For discussion
on 25 June 2016

Legislative Council Panel on Welfare Services
Pilot Scheme on Residential Care Service Voucher for the Elderly

Purpose

This paper briefs Members on the findings of the feasibility study on introducing a voucher scheme on residential care services for the elderly conducted by the Elderly Commission (EC) and the implementation details of the Pilot Scheme on Residential Care Service Voucher for the Elderly (Pilot Scheme).

Background

2. In January 2014, the Chief Executive announced in his Policy Address that EC[1] would be tasked to study the feasibility of introducing residential care service voucher (RCSV) in a year's time. The Chief Executive also announced that the Government had earmarked about $800 million to meet the expenses incurred for issuing a total of 3 000 RCSVs in three phases in a three-year period if it was considered feasible to run a RCSV pilot scheme.

3. At its meeting on 4 March 2014, EC agreed to task its Working Group on Long Term Care Model (WGLTCM)[2] to take forward the feasibility study. A team of consultants from the Department of Social Work and Social Administration of The University of Hong Kong[3], comprising also members of other Universities, was engaged to provide assistance to EC and WGLTCM. We reported the progress and preliminary recommendations of the feasibility study to this Panel at its meeting on 9 February 2015 and attended two deputation meetings in March 2015.

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1 The membership and terms of reference of EC, set up in 1997, are provided at **Annex A**.

2 The membership and terms of reference of WGLTCM are provided at **Annex B**.

3 The consultant team is led by Dr CHUI Wing-tak, Ernest and Dr LAW Chi-kwong of The University of Hong Kong. The composition of the consultant team is set out at **Annex C**.

Methodology of the Study

4. In assessing the desirability and feasibility of RCSV and drawing up a framework for a Pilot Scheme, the consultant team conducted literature review; analysed existing service statistics and data; conducted questionnaire surveys with elderly persons/carers and operators of residential care homes for the elderly (RCHEs)[4]; and interviewed stakeholders including those non-governmental organisations (NGOs) providing elderly services, operators of RCHEs, and relevant government bureaux and departments.

5. A series of public engagement events were held from February to March 2015[5] to gather the views of stakeholders on the preliminary findings and recommendations. In the light of public concern over the service quality of RCHEs arising mainly from an incident at a privately run RCHE in May 2015, WGLTCM invited the consultant team to revisit the preliminary recommendations and further elaborate on the proposed design of the pilot scheme, especially on those aspects such as case management, quality assurance, complaint handling, etc.

6. The consultant team completed the further work as required by WGLTCM in early-2016 and submitted the revised findings and recommendations to WGLTCM in March 2016, and then to EC[6] in June 2016. After deliberation, EC endorsed the consultant's final report at its meeting on 7 June 2016. The study report has now been uploaded to EC's website (www.elderlycommission.gov.hk/en/library/). A copy of its executive summary is at **Annex D**.

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[4] For the questionnaire survey for elderly persons, the consultant team successfully interviewed 1,030 elderly persons waitlisted for subsidised RCS and their carers. Information gathered from 1,029 cases was valid and used for further analyses. For the questionnaire survey for RCHEs, questionnaires were sent to all 633 homes (at the time when the survey was prepared), and response from 346 homes were received. The questionnaire surveys were conducted to gauge elderly persons/carers' receptiveness to taking up RCSV, and the likelihood of operators of RCHEs to participate in the Pilot Scheme as service providers.

[5] Two engagement sessions were held on 11 and 14 February 2015. Invitations were sent to over 730 RCHEs, 550 offices providing referral for elderly services, as well as 82 concern groups, professional bodies and industry associations. A total of 246 participants joined the two sessions. 13 written submissions also received after the engagement sessions.

[6] In response to a meeting request, EC also had a meeting with some concern groups in April 2016 to listen to their views.

Key Findings of the Study

7. The key findings of the study are summarised as follows:

(a) Hong Kong is facing the challenges of a rapidly ageing population. The Government's policy is to promote "ageing in place as the core, institutional care as back-up". Under "institutional care as backup", the care needs of some frail elderly persons should be met in an institutionalised setting. While the Government is committed to providing more subsidised residential care services (RCS) through "traditional" means (such as subvented homes, contract homes and purchasing places from private homes), exploration into new possibilities of subsidised RCS can serve to provide additional choices to elderly persons on the Central Waiting List (CWL) administered by the Social Welfare Department (SWD), who have been assessed as being eligible for RCS through the Standardised Care Need Assessment Mechanism for Elderly Services (SCNAMES);

(b) A RCSV scheme, adopting the "money-following-the-user" principle, would allow those elderly persons who have more means to co-pay with the Government the RCSV value and even to top-up the RCSV value. It would enhance the choice of the consumers (who are elderly persons) and consumer's purchasing power, incentivise the provision of higher quality of services, channel public fund to those most in need, encourage sharing of responsibility by RCS users and shorten the waiting time for services;

(c) A significant percentage of elderly persons on the CWL are residing in non-subsidised places in the private RCHEs and some of them are recipients of the Comprehensive Social Security Assistance (CSSA). Though they and/or their family may have limited resources to co-pay the voucher value or to top it up for better RCS, they would benefit significantly from a RCSV Scheme (if they choose to opt for RCSV in lieu of CSSA) where the voucher value (paid by the Government) would be pegged to the required service standard, but not to CSSA rates (which on average is around $7,600 per month per elderly person as at 30 September 2015) and that they would have greater choices of service providers;

(d) There should be sufficient demand for vouchers and supply of suitable RCS places to support the roll-out of a pilot scheme. On the demand side, based on the feedback to the questionnaire survey conducted by the consultant team with the waitlistees on the CWL, the projected number of elderly persons interested in joining the scheme would be at around 3 000 at the commencement of a pilot scheme[7]. On the supply side, the available places from RCHEs interested in becoming a service provider under the scheme should also be enough to meet the demand from at least 3 000 voucher users[8], particularly so as the pilot scheme is designed to be implemented in three phases (as announced in the 2014 Policy Address) to allow time for some RCHEs to upgrade their service. A pilot scheme on RCSV with 3 000 vouchers would be manageable in testing out the receptiveness to RCSV, the practicality of the implementation mechanism, any adverse consequences and whether the scheme could achieve its objectives and desired effects;

(e) A series of measures are proposed to address the concerns of stakeholders and the public over service quality. These include allowing only RCHEs meeting the prescribed service standards and with acceptable track records to become service providers, instituting an effective monitoring mechanism, requiring service providers to be monitored by a designated team of case managers under SWD and community stakeholders in addition to service users and officers from SWD's Licensing Office of Residential Care Homes for the Elderly, as well as encouraging service providers to join accreditation schemes. The new

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[7] Some 11.8% of the CWL waitlistees interviewed in the questionnaire survey indicated that they were interested in taking up RCSV irrespective of the design of the means test, while another 3.4% indicated that they would take up the voucher when needs arise and their preference would not be affected by the design of the means test. By applying the most conservative figure (i.e. 11.8%) to the 25 525 elderly persons waiting for subsidised C&A places as at July 2015, the consultant team estimated that some 3 012 elderly persons would be interested to join the Pilot Scheme on the day of its implementation. Furthermore, based on the fact that in the year immediately before July 2015 there were 15 525 new applications for subsidised C&A places, the consultant team estimated that an additional 1 832 elderly persons (i.e. 11.8% of 15 525) might become interested in RCSV every year.

[8] Based on the percentage of RCHEs expressing interest in joining RCSV in the questionnaire survey, the consultant team estimated that among the 10 808 vacant non-subsidised places in July 2015 alone, there would be 2 043 places available for a Pilot Scheme set at EA1 standard or above. Taking into account that some voucher users might already be residing in eligible RCHEs prior to joining RCSV, the additional new non-subsidised places to be provided by new contract homes and the Special Scheme on Privately Owned Sites for Welfare Uses, as well as the turnover of non-subsidised places that were not vacant in July 2015, the consultant team estimated that the number of available RCSV places would be able to meet the demand from at least 3 000 voucher users.

designated team of case managers under SWD would assist the RCSV holders in making informed choice in selecting service providers and the team would provide the necessary follow up services. They would also assist in monitoring the performance of the service providers and act as an advocate on behalf of the RCSV holders. It would help address the concern raised by stakeholders over the heavy workload (and possible conflict of interest) upon responsible workers (RWs)[9]; and

(f) While there are concerns that a RCSV scheme may induce price increases and stimulate premature or unnecessary institutionalisation, these possible unintended consequences would either have a limited effect or could be minimised by introducing appropriate mechanisms in the scheme design to counteract the potential undesirable consequences. To avoid the undesirable effect of participating RCHEs marking up the price level without improving service quality and to ensure that the service quality would reach the required standard, SWD could prescribe the space and staffing standards of participating RCHEs as well as specifying a "standard service package" for the service providers. As to possible premature or unnecessary institutionalisation, the risk is not considered to be high, as only elderly persons who have passed SCNAMES and who are waitlisted on the CWL would be eligible for RCSVs. It is also noted that as a matter of fact, the elderly persons on the CWL continue to indicate a strong preference for ageing at their homes should circumstances allow[10].

8. In the light of the key findings above, the study concludes that introducing RCSV would be both desirable and feasible.

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[9] When an elderly person is assessed to have long-term care needs under SCNAMES, an RW will be available to provide assistance and advice to the elderly person in choosing and applying for suitable subsidised services. Once an elderly person enters his/her selected service, staff of the service unit will take over the case and provide the needed care services to the elderly person.

[10] It is reported that when elderly persons were asked in the questionnaire survey whether they would take up a subsidised place meeting their preference (be it a bought place or a subsidised place provided by contract or subvented homes) if they were offered one at the time of the survey or in the near future, a majority of them (54.5%) indicated that they would not, or probably would not take the offer. Furthermore, it was noted from SWD's service statistics that when elderly persons were offered a subsidised place meeting their stated preference, a significant proportion of the offers were not accepted (over 20% in the case of C&A places).

The RCSV Pilot Scheme

9. The consultant recommends that a Pilot Scheme on RCSV should be designed to test whether RCSV can:

(a) provide elderly persons in need with a viable alternative for financial support other than CSSA so that they may receive RCS from eligible private or NGO-run RCHEs;

(b) allow those financially more capable elderly persons and their families to share part of the service costs in accordance with their financial ability;

(c) offer eligible elderly persons a wider choice of RCS, thereby better utilising the capacity of private RCHEs and enhancing their service quality; and

(d) encourage the overall participation of private and self-financing RCHEs in the provision of elderly services with a view to making available more quality care places in the medium to long term.

EC agrees with the above recommendations.

10. EC has endorsed the 22 recommendations put forward by the consultant team on the design of the Pilot Scheme as set out in pages 9 – 12 of the Executive Summary at **Annex D** and the observations made by the consultant team on "Other Issues" and "Evaluation of Pilot Scheme" as set out in paragraphs 52 – 53 of the same Executive Summary. Briefly it is recommended that a Pilot Scheme could be implemented with the following key features:

(a) Eligibility criteria

While the supply of non-subsidised care-and-attention (C&A) places would be sufficient to support a Pilot Scheme of a total of 3 000 vouchers, it is not clear that this would apply to nursing home places for the time being. It is therefore recommended that voucher users of the Pilot Scheme should be elderly persons who have been assessed under SCNAMES to be moderately or severely impaired and who are waitlisting for C&A places on CWL.

(b) Recognised service providers and scope of service

Having regard to the objectives of encouraging improvement in the quality of service and making available sufficient number of choices to users, and noting the fact that SWD's purchase of new places from private RCHEs has been confined to EA1 level only since 2011-12, it is recommended that all licensed RCHEs (including private RCHEs, subvented and contract homes and self-financing homes) providing non-subsidised C&A places and with space and staffing standards meeting or exceeding the requirements of EA1 homes of the Enhanced Bought Place Scheme (EBPS) may apply for registering as a service provider i.e. Recognised Service Providers (RSPs) under the Pilot Scheme. RSPs are required to provide to an RCSV holder a standard service package, the scope of which should be comparable to those offered by bought places under EBPS[11].

To ensure the quality of RSPs, it is also recommended that the track record of RCHEs applying to participate in the Pilot Scheme should be considered, subject to, among others, that : (i) the RCHE should have been licensed under the Residential Care Homes (Elderly Persons) Ordinance (Cap 459) (RCHE Ordinance) for at least one year prior to the application; (ii) the RCHE should not have any record of conviction under the RCHE Ordinance or for any criminal offence directly related to operation of the RCHE in the five years preceding the application; and (iii) the RCHE should have a clean record in the six months preceding the application and have received no more than two warning items in the year prior to the application.

[11] Services may include:
(a) accommodation within shared rooms;
(b) at least three meals a day, plus snacks;
(c) nursing services, including administration and supervision of medication;
(d) medical consultation service by a medical practitioner on regular basis;
(e) personal care services, including assistance with activities of daily living;
(f) therapeutic exercise and treatment, on either a group or individual basis, to maintain or improve the physical and cognitive functioning of residents;
(g) activities organised on a regular basis to meet the social and recreational needs of residents, to encourage residents to pursue their own interest and to maintain contact with the community and families;
(h) laundry service; and
(i) staff on duty 24 hours per day.

(c) Voucher value

As RCHEs participating in the Pilot Scheme will be required to fulfil or exceed the staffing and space requirements of EA1 RCHEs and provide a standard service package comparable to the service scope of subsidised places offered under EBPS, it is recommended that the voucher value should be pegged at the purchase price level[12] for an EA1 place in urban area under EBPS. For 2016-17, the monthly service cost of such a place is $12,416[13].

(d) Co-payment and means test

A sliding scale of co-payment with eight levels (from Level 0 to Level 7) determined by users' affordability is proposed so that the less the user can afford, the more the Government will subsidise. Users will be assessed on an individual basis in the means test, and both asset and income will be taken into account in determining the co-payment level.

For the income test, the monthly income of the user is proposed to be benchmarked against the latest Median Monthly Domestic Household Income (MMDHI) for singleton household. For users at the lowest level (Level 0), their monthly income should not be more than 50% of the latest MMDHI for singleton households. For users with monthly income level of more than 300% of MMDHI (or users who do not wish to be means-tested), they will be of the highest level (Level 7).

The asset limit for users at Level 0 will be pegged to that for singleton elderly persons under CSSA[14]. For Levels 1 to 6, the asset limit will be pegged to the limit for singleton elderly persons to apply for public rental housing[15]. A user with asset exceeding this amount (or who do not wish to be means-tested) will fall within Level 7. In other words, there is no asset limit for Level 7 users.

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[12] Total of subsidy and user fee.

[13] The 2015-16 figure of $12,134 was used in the report. The 2016-17 figure was announced by SWD after the report's endorsement. The service cost comprises both Government subsidy and monthly fee.

[14] The current figure is $45,500.

[15] The current figure is $484,000.

Level 0 users are either existing or potential CSSA recipients. The basic residential care needs of these users will be met by the RCSV instead of CSSA if they opt for RCSV in lieu of CSSA. They will not be required to make any co-payment when using the voucher and the voucher value (which is $12,416 per month as at 2016-17) will be fully paid by the Government. Level 0 users may as appropriate still apply for Old Age Living Allowance (OAA) or Old Age Allowance (OALA) or Disability Allowance (DA) under the Social Security Allowance Scheme[16]. In addition, Level 0 users may apply for a Care Supplement under the Pilot Scheme to meet the expenses arising from their proven medical and rehabilitation needs (e.g. special diets, diapers, etc.), and may be provided a fee waiver for their public healthcare expenses as well as full assistance under the Samaritan Fund and Community Care Fund Medical Assistance Programme (First Phase).

For Level 1 to 6 users, their co-payment amount will range from 10% for Level 1 users (around $1,240 per month based on the voucher value of $12,416 in 2016-17) to 62.5% for Level 6 users ($7,760 per month based on the voucher value of $12,416 in 2016-17). In other words, the Government's subsidy would range from 90% (around $11,170 per month based on the voucher value of $12,416 in 2016-17) of the voucher value for Level 1 users to 37.5% (around $4,660 per month based on the voucher value of $12,416 in 2016-17) for Level 6 users. In addition, these users may apply for OAA/OALA[17] or DA as appropriate.

For Level 7 users, who are either elderly persons who may afford to co-pay more (with a monthly income above $24,000 based on the MMDHI figures of the first quarter of 2016) or who prefer not to be means-tested, their co-payment ratio will be about 75% (around $9,310 per month based on the voucher value of $12,416 in 2016-17). The Government would provide a subsidy of around 25% of the voucher value (around $3,100 per month based on the voucher value of $12,416 in 2016-17) to

[16] A person is eligible for an allowance under the Scheme if he/she is not in receipt of any other allowance under the Scheme or assistance under the CSSA.

[17] The current income and asset limits for single persons under OALA are $7,580 per month and $219,000 respectively. Comparing these figures to Annex E which adopts the MMDHI figure of the first quarter of 2016, Levels 1 and 2 users may also be eligible for OALA, subject to their satisfying of the eligibility criteria including the means test requirement.

them. In addition, these users may apply for OAA or DA as appropriate.

The proposed sliding-scale co-payment arrangements, based on the MMDHI figure of the first quarter of 2016, are set out at **Annex E**.

(e) Top-up payment

Apart from receiving the standard service package, voucher users and their families may make top-up payments to purchase enhanced or value-added services if they so wish. The fees and charges to be charged by RSPs for any such top-up services should be made transparent to enhance the informed choice on the part of the voucher holders. The maximum amount of top-up payment that a user can pay should be capped at 75% of the voucher value. Assuming a voucher value of $12,416, the maximum top-up amount per month is $9,312.

(f) Case management service

As stated in paragraph 7(e) above, SWD will set up a designated team of case managers to provide case management services to voucher users and their carers. Case managers would carry the important function of acting as advocates for the voucher users. They will assist voucher users in selecting a suitable RSP according to their needs and preferences, and provide follow-up support to voucher users throughout their participation in the pilot scheme, including regular visits, referrals to other services, or switching to another RSP, etc. In addition, case managers will help ensure the quality of services received by users through monitoring voucher users' individual care plans and ensuring RSPs' compliance with relevant statutory requirements, SWD's guidelines and service requirements, etc.

(g) Trial period

A six-month trial period will be provided to voucher users. A user's status on CWL will be changed to "inactive" once a voucher is issued to him/her [18]. During the trial period, case managers will assist each of the voucher users in selecting an

[18] Offers for other subsidised RCS will not be made to the elderly person while the case is "inactive".

RSP and provide other assistance as necessary. If a voucher user decides to continue using the voucher after the trial period, he/she will be removed from CWL upon the expiry of the trial period. If, on the other hand, the user decides to opt out of the Pilot Scheme during the trial period, his/her status on CWL will be reactivated and the original position will be resumed. If a user withdraws from the Pilot Scheme after the trial period, he/she may still apply for subsidised RCS and CCS again as a new application. He/she may also return to the community with the support of a community care service voucher subject to availability.

(h) Service assurance requirement

All RSPs will need to enter into a service agreement with SWD. Monitoring mechanisms will be put in place to ensure the service quality of RSPs. Visits, random checks, auditing of files and records, as well as complaint investigations, etc. will be carried out by SWD. Warnings and sanctions may be imposed if an RSP is found to have breached the service agreement.

To help ensure service quality, RSPs will be required to join SWD's Service Quality Groups so that the RSP will need to receive regular visits from community stakeholders who can assist in monitoring the RSP. Warnings and sanctions may be imposed by SWD on RSPs for breaching service requirements. Specifically, if an RSP has received more than two warning items in any one-year period, its status as an RSP will be suspended for at least six months. If the RCHE has been convicted under the RCHE Ordinance or for any criminal offence directly related to operation of the RSP, the period of suspension will be three years. If the licence of the RSP is being terminated or not renewed, its status as an RSP will be terminated.

As an additional service quality assurance measure, RSPs will be encouraged to participate in accreditation[19] and be reimbursed

[19] Currently, the accreditation of elderly services is mainly provided by four certification bodies through the Residential Aged Care Accreditation Scheme (RACAS) operated by Hong Kong Association of Gerontology (HKAG), the Quality Elderly Service Scheme operated by Hong Kong Health Care Federation, Hong Kong Safe and Healthy Residential Care Home Accreditation Scheme operated by the Occupational Safety & Health Council, and the Service Quality Management Certification Scheme – Elderly Services operated by the Hong Kong Quality Assurance Agency. It is recommended that RSPs may choose to be accredited by any

50% of the accreditation costs on successfully acquiring the accreditation.

(i) Phased implementation

The proposed RCSV Pilot Scheme will be implemented in three phases. This will allow sufficient time for elderly persons, service operators, as well as SWD staff to prepare for, and familiarise themselves with, the new system. The first phase will be confined to the non-subsidised places in qualified contract, subvented and self-financing RCHEs. Furthermore, taking into account that time is required for some RCHEs for the second[20] and third[21] phases to upgrade their service standards to meet the requirements stipulated for the Pilot Scheme, the vouchers involved in each of these two phases will be issued in two separate batches. In other words, the implementation of the Pilot Scheme will be divided in three phases and five batches.

Details of the proposed phased implementation arrangements are at **Annex F**.

(j) Evaluation and review

The evaluation of the Pilot Scheme will start about one year prior to the end of the pilot period. The evaluation would cover aspects such as the level of acceptance of RCSV by users and service providers, users' satisfaction, and whether the scheme can incentivise RCHEs to improve their service, etc.

Way Forward

11. The Government generally agrees with the findings and recommendations of the consultant team, as endorsed by EC. SWD will take steps to implement the RCSV Scheme, with a view to launching the first phase around the fourth quarter of 2016 or first quarter of 2017.

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accreditation scheme that has been accredited by the Hong Kong Accreditation Service, so as to ensure that the accreditation itself has proper standards and procedures. So far, of the four schemes mentioned above, only the RACAS operated by the HKAG has been accredited.

[20] For the second phase, existing EA1 RCHEs under SWD's EBPS will also be eligible to apply as RSPs.

[21] For the third phase, all RCHEs meeting the criteria stated in paragraph 10(b) will be allowed to apply as RSPs.

