

Research Brief

Issue No. 1
2015 – 2016

Challenges of population ageing

December 2015

Like many other economies, Hong Kong is facing the challenges posed by a rapidly ageing population. These include increasing demand for residential care services ("RCS") and community care services ("CCS") by the frail elderly, and the need for a comprehensive active ageing policy catering to the able-bodied elderly.

Amid increasing demand for RCS, the number of subsidized RCS places remained virtually unchanged over the last decade. This has resulted in the long waiting list and waiting time for the places. The varying services quality among different residential care homes for the elderly ("RCHes") is another concern, as many private RCHes not participating in the Government's bought-place scheme fare less favourably in spacing and staffing provision.

Enhancement of CCS could help delay or even reduce institutionalization of the elderly. Yet, there is an imbalance between CCS and RCS in terms of the number of places provided and the amount of government funding received. The small provision of CCS places does not tally with the Government's policy of "ageing in place as the core, institutional care as back-up".

There is no guiding policy for active ageing in Hong Kong. The provision of support services for the able-bodied elderly follows more of an incremental approach with the delivery of the services straddling across various bureaux/departments.

The subject of population ageing falls within the policy area of the Panel on Welfare Services.

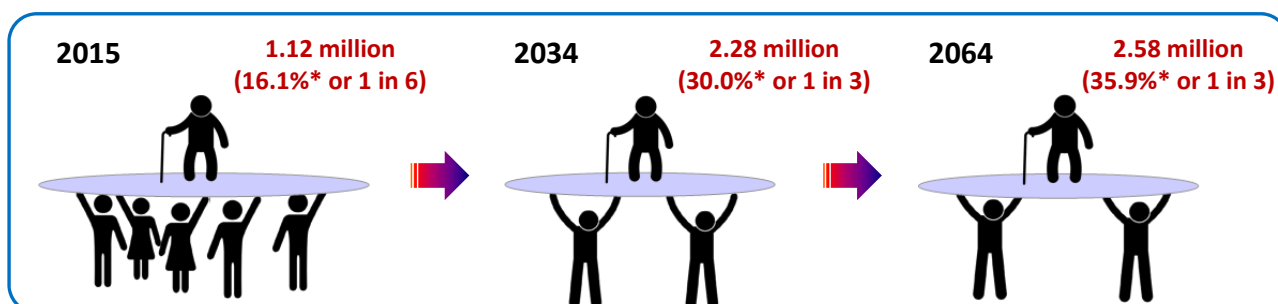


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1. Background

1.1 The world is ageing rapidly and Hong Kong is no exception. There are currently about 1.12 million people aged 65 or above in Hong Kong, meaning that one in six persons is an elderly person. This figure will rise to 2.28 million in 2034 and further to 2.58 million in 2064 (**Figure 1**), translating into a ratio of one to three in both years.¹ Continuing improvement in life expectancy contributes to the increasing proportion of older people in the total population. Over the next 50 years or so, the expectation of life at birth is expected to increase by 5.8 years for males and 5.6 years for females, meaning that people aged 80 or above will surge from the current some 4.6% to 15.9% in 2064.

Figure 1 – Number of elderly people aged 65 or above, 2015-2064



Note: (*) The figures represent the proportions of elderly people in total population.
Data source: Census and Statