medical advice on alternative treatment before the FSD members can decide whether CPR or other treatment can be withheld for a particular patient. Such confirmation may not be feasible in an emergency situation where the FSD members have to make such on-the-spot confirmation within a very short time in the absence of an efficient, effective and reliable communication system/mechanism. Unless the above can be dealt with, it will not be feasible for FSD to implementation such DNACPR Guidelines at present.

53. According to the Administration, a number of RCHEs have been practicing various forms of end-of-life care programmes on their own initiatives. Drawing on these experiences, the Administration has secured additional resources to provide end-of-life care services for elderly residents and support to their carers in five new contract RCHEs which will commence service from 2015-2016 to 2016-2017. Members consider that the Administration should take into account the experiences of these new contract RCHEs in mapping out the future provision of hospice care services in RCHEs.

54. Noting that HA has over 360 palliative care beds as at end-March 2014, members call on HA to evaluate whether there are adequate palliative care beds with reference to international benchmarks as well as the number of patients with chronic and terminal illness who have passed away in hospital.

Recommendations

55. The Joint Subcommittee recommends that the Administration should –

Policy and planning

(a) conduct a comprehensive review of the Administration's LTC policy with a view to offering services according to the needs of recipients, instead of their age. In this connection, in preparing the Elderly Services Programme Plan, the Administration should prepare the Rehabilitation Programme Plan in tandem, so that it can map out holistically the direction of LTC policy according to the needs of recipients (paragraph 7 refers);

(b) have long-term planning, in terms of manpower and training, as well as funding for RCS and CCS, with scientific data and analyses from the information collected under SCNAMES and the central referral system for rehabilitation services, with a view to making a projection of LTC needs of the elderly and persons with disabilities in the next 10 to 20 years (paragraph 8 refers);

RCS

(c) set target waiting time for subsidized places in RCHEs and RCHDs (paragraph 9 refers);

(d) expeditiously increase the number of subsidized RCS places (including purchased places in private RCHEs) (paragraphs 9 and 12 refer);

(e) provide an additional allowance, on top of the standard CSSA payments, for needy elderly persons residing in private RCHEs, so as to subsidize their expenditure on accommodation fee (paragraph 12 refers);

(f) explore ways to attract people to work in private RCHEs (paragraph 12 refers);

(g) develop service yardsticks and encourage private RCHEs to participate in accreditation programmes (paragraph 12 refers);

(h) step up its monitoring measures against abuse of the elderly and people with disabilities, non-compliance of staffing requirements and other irregularities in private residential care homes (paragraphs 14 and 15 refer);

(i) address the problem of non-admission of elderly persons with HIV to RCHEs, so as to ensure that elderly persons receive the same level of care without unlawful discrimination (paragraph 14 refers);

(j) review the RCHE Ordinance and RCHD Ordinance with a view to upgrading the quality and stepping up the monitoring of private RCHEs and private RCHDs (paragraphs 14 and 15 refer);

CCS

(k) strengthen the provision of home care and community care services to facilitate the elderly to age in place (paragraph 16 refers);

(l) assign independent social workers to draw up care plans for voucher holders of the CCS Voucher Scheme to ensure impartiality (paragraph 20 refers);

(m) in respect of Integrated Home Care Services for the Elderly (paragraph 22 refers) –

(i) reintegrate the existing services under IHCS(OCs), IHCS(FCs) and EHCCS with a view to alleviating the heavy workload of the service teams for IHCS(OCs); and

(ii) provide a concrete timetable for a comprehensive review of IHCS (including its service content, operating costs, and coordination among service providers), and invite different stakeholders, in particular service users, to give views on the way forward;

(n) set specific targets to reduce the waiting time for the training places in DACs and sheltered workshops (paragraph 24 refers);

Care services for people with dementia

(o) enhance the collaboration between FHB/HA and LWB regarding the planning of services, assessment, and service referrals for persons with dementia (paragraph 29 refers);

(p) develop a long-term policy on dementia with a view to addressing the special needs of persons with dementia (paragraph 29 refers);

(q) enhance SCNAMES to provide for assessment of mental and cognitive conditions of persons with dementia (paragraph 29 refers);

(r) shorten the waiting time for training and community care services for persons with dementia (paragraph 29 refers);

(s) set up dedicated service units and DEs/DCUs for people with dementia (paragraph 29 refers);

Respite service

(t) set up a computerized central platform providing latest updates on the availability of respite places for elderly persons and persons with disabilities in different districts (paragraph 31 refers);

(u) offer recurrent funding for the continuation of provision of residential respite places for children with disabilities aged below 15 and increase the number of such places for children with severe disabilities (paragraph 33 refers);

(v) offer stronger incentives to encourage private RCHEs to provide residential respite places (paragraph 33 refers);

Allowance for carers

(w) extend the pilot scheme on carer allowance for the elderly to carers of persons with disabilities, chronic patients and

people with dementia (paragraphs 29 and 34 refer);

(x) provide subsidized CCS for the elderly persons even though allowance has been granted to their carers (paragraph 34 refers);

Ageing of persons with intellectual disabilities

(y) restore the psychiatric outreach services provided before 2003 for persons with intellectual disabilities in moderate and mild levels, provide psychiatric outreach services for persons with intellectual disabilities in RCHDs, and consider increasing funding to attract more psychiatric doctors from overseas to provide psychiatric outreach services in Hong Kong (paragraphs 36 and 38 refer);

(z) extend the scope of the Pilot Project on Dental Services for Persons with Intellectual Disability to cover those with severe intellectual disabilities (paragraph 38 refers);

Mental health case management

(aa) initiate a joint review by HA, LWB and SWD on the Case Management Programme (paragraph 41 refers);

(bb) improve the manpower supply of case managers, social workers and paramedical staff to meet future service needs (paragraph 41 refers);

(cc) review the case manager-to-patient ratio to strengthen support for people with severe mental illness, promote public awareness and understanding of mental health, and identify permanent sites for ICCMWs in all districts for the provision of full-fledged service as soon as possible (paragraph 41 refers);

(dd) collect views of different stakeholders and the public on the Service Manual on Mental Health Case Management and take them into account in finalizing the Manual by the end of 2014 (paragraph 41 refers);

Guardianship system for mentally incapacitated persons

(ee) explore whether the guardian's financial power can be expanded to cover management of property and other financial affairs of a mentally incapacitated person (paragraph 43 refers);

(ff) review the eligibility of doctors for making guardianship application, with a view to safeguarding the best interest of mentally incapacitated person in relation to receiving medical treatment (paragraph 44 refers);

(gg) strengthen the Administration's support for mentally incapacitated person through a case management system to provide advice on the procedures of making guardianship applications and coordinate different parties (doctors, medical social workers, and mentally incapacitated persons' family members) for matters concerning medial treatments (paragraph 44 refers);

(hh) appoint an independent public trustee (or public advocate) to protect the interest of mentally incapacitated persons, and replace the existing model of "substitute decision making" by "supported decision making" (paragraph 45 refers);

Financial assistance on medications and medical/rehabilitation appliances

(ii) further relax the financial assessment criteria for SF to benefit more needy patients and allow patients living with their family members to apply for assistance from SF on an individual basis (paragraph 47 refers);

(jj) invite representatives of patient groups to sit on relevant drug committees of HA to enhance operational transparency of drug formulary management (paragraph 48 refers);

(kk) draw up different levels of subsidies under DA for the purchase of drugs and medical equipment/appliances. The amount of DA received by a person with disabilities should be in accordance with his/her degree of disabilities (paragraph 49 refers);

Hospice care services

(ll) set up, under the purview of the Chief Secretary for Administration, an inter-departmental committee dedicated to formulate a comprehensive hospice care policy and coordinate the work of different bureaux/departments to improve hospice care services (paragraph 50 refers);

(mm) allocate more resources to enhance and broaden the Administration's existing hospice care services to cover palliative care (including home visits), RCS and CCS for the elderly, bereavement care, life and death education, monitoring of funeral and columbaria services as well as guardianship orders for mentally incapacitated persons (paragraph 50 refers); and

(nn) request HA to evaluate whether there are adequate palliative care beds with reference to international benchmarks as well as the number of patients with chronic and terminal illness who have passed away in hospital (paragraph 54 refers).

56. In view of the wide public concern on LTC policy and services, the Joint Subcommittee further recommends that the support of the WS Panel and HS Panel as well as agreement of HC be sought for the priority allocation of a debate slot to the Chairman of the Joint Subcommittee under rule 14A(h) of the House Rules, so as to enable him to move a motion to take note of the Joint Subcommittee report at the Council meeting of 29 October 2014.

Advice sought

57. Members are invited to note the work of the Joint Subcommittee and endorse its recommendations.

Council Business Division 2
Legislative Council Secretariat
30 July 2014

Appendix I

Panel on Welfare Services and Panel on Health Services

Joint Subcommittee on Long-term Care Policy

Terms of reference

To study the long-term care policy and services, including home-based, community-based and residential care services for the elderly, people with disabilities and the chronically ill as well as discuss the policy concerned with the Administration and make timely recommendations.

Appendix II

Panel on Welfare Services
and Panel on Health Services

Joint Subcommittee on Long-term Care Policy

Membership list

Chairman	Dr Hon Fernando CHEUNG Chiu-hung
Deputy Chairman	Hon TANG Ka-piu, JP
Members	Hon Albert HO Chun-yan (up to 28 June 2013) Hon LEUNG Yiu-chung Hon TAM Yiu-chung, GBS, JP Hon Vincent FANG Kang, SBS, JP (up to 28 December 2012) Prof Hon Joseph LEE Kok-long, SBS, JP, PhD, RN Hon Ronny TONG Ka-wah, SC Dr Hon LEUNG Ka-lau (up to 23 September 2013) Hon CHEUNG Kwok-che Hon LEUNG Kwok-hung Hon CHAN Han-pan, JP (up to 16 October 2013) Hon WONG Yuk-man (up to 25 February 2014) Dr Hon Helena WONG Pik-wan (up to 14 March 2014) Hon POON Siu-ping, BBS, MH
Clerk	Mr Colin CHUI
Legal adviser	Ms Wendy KAN

Appendix III

List of the deputations/individuals which/who have given views to the Joint Subcommittee on Long-term Care Policy

Deputations

1. 1st Step Association
2. Aids Concern
3. Alliance for Residential Care
4. Alliance of Ex-mentally Ill of Hong Kong
5. Amity Mutual-Support Society
6. Association for the Rights of the Elderly
7. Association of Women with Disabilities Hong Kong
8. Baptist Oi Kwan Social Service
9. Carer Alliance for the Dementia
10. Care for the Elderly Association Limited
11. Care-taker's Concern Group
12. Caritas Federation of Senior Citizens
13. Caritas Hong Kong/Wellness Link – Tsuen Wan
14. Chosen Parents' Network
15. Chosen Power (People First Hong Kong)
16. Christian Family Service Centre
17. Christian Oi Hip Fellowship Ltd
18. Civic Party
19. Concern Group for Services for Disabled Adults
20. Concern Group on Elderly Community Care Services
21. Concord Mutual-Aid Club Alliance
22. CRN, The Hong Kong Society for Rehabilitation
23. Democratic Alliance for the Betterment and Progress of Hong Kong
24. Department of Social Work and Social Administration, The University of Hong Kong
25. Direction Association for the Handicapped
26. Elderly Council of Hong Kong Christian Service
27. Elderly Rights League (H.K.)
28. Elderly Welfare Concern Group
29. Grace Parent Association
30. Grassroots Development Centre
31. Harmonic Recreation Society Limited
32. Hong Kong Alzheimer's Disease Association
33. Hong Kong Association for Parents of Persons with Physical Disabilities
34. Hong Kong Association of Gerontology
35. Hong Kong Association of the Deaf
36. Hong Kong Blind Union
37. Hong Kong Bone Marrow Transplant Patients' Association

38. Hong Kong Cancer Fund Cancer Link Support Centre – Tin Shui Wai
39. Hong Kong Chinese Women's Club
40. Hong Kong Evangelical Church Social Service Centre
41. Hong Kong Evergreen Association of the Elderly
42. Hong Kong Family Welfare Society
43. Hong Kong Federation of Handicapped Youth
44. Hong Kong Federation of Women's Centres
45. Hong Kong Human Rights Monitor
46. Hong Kong Joint Council for People with Disabilities / The Hong Kong Council of Social Service
47. H.K. Neuro-Musular Disease Association Limited
48. Hong Kong Occupational Therapy Association
49. Hong Kong Parkinson's Disease Association
50. Hong Kong Physiotherapists' Union
51. Hong Kong Pioneers Mutual Support Association Ltd
52. Hong Kong Private Hostel and Rehabilitation Association
53. Hong Kong Private Nursing Home Owners Association
54. Hong Kong Psychogeriatric Association
55. Hong Kong Red Cross Princess Alexandra School
56. Hong Kong S.K.H. Lady MacLehose Centre
57. Hong Kong Society for Rehabilitation (Centre on Research and Advocacy)
58. Hong Kong Society of Palliative Medicine
59. Hong Kong Spinocerebellar Ataxia Association
60. HK Stoma Association
61. Hong Kong Women Workers' Assoication
62. Jockey Club Centre for Positive Ageing
63. Labour and Welfare Group of Democratic Party
64. Labour Party
65. Liberal Party
66. New People's Party
67. Po Leung Kuk
68. Policy Research Group of The Elderly Services Association of Hong Kong
69. Production Team of Documentary "Independent Living of Disable Community"
70. Rehabilitation Alliance Hong Kong
71. Richmond Fellowship of Hong Kong
72. Senior Citizen Home Safety Association
73. Sham Shui Po Carer Concern Group
74. Silence
75. SKH Holy Carpenter Church District Elderly Community Centre
76. SME Global Alliance Limited Elderly Affairs Committee
77. Society for Community Organization
78. Society for the Promotion of Hospice Care
79. St. James' Settlement