The Government would wish to stress that RCSV will serve as a choice of RCS additional to, but not in substitution of, the existing choices of RCS (and community care services etc.) made available for eligible elderly persons on the CWL. No elderly persons would be forced to take up the RCSV; and they would each be given a trial period to try the RCSV and be assisted by a designated team of case managers under SWD right from the time they opt for RCSV. Suitable mechanisms and measures will be taken to monitor the service provided by the RSPs under the Pilot Scheme and to ensure their service quality.

12. The Government also wishes to reassure the community that piloting RCSV will not detract from the Government's commitment to providing subsidised RCS through a multi-pronged approach, including, among others, the construction of new contract homes and the implementation of the Special Scheme on Privately Owned Sites for Welfare Uses. From 2016-17 to 2018-19, seven new contract homes with some 700 RCS places will come into operation. As at June 2016, SWD has reserved sites in 13 development projects for providing additional contract homes, providing a total of some 1 400 RCS places. For the Special Scheme on Privately Owned Sites for Welfare Users, based on the rough estimation of the applicant organisations and assuming that all the proposals received could be implemented smoothly, a range of welfare facilities would be provided including, inter alia, about 17 000 additional service places for persons with disabilities and for the elderly (and about 7 000 of them would be for RCS).

Conclusion

13. The Government is conscious of the immense challenges posed by our rapidly ageing population. We will continue to promote our objective of enabling our elderly persons to age in place for as long as possible, while also making available a range of services suited to the varying circumstances of those frail elderly persons who are in need of RCS. In the process, we are mindful of the need to provide our senior citizens with viable choices. The proposed Pilot Scheme on RCSV will provide an additional choice to our senior citizens in need of RCS while help safeguarding the quality and sustainability of our services.

Labour and Welfare Bureau
Social Welfare Department
June 2016

Annex A

Elderly Commission

Terms of Reference

1. To advise the Government on the formulation of a comprehensive policy for the elderly including matters relating to the care, housing, financial security, health and medical, psychological, employment and recreational needs of the elderly;

2. To co-ordinate the planning and development of various programmes and services for the elderly, and to recommend priorities for implementation having regard to manpower, financial and other resources available; and

3. To monitor implementation of policies and programmes affecting the elderly, and to make recommendations to the Government to ensure that agreed objectives are met.

Membership

	Name	Background
Chairman:	Dr LAM Ching-choi	Medical and Social Service
Member:	Mrs CHAN LUI Ling-yee, Lilian	Education and Social Service
	Ms CHAN Man-ki, Maggie	Legal
	Miss CHAN Man-yee, Grace	Social Service
	Mr CHEUNG Leong	Social Service
	Mr LAM Hoi-cheung, Victor	Commercial
	Dr LOU Wei-qun, Vivian	Academic
	Prof LEE Tze-fan, Diana	Academic
	Mr SHIE Wai-hung, Henry	Commercial and Social Service

Member: (cont'd)	Mrs SO CHAN Wai-hang, Susan	Commercial
	Dr TSE Man-wah, Doris	Medical
	Dr TUNG Sau-ying	Medical
	Mr WONG Fan-foung, Jackson	Commercial
	Mr WONG Kit-loong	Housing
	Mr WONG Tai-lun, Kenneth	Commercial
	Mrs WONG WONG Yu-sum, Doris	Social Service
	Dr YEUNG Ka-ching	Academic

Official Representative:	Secretary for Food and Health or representative
	Secretary for Labour and Welfare or representative
	Secretary for Transport and Housing / Director of Housing or representative
	Director of Health or representative
	Director of Social Welfare or representative
	Chief Executive, Hospital Authority or representative
Secretary:	Principal Assistant Secretary for Labour and Welfare (Welfare) 4

Annex B

Elderly Commission
Working Group on Long Term Care Model

Terms of Reference

To advise the Elderly Commission on:

a. means to further enhance long-term care (LTC) services, including recommendations on re-engineering/enhancing existing services and formulating new measures, manpower development strategy and long-term policy on elderly services, with a view to facilitating "ageing in the community", and enhancing the quality of residential care homes for the elderly;

b. means to co-ordinate and enhance the interface among the medical, health, welfare, housing and other departments and the private sector in the provision of elderly care services, making reference to the discussions at the Health and Medical Development Advisory Committee; and

c. possible options for LTC financing, such as the feasibility and desirability of the proposed Fee Assistance Scheme.

Membership

	Name	Background
Chairman[1]**:**	Dr LAM Ching-choi	Medical and Social Service
Member:	Ms CHAN Man-ki, Maggie	Legal
	Miss CHAN Man-yee, Grace	Social Service
	Mrs CHAN LUI Ling-yee, Lilian	Education and Social Service
	Prof LEE Tze-fan, Diana	Academic

[1] The Chairman of the Elderly Commission is also an ex-officio member to the Working Group on Long Term Care Model.

	Mr SHIE Wai-hung, Henry	Commercial and Social Service
	Mrs SO CHAN Wai-hang, Susan	Commercial
	Dr TUNG Sau-ying	Medical
	Mr WONG Fan-foung, Jackson	Commercial
	Mr WONG Tai-lun, Kenneth	Commercial
	Mrs WONG WONG Yu-sum, Doris	Social Service
	Dr YEUNG Ka-ching	Academic
Co-Opted Member:	Dr LEUNG Man-fuk, Edward	Medical and Social Service
	Dr LUM Shun-sui, Susie	Academic

Official Representative:	Secretary for Labour and Welfare or representative
	Secretary for Transport and Housing / Director of Housing or representative
	Director of Social Welfare or representative
	Director of Health or representative
	Chief Executive, Hospital Authority or representative
Secretary:	Assistant Secretary for Labour and Welfare (Special Duties)

Annex C

Membership of the Consultant Team

	Name	University
Principal Investigators:	Dr CHUI Wing-tak, Ernest	University of Hong Kong
	Dr LAW Chi-kwong	University of Hong Kong
Team Members:	Prof Daniel LAI	Hong Kong Polytechnic University
	Dr MA Hok-ka, Carol	Lingnan University
	Mrs TSIEN WONG Bik-kwan, Teresa	Hong Kong Polytechnic University
	Dr BAI Xue	Hong Kong Polytechnic University
	Dr DAI Lok-kwan, David	Chinese University of Hong Kong

Annex D

EXECUTIVE SUMMARY

Background of study

1. The Elderly Commission (EC) commissioned a Consultancy Study on Residential Care Services for the Elderly in 2008 to explore whether a means-tested voucher scheme on residential care services for the elderly (RCS) could be introduced to meet the long-term care (LTC) needs of our ageing society in a sustainable manner. The report of the study was released in 2009.

2. Pursuant to the 2009 study, the EC commissioned another study to examine possible enhancement on community care services in 2010. To take forward the recommendations in the Report of the Consultancy Study on Community Care Services of the Elderly commissioned by the EC (2011), the Social Welfare Department (SWD) implemented a 4-year Pilot Scheme on Community Care Service Voucher for the Elderly (CCSV) in September 2013.

3. With the implementation of the CCSV Pilot Scheme, it is considered opportune to explore whether it would be feasible to implement a similar subsidised voucher scheme in the aspect of RCS. In the 2014 Policy Address, the Chief Executive tasked EC to study the feasibility of introducing residential care service voucher for the elderly (RCSV).

4. In July 2014, the Labour and Welfare Bureau (LWB), on recommendation of EC, appointed a consultant team from the Department of Social Work and Social Administration, The University of Hong Kong, to assist EC in conducting a Feasibility Study on Introducing a Voucher Scheme on Residential Care Services for the Elderly (the Study).

Aims and objectives

5. The Study aimed at assessing the feasibility of introducing RCSV. Specific objectives are:

    a) to assess the feasibility and desirability of introducing a voucher scheme on RCS, having regard to the potential benefits of such a scheme, whether such a scheme would bring about unintended and undesirable consequences, the market capacity, the practicability of such a scheme, the expected response from elderly persons with LTC needs and other stakeholders, as well as other issues identified in EC's 2009 study report on RCS; and
    b) to draw up the details of a pilot scheme on RCSV if the feasibility and desirability of introducing RCSV can be established; including eligibility criteria, types of service providers and scope of services to be covered by the pilot scheme, voucher value, co-payment mechanism and means-testing mechanism, quality assurance requirements, and how the pilot scheme should be implemented and assessed.

Methodology

6. Multiple methods were adopted in achieving the above objectives. These included: (a) pre-survey focus groups and interviews with stakeholders, (b) questionnaire survey with elderly persons and carers, (c) survey with operators of residential care homes for the elderly (RCHEs), (d) secondary analysis of existing data; and (e) public engagement on preliminary recommendations.

7. A questionnaire survey was conducted to 3 951 samples drawn from applicants on the Central Waiting List (CWL) waitlisted for subsidised places in care-and-attention (C&A) homes or nursing homes (NH) with stratified systematic sampling that included (a) elderly persons living in the community and using community care services (CCS), (b) elderly persons living in the community and not using CCS; and (c) elderly persons living in institutions. These applicants included both Comprehensive Social Security Allowance (CSSA) and non-CSSA recipients. A total of 1 030 cases were successfully enumerated with either the elderly persons or their family caregivers. The data were weighted with respect to the 13 strata used in the sampling to ensure representativeness of the population.

8. The questionnaire survey with RCHE operators included all the 622 RCHEs providing non-subsidised places as at the end of September 2014, including (a) private homes not under the Enhanced Bought Place Scheme (EBPS), (b) private homes at Category EA2 under EBPS (EA2 homes), (c) Private homes at Category EA1 under EBPS (EA1 homes), (d) self-financing homes[1]; and (e) subvented and contract homes. The survey was to explore the interests of RCHEs providing non-subsidised places towards the proposed RCSV, their readiness to accept RCSV, intention to upgrade service standard, and vacancy status. A total of 346 cases were successfully completed and the data were weighted by the proportion of the type of homes in the population and the corresponding response rate of each type of home to ensure representativeness.

9. Data were collected from various government departments and analysed for estimating the service demand and availability of suitable vacancies.

10. Public engagement on preliminary recommendations was conducted, including (a) two public engagement events with a total of 246 representatives from 153 organisations/units, (b) presentation at the Panel on Welfare Services, Legislative Council, (c) two deputation sessions at the Panel on Welfare Services, Legislative Council, (d) meetings with representatives from interest groups; and (e) 13 written submissions.

11. Public views expressed at other forums were also noted and taken into consideration in the Study, including (a) views pertinent to the proposed RCSV received at the 2015 Welfare Agenda and Priorities Setting Exercise; and (b) deputation sessions on the service quality and monitoring of private RCHEs at the Panel on Welfare Services, Legislative Council; and (c) written submissions pertinent to the RCSV study.

Current and planned provision

12. In Hong Kong, RCS for the elderly are provided through a mix of public and private modes. Subsidised RCS places are provided by subvented/contract RCHEs; and through EBPS and Nursing Home Place Purchase Scheme (NHPPS) that purchase places from private and self-financing RCHEs respectively. Non-subsidised RCS places are mainly provided by operators of private RCHEs; but self-financing homes, contract homes and subvented homes also provide a small portion of non-subsidised places (around 7%).

13. As at 31 July, 2015, there were 156 subvented/contract homes and 143 private RCHEs providing 26 384 subsidised places; and 74 subvented/self-financing/ contract homes and 546 private homes providing 47 022 non-subsidised RCS places in Hong Kong. A

[1] In this report, self-financing homes refers to non-profit-making self-financing homes.

majority (64%) of RCS places was non-subsidised, including 57% offered in the private sector; and subsidised places occupied 36% of the total supply.

14. A multi-pronged approach was used by the Government to provide additional subsidised RCS places. According to information available at the end of 2015, there would be an additional 1 700 subsidised places planned for the period from 2014-15 to 2017-18, provided through new RCHEs in new public rental housing developments, private housing developments, urban renewal projects and vacant school premises. Another 1 000 places had also been planned in 16 projects in the pipeline. Furthermore, the Government had launched the Special Scheme on Privately Owned Sites for Welfare Uses which was expected to provide around 7 000 additional RCS places. In short, as of December 2015, a total of over 9 000 RCHE places have come into operation in recent years or are already in the pipeline.

Issues pertinent to the provision of RCS

Ageing population and rising RCS needs

15. Hong Kong is facing the challenges of a rapidly ageing population. The life expectancy of people in Hong Kong is increasing and the demand for RCS is expected to increase.

16. While the Government's policy is to promote 'ageing in place as the core, institutional care as back-up', the care needs of some frail elderly persons could only be catered for in an institutionalised setting.

Financing

17. The Government has been allocating substantial resources for the provision of elderly services. The Government provides direct and/or indirect subsidies to non-governmental organisations (NGOs) for providing subsidised RCS, and through EBPS to up to 50% of the places in a private RCHE. Among all RCS places in private homes, around 16% are subsidised.

18. Substantial portions of older person living in non-profit making or private RCHEs are receiving CSSA, which constitutes an indirect subsidy by the Government on RCS. The average percentage of CSSA recipients residing in subsidised places is 63.5% and non-subsidised places in private homes is 80.0%

19. The current publicly–funded mode of provision by universal coverage regardless of the recipients' financial means may not be sustainable in the long run. There should be measures to ensure that the financial risk associated with LTC should be protected for people with limited means. Public resources should be targeted at those with the highest care and financial needs.

Long waiting list for subsidised services and underutilisation of non-subsidised places

20. As at 31 July 2015, there were 31 737 applicants waitlisted for subsidised RCS on the CWL, thus resulting in long waiting time. On the other hand, non-subsidised RCS places were underutilised.

21. A significant percentage (estimated to be around 80%) of elderly persons residing in non-subsidised places in the private RCHEs are CSSA recipients, receiving an average of

around $7,600 per month[2]. They have very limited resources and there is little incentive for the family to top up for better RCS. As a result, many private RCHEs could only peg their services to CSSA rates, and thus have low incentive to upgrade their services.

22. While the Government is committed to providing more subsidised RCS through traditional means (i.e. subvented homes, contract homes and EBPS places), it would be worthwhile to explore if non-subsidised places, especially the existing, underutilised resources in the private non-subsidised RCS sector could be tapped to meet the service demand of the elderly. Exploration into new possibilities of subsidised service can serve to provide additional choices to the older people on CWL.

Overview on the use of voucher as a form of subsidy

23. The EC's two study reports on RCS and CCS released in 2009 and 2011 respectively suggested that the use of voucher could provide freedom of choice to users, ensure fees paid are commensurate with service quality, and incentivise providers to compete on quality and be more responsive to the needs of the elderly.

24. A voucher scheme, through providing more quality choices for users, may also help develop a 'market segmentation' mechanism where people who can afford higher service fees could be diverted to higher-end non-subsidised services.