80. St. James' Settlement Family Club of Rehabilitation Services
81. The Against Elderly Abuse of Hong Kong
82. The Association of Parents of the Severely Mentally Handicapped
83. The Democratic Party
84. The Elderly Care Alliance
85. The Elderly Services Association of Hong Kong
86. The Federation of Hong Kong and Kowloon Labour Unions
87. The Forthright Caucus
88. The Hong Kong College of Psychiatrists
89. The Hong Kong Council of Social Service
90. The Hong Kong Down Syndrome Association
91. The Hong Kong Federation of Trade Unions – Social Affairs Committee
92. The Hong Kong Joint Council of Parents of the Mentally Handicapped
93. The Hong Kong Society for Rehabilitation Centre on Research and Advocacy
94. The Hong Kong Society for the Blind Morning Glory DAC cum Hostel
95. The Lion Rock Institute
96. The Parents' Association of Pre-School Handicapped Children
97. The Salvation Army
98. The Salvation Army Carer Association
99. The Salvation Army Yau Tsim Integrated Service for Senior Citizens
100. Tin Shui Wai Community Development Network
101. Tung Wah Group of Hospitals
102. Tung Wah Group of Hospitals Lok Kwak District Support Centre
103. Union of Hong Kong Rehabilitation Agencies Workshop Instructor
104. University of Hong Kong Sau Po Centre on Ageing
105. Visual Impairment Television
106. MS 倡議小組
107. 明愛長者聯會
108. 安老服務關注組
109. 長者服務大聯盟
110. 院舍服務關注組
111. 耆康會(柴灣中心)
112. 多發性硬化症小組
113. 長沙灣託兒關注組
114. 爭取資助院舍聯席
115. 香港老人權益聯盟
116. 麗閣邨媽媽互助會
117. 天水圍照顧者關注會
118. 天水圍照顧者權益會
119. 肌肉萎縮症倡議小組
120. 長者社區服務關注組

121. 香港區私營院舍聯會
122. 婦女就業致癌關注組
123. 智障人士老化關注組
124. 關注照顧者權益聯盟
125. 將軍澳長者民生關注會
126. 智障人士老齡化關注組
127. 嚴重殘疾人士關愛小組
128. 麗閣邨婦女權益關注組
129. 爭取私營院舍權益大聯盟
130. 殘疾人士私營院舍新界西
131. 新界西私營復康院舍聯會
132. 新界東私營復康院舍聯會
133. 精神病康復者同路人小組
134. 關注精神病康復者權益會
135. 全港長者及護老者權益聯席
136. 全港認知障礙症照顧者聯盟
137. 長者政策監察聯席-聯席之友
138. 人手比例不符最低工資關注組
139. 西貢長者地區網絡代表委員會
140. 香港安老服務協會政策研究組
141. 香港大學社會工作及社會行政學系「特別護理費津貼」關注小組

Individuals

142. Mr CHAN Wing-yin
143. Ms CHENG Tak-yin
144. Ms CHENG Yuk-chun
145. Ms CHEUNG Lai-man
146. Mr CHIU Kin-leung
147. Ms CHU Yim-chun
148. Mr CHUNG Cham-nin
149. Ms Christine M.S. FANG
150. Ms HO Bo-ching
151. Mr HOU Cheung-shing
152. Ms HUI Ching-yee
153. Mr HUI Wai-chun
154. Mr KEUNG Wai-kuen
155. Ms KWOK Lai-sheung
156. Mr LAM Lai-shing
157. Ms Cindy LAU
158. Dr Gemma LAW
159. Ms Alice LEE Fung-king
160. Mr LEE Siu-po

161. Miss LEE Siu-ying
162. Mr Michael LEE, Member of Eastern District Council
163. Ms LEUNG Fung-ping
164. Ms LI Lai-han
165. Ms LO Yuen-ching
166. Ms LUI Pui-yee
167. Mr Jose NG Kwok-wah
168. Ms NG Yan-yee
169. Miss TAM Fung-yung
170. Ms Pauline TANG
171. Mr TIK Kwok-fat
172. Mr TSANG Kai
173. Ms YAN Ming-kit
174. Ms Maggie YEUNG Ying-mui
175. Mr YIP Kei-chun
176. Ms Doris YUNG Kit-chun

Written submissions only

1. Association of Hong Kong Nursing Staff
2. Dementia Joint Professional Conference
3. Social Affairs Committee of the Federation of Hong Kong and Kowloon Labour Unions
4. 工聯會認知障礙症關注組
5. 新界西殘疾人士院舍聯會
6. 香港社會工作者總工會 - 精神健康服務關注組
7. Dr YANG Mo, PhD, member of Southern District Council
8. Mr YEUNG Wai-sing, MH, Member of Eastern District Council
9. 陳曼儀女士
10. 唐佩華女士