25. Voucher, as a kind of 'consumer-directed care', is often used to encourage elderly to age in place or for their family caregivers to take care of the elderly in their own homes. A number of economies with similar social and economic development with Hong Kong are reviewed and benefits in cash for LTC are found to be available in United Kingdom, United States, Germany, the Mainland and Taiwan. Experiences outside Hong Kong show both potential benefits and undesirable effects.

26. A voucher scheme enhances consumer choice, increases consumers' purchasing power, incentivises provision of higher quality of services, channels public fund to those most in need, encourages sharing of responsibility by users, and shortens waiting time for service. While it may also induce price increases and stimulate premature or unnecessary institutionalisation, on further examination of the issues and the situation in Hong Kong, it is noted these unintended consequences would either have a limited effect, or could be minimised by introducing corresponding mechanism in the scheme design to counteract the potential undesirable consequences.

[2] Figure as at 30 September 2015.

Results of questionnaire survey with elderly persons on CWL[3]

Willingness to consider RCSV and views on means test

27. Over one-third of the respondents (36.5%) were willing to consider taking up the RCSV, with co-payment, to get a non-subsidised EA1-equivalent RCS place provided by private operators and/or NGOs. Another 14% would consider it in the future when needs arose. Respondents currently living in an institution were more likely to consider taking up the RCSV.

28. Among those who were willing to consider RCSV or willing when needs arose, 43.3%, agreed to having means test, 45.4% disagreed and 11.3% had no opinion. For those who agreed to means test, 72.2% said that having means test would not affect their inclination to accept RCSV.

29. Overall, 11.8% of all respondents showed relatively strong inclination to consider opting for the RCSV with means-test. This would increase to 15.2% if those who alleged themselves having no immediate need but would consider RCSV when needs arise were also taken into account.

30. Over half (53.7%) suggested that only the older person him/herself should be assessed as an individual if a means-test was to be implemented; 45.5% of the respondents considered that financial situation of family members should be taken into account.

Views on fixed amount/sliding scale of voucher subsidy

31. Among those who were interested in taking up RCSV, 62.6% agreed to a sliding scale of voucher subsidy depending on the financial situation of the person; and 31.5% stated that the subsidy should be a fixed amount.

Willingness to top up for enhanced or additional service

32. Among non-CSSA recipients who were interested to take up RCSV, 78.9% were willing to consider paying top-up for enhanced or additional service. For CSSA recipients, 53.2% were willing to contribute more for enhanced or additional services.

CSSA status and willingness to give up CSSA for RCSV

33. Among all respondents, 35.2% were CSSA recipients and those who were living in an institution at the time of the survey constituted the highest proportion (58.3%). Among them, 47.4% indicated that they would be willing to choose RCSV and withdraw from CSSA.

[3] Since one of the main purposes of conducting the study was to assess elderly person's receptiveness to the service and funding mode of RCSV and identify factors that may affect their willingness to take up RCSV , the survey was conducted before the detailed recommendations for the pilot scheme (summarised from paragraph 51 onwards in this executive summary) were drawn up. That said, to assist the interviewees in understanding and visualising the service mode of RCSV, some core elements of RCSV were mentioned to the interviewees before conducting the survey, such as that all types of service providers (private or NGO homes) meeting certain standard requirements will be allowed to participate, users will be allowed to choose from and switch between providers as they see fit, a sliding scale co-payment arrangement will be adopted, users will need to withdraw from CWL, etc. Details of the information provided to interviewees are provided in Chapter IV.

Results of questionnaire survey with RCHEs providing non-subsidised places[4]

34. On the assumption that the resources provided through an RCSV and the corresponding requirement would be similar to those applicable to a Category EA1 place under EBPS, RCHEs at Category EA1 showed the most interest in becoming a Recognised Service Provider (RSP) (90.9%). For other types of RCHEs, 61.1% of responding subvented/contract homes and 30% of self-financing homes showed interest. Among private homes that needed to upgrade their staffing and space standards to meet the suggested EA1 standard, 63% of EA2 homes and 33.6% of non-EBPS private homes indicated their interest as an RSP.

35. Among respondents who indicated interest or not yet decided in becoming an RSP, all EBPS EA1 homes indicated readiness to take RCSV residents when the scheme commenced. EBPS EA2 homes appeared to be very optimistic about their readiness to join the scheme with 94.4% saying that they would be ready when a pilot scheme was launched. For subvented/contract homes and self-financing homes, 70% stated that they were ready.

36. Having regard to the relevant considerations, it is expected that if a pilot scheme on RCSV is introduced, the spectrum of potential RSPs could be found in both private and the non-profit sector, providing choices for the users.

Views expressed in public engagement

37. There were divided views as to whether higher or lower staffing and space standards should be set for RSPs, i.e. whether the minimum requirement should be set higher than, lower than or at EA1 standards. Quality of service, effective monitoring mechanism, whether RSPs would mark up the price without correspondingly improving the service were the major concerns.

38. There was concern about the introduction of RCSV might induce premature or unnecessary institutionalisation or a shift from CCS to RCSV, in view of the higher value of an RCSV comparing with the unit cost of CCS or the value of CCSV; and the possibility of shortening their waiting time on CWL.

39. Concern was raised on possible workload upon responsible workers (RWs) with the proposed case management services to voucher users. Some expressed concern that if the case management services were to be provided by RWs, there might be potential role conflict as a significant number of RWs were employed by NGOs that also provide RCS.

Feasibility and desirability of introducing RCSV

40. As stated in paragraph 29, 11.8% of all respondents showed relatively strong inclination to consider opting for the RCSV with means-test. This would increase to 15.2% if those who alleged themselves having no immediate need but would consider RCSV when needs arise were also taken into account. The interest of another 35.3% of the

[4] Similar to the survey with elderly persons, the survey with RCHEs was conducted before the detailed recommendations for the pilot scheme were drawn up. To assist the interviewees in understanding and visualising the service mode of RCSV, some core elements of RCSV were provided as well. Details of the information provided are also provided in Chapter IV.

respondents would depend on the actual design, in particular the means test, of the scheme. Overall, the interest on the RCSV was moderate among all respondents.

41. On the demand side, if a prudent approach (i.e. discounting those alleged to be interested when needs arose) was adopted and the 11.8% figure were to be projected onto the sampling population of elderly persons waiting for a subsidised C&A place (N=25 525 as at July 2015), it could be assumed that roughly 3 012 elderly persons would have a clear inclination to consider RCSV at its commencement. Based on the number of new applications for subsidised C&A places in the year before July 2015 (N=15 525), it is estimated that each year, an additional 1 832 elderly persons might be interested in the RCSV. Both figures above have yet to take into account the 3.4% elderly persons who would be expected to take up the voucher when needs arose.

42. On the supply side, some RCHEs currently at a standard below EA1 had indicated their intention to upgrade; and a considerable percentage of RCHEs in the non-profit sector also showed their interest as a service provider (see paragraphs 43 to 46). Therefore, the study findings suggest that RCSV could offer an opportunity for RCHEs to improve their service quality and widen users' choice of service providers.

43. Based on the survey on RCHE operators on their readiness to become RSP, and assuming the places of subvented/contract homes and over half of the self-financing homes could meet the EA1 level, the existing number of readily available vacancies reaching EA1 standard in the market is 952.

44. For RCHEs not yet attained EA1 standards, they have to upgrade their space and staff requirements in order to be eligible for RSP. Findings from service providers showed that 63.0% EA2 EBPS homes and 33.6% non-EBPS private homes were still interested in admitting RCSV users. After taking into account the interest of RCHEs in joining RCSV and intention to make necessary upgrades, the estimated number of available RCSV places from the existing pool of vacant places in three years is 2 043. Taking into account the fact that some vouchers would be issued to elderly persons on CWL living in would-be RSPs, it is expected that the potential supply of places in all types of RCHEs would be able to meet the demand from 2 482 vouchers.

45. The potential supply of places for RCSV will be further supplemented by new non-subsidised places to become available through new contract homes and the Special Scheme on Privately Owned Sites for Welfare Uses in the coming years, as well as turnover in RSPs. Based on the above, it is expected that there should be a sufficient supply for meeting the service demand from at least 3 000 voucher users. Given the general preference of elderly persons for services provided by contract or NGO-run RCHEs, it is likely that non-subsidised places in self-financing, subvented and contract homes offered would be more popular to voucher users. In view of the additional RCHE places in the pipeline, all of which will be provided by new contract or NGO-run homes, it is further expected that in the long-run contract and NGO-run RCHEs will take up a larger share in the non-subsidised RCS sector; and the pool of potential RSPs from these types of homes will be expanded. The spectrum of service choices is therefore likely to be widened with a more competitive environment for improving service quality.

46. To sum up, figures from the two questionnaire surveys suggested that there should be enough interest among service users as well as potential service providers to launch a pilot scheme on RCSV with 3 000 vouchers. The number would be manageable in testing out the actual receptiveness to the RCSV, the practicality of the implementation mechanism, any adverse consequences and whether the scheme could achieve its objectives and desirable effects.

Avoiding premature or unnecessary institutionalisation

47. Findings from the survey revealed that the response to the proposed RCSV with means-test and co-payment mechanism was moderate and not extraordinarily high. Even when an offer of a subsidised RCS place (i.e. be it RCSV or a subsidised place in contract/subvented/EBPS homes) was made at the time of the survey or in the near future, 54.5% of the respondents indicated that they would not take it up. This reflects a strong preference for ageing at home should circumstances allow. In fact, service statistics from SWD showed that the non-acceptance rate when being offered a subsidised C&A place was 22.3%, reinforcing the understanding that most CWL applicants would still prefer living in the community. Against this background, together with the Government's effort in stepping up the provisioning of CCS in recent years, it appears that the risk of premature or unnecessary institutionalisation may not be high.

48. As elderly persons have to be assessed for their level of care needs through the Standardised Care Need Assessment Mechanism for Elderly Services (SCNAMES), before they are eligible for RCSV, it is unlikely that someone could be drawn to the scheme without being assessed to have such need. RCSV, therefore, only serves to provide an additional choice for CWL applicants.

Impact on pricing and service quality

49. To avoid the undesirable effect of participating RCHEs marking up the price level without improving service quality and to ensure the service quality reaching the required standard, it would be important for SWD to prescribe the space and staffing standards of participating RSPs. In addition, coverage of a 'standard service package' should be specified under the service agreement for RSPs. Other fees and charges to be charged by RSPs should also be transparent to enhance the informed choice of users.

50. An effective control and monitoring mechanism should be implemented with participation of the users as an integrated part of the pilot scheme. Instigating a designated team of case managers under the SWD could carry the function of advocating for the voucher users on a case-basis and assist in monitoring the performance of RSPs.

A proposed pilot scheme on RCSV

Objectives of the pilot RCSV scheme:

51. The main objective of the pilot RCSV scheme is to test the "money-following-the-user" approach in subsidised RCS. Having regard to the analysis on the potential benefits of RCSV, this means that the pilot scheme should be designed in order to test whether RCSV can:

(a) provide elderly in need with a viable alternative for financial support other than CSSA so that they may receive RCS from eligible private or NGO-run RCHEs;
(b) allow those financially more capable elderly and their families to share part of the service costs in accordance with their financial ability;
(c) offer eligible elderly a wider choice of RCS, thereby better utilising the capacity of private RCHEs and enhancing their service quality; and
(d) encourage the overall participation of private and self-financing RCHEs in the provision of elderly services, with a view to making available more quality care places in the medium to long term.

Recommendations

Recommendation 1: All RCHEs that have been licensed for at least one year and are providing non-subsidised places (private homes, subvented homes, self-financing homes and contract homes) that meet or exceed the EA1 space and staffing standard are eligible to apply to be an RSP. Applicants should also meet the following criteria:

(i) have no record of conviction under Residential Care Homes (Elderly Persons) Ordinance (RCHE Ordinance) (Cap 459) or other criminal offences directly related to operation of the RCHE in the last five years prior to the date of application for RSP; and
(ii) in one year prior to the date of application for RSP, have received no more than two warning items from SWD and a clean record in the past 6 months.

In addition to the above, SWD should be the approving authority of RSP applications and may reject an application even if the applicant has no conviction or warning record. Applicants of RSP should be encouraged to join recognised accreditation scheme(s).

Recommendation 2: Application as an RSP should be opened to all eligible RCHEs in all the 18 districts. This serves to enable CWL applicants in all districts to exercise their choice, especially in view of the high prevalence of preference on district/region.

Recommendation 3: The scope of services to be provided by RSPs under a voucher should be comparable to that provided by C&A homes under the EBPS. RSPs cannot refuse admission of any voucher users as long as there is suitable vacancy in the home. Once a voucher user is accepted by the RSP, it would be the responsibility of the RSP to provide the required services. RSP cannot arbitrarily discharge a voucher user unless with full justifications and prior consent of SWD (e.g. contravention of admission regulations, etc.). Voucher users whose health condition deteriorate and are in need of a higher level of care will be re-assessed for waitlisting for higher-level care service on CWL. Supplements (i.e. Dementia Supplement and Infirmary Care Supplement) to RSPs for voucher users will be provided by drawing reference to the existing practice for subsidised RCS.

Recommendation 4: The RCSV scheme should be implemented in three 12-month phases with the following schedule:

- Phase I: limited to all eligible subvented/contract and self-financing homes;
- Phase II: limited to homes eligible for Phase I plus EA1 EBPS homes that have met the requirements of RSP
- Phase III: limited to homes eligible under Phase I and II, plus any other RCHEs that have met the requirements of RSP.

Recommendation 5: For the first phase, a total of 250 RCSVs should be issued. For each of the second and third phases, the RCSVs should be issued over two batches of six months each. The additional number of RCSVs to be issued for the two batches of the second phase and the first batch of the third phase should be 500, while the last batch of the third phase will be 1 250. The actual number of offers to be made in each batch can be adjusted having regard to the availability of voucher places and the actual take-up rate.

Recommendation 6: SWD should set up a designated team of case managers to provide case management service to assist the elderly persons or their family members to make informed choice in selecting RSPs and to provide the necessary follow-up services, such as administrative procedures, site visits, and referrals where appropriate. They should also assist in monitoring the performance of RSPs; and advocating on behalf of the voucher user whenever appropriate.

Recommendation 7: The SWD should set up a dedicated webpage to publicise relevant information about RSPs. Information to be provided should include the type of RCHE of the RSP, location, number of beds, current vacancies, staffing, fees and other charges with detailed itemised breakdown; participation in accreditation schemes as well as significant change in status of the RCHE as RSP(e.g. termination or suspension), etc.

Recommendation 8: Voucher users should be elders who have been assessed by SCNAMES to be of moderate or severe level of impairment with RCS needs at the C&A level.

Recommendation 9: Application for the voucher would be by open application subject to a specific quota. If the number of applications received exceeds the voucher quota in a particular batch, allocation may be prioritised with factors such as the position on CWL, CSSA status, level of family support available and current residency in an RCHE.

Recommendation 10: A period of 6 months (counting from the date of issue of the RCS voucher to the applicant on CWL) should be allowed as a trial period[5] for an applicant opting for RCSV. RCSV users can switch between RSPs during and after the trial period. If an RCS voucher user chooses to opt out of pilot scheme and return to the community after the trial period, he/she will be offered a CCSV as an alternative subject to availability.

Recommendation 11: Once a voucher user is in the six-month 'trial period', their status on CWL would be changed to 'inactive'. Upon the expiry of the trial period, if they are still using RCS provided by an RSP, they will be off the CWL automatically. An applicant would resume the original status if he/she decides to withdraw from the pilot scheme within the trial period or if he/she fails to use the voucher within the trial period. In that case, he/she will be considered withdrawn from the RCSV scheme and will resume the original status on CWL.

Recommendation 12: The full voucher value RSPs should be pegged at the purchase price level (i.e. total of subsidy and user fee) for a bought place of EA1 level under EBPS in urban area ($12,134 for 2015-16).

[5] If a voucher applicant is placed during the 6th month, the expiry date of the trial period will be one month after the placement date. In any case, the trial period will not exceed 7 months.

Recommendation 13: Given a voucher value of $12,134, benchmarked at EA1 level, the recommended levels of co-payment[6] is:

Recommended levels of co-payment

Levels	Income Test				Asset Limit $	Co-payment		Government subsidy $
	Lower limit		Upper limit					
	MMDHI	$	MMDHI	$		ratio	$	
0	0%	-	50%	4,000	45,500	0.0%	0	12,134
1	50%	4,000	75%	6,000	484,000	10.0%	1,213	10,921
2	75%	6,000	100%	8,000		20.0%	2,427	9,707
3	100%	8,000	125%	10,000		30.0%	3,640	8,494
4	125%	10,000	150%	12,000		40.0%	4,854	7,280
5	150%	12,000	200%	16,000		50.0%	6,067	6,067
6	200%	16,000	300%	24,000		62.5%	7,584	4,550
7	300%	24,000	--	--	--	75.0%	9,101	3,033

* MMDHI - Median Monthly Domestic Household Income

Recommendation 14: For voucher users assessed to be at level 0, subject to assessment on their need for additional disposable items such as diaper, special diet, or medical / rehabilitation consumable items, care supplement should be provided.

Recommendation 15: Users of RCSV who are assessed to be at Level 0 of the co-payment sliding scale should be considered eligible for the health care services that are offered to CSSA recipients where appropriate (e.g. Medical Fee Waiving Mechanism of Public Hospitals, Samaritan Funds, Public Private Partnership Programmes, etc).

Recommendation 16: It will be more practical to use means-test for RCSV on individual basis, including both income and asset. The co-payment level of an RCSV user will be subject to his income and asset level. The asset limit for level 0 would be pegged with that for applications for CSSA[7]; while for levels 1 to 6, it would be pegged with that for applications for public rental housing for singleton elderly households[8]. Applicants with income or asset exceeding Level 6, or applicants who choose not to take the means test, will be assessed as Level 7.

Recommendation 17: CSSA recipients opting for the RCSV should withdraw from CSSA.

Recommendation 18: RCSV users should be allowed to top up for enhanced/value-added services up to an amount of 75% of the full voucher value. (For example, if the voucher value is $12,134, the elderly or his/her family member may top it up to $21,235 to purchase the standard package of RCS plus other enhanced/value-added services.)

Recommendation 19: A monitoring mechanism should be introduced to ensure service quality of RSPs. Visits, random checks, audit on files and records and complaint investigation, etc. should be conducted. Warnings may be issued and sanctions (e.g. suspension or termination of RSP status) may be imposed if an RSP has breached the service

[6] The co-payment arrangement recommended is applicable to the voucher value only.
[7] $45,500 at the time of the preparation of the report.
[8] $484,000 at the time of the preparation of the report.

agreement. The RSP should be required to join a Service Quality Group (SQG) and be monitored by community stakeholders.

Recommendation 20: If an RSP has received a total of three warning items in one year, its status as RSP will be suspended[9] for a period of at least 6 months until it meets the qualification requirement again, i.e. no more than 2 warning items in one year. If an RSP is convicted under the RCHE Ordinance or other criminal offence(s) which is(are) directly related to the operation of RCHE, its status as RSP will be suspended for three years. Its status of RSP would be resumed only after the expiry of the suspension and when it meets the qualification requirements of RSP again, i.e. no more than 2 warning items in one year and/or conviction record in three years. SWD should reserve the right of final decision and may suspend the status of an RSP even if the RSP has no conviction or warning record.

Recommendation 21: The RSP status will be terminated[10] if the license of an RSP is being terminated or not renewed upon expiry. SWD should reserve the right of final decision and may terminate the status of an RSP even if the RSP has no conviction or warning record.

Recommendation 22: Regular outcome evaluation should be introduced as an integral part of the RCSV scheme.

Other issues

52. The implementation of the RCSV would incur increased demand for various levels of staff including personal care workers, health workers, nurses and physiotherapists (PTs). Considerations should be given to expanding the potential source of manpower in this field.

Evaluation of pilot scheme

53. Evaluation should start at least one year prior to the completion of the pilot scheme. Effectiveness of the pilot scheme should be evaluated against the objectives.

[9] An RSP is not allowed to receive new voucher users during the suspension period. For voucher users living in an RSP the status of which has been suspended, the case managers will approach the elderly to check if the elderly wishes to switch to another RSP.

[10] SWD will arrange voucher users living in the RSP with RSP status terminated to move to other RSPs.

Annex E

Co-Payment Levels

Levels	Income Limit				Asset Limit	User co-payment		Government subsidy ($)
	Lower		Upper					
	MMDHI[1]	Amount ($)	MMDHI	Amount ($)	Amount ($)	Ratio	Amount ($)	
0	0%	-	50%	4,000	45,500	0%	0	12,416
1	50%	4,000	75%	6,000	484,000	10%	1,242	11,174
2	75%	6,000	100%	8,000		20%	2,483	9,933
3	100%	8,000	125%	10,000		30%	3,725	8,691
4	125%	10,000	150%	12,000		40%	4,966	7,450
5	150%	12,000	200%	16,000		50%	6,208	6,208
6	200%	16,000	300%	24,000		62.5%	7,760	4,656
7	300%	24,000	No upper limit		No upper limit	75%	9,312	3,104

[1] MMDHI stands for Median Monthly Domestic Household Income. The figures used in the table above are based on the figures for the first quarter of 2016. The Pilot Scheme will update the figures regularly.

Annex F

Phased Implementation Arrangements

Phase	Months	Recognised Service Providers	Batch	Vouchers to be issued	Cumulative Number of Vouchers issued
I	1 – 6	-	-	-	-
	7 - 12	Contract, subvented and self-financing homes meeting entry requirements	1	250	250
II	13 – 18	Contract, subvented, self-financing and existing EA1 homes meeting entry requirements	2	500	750
	19 – 24		3	500	1 250
III	25 - 30	All RCHEs meeting entry requirements	4	500	1 750
	31 - 36		5	1 250	3 000

Note 1: The actual number of vouchers to be issued in each batch may be adjusted subject to response and actual number of available places.

Note 2: The first six months of the first phase will be reserved for SWD's preparation (e.g. arranging briefings to operators and stakeholders, inviting eligible operators to apply to become service providers and vetting the applications received, inviting eligible elderly persons to join, etc.) and no vouchers will be issued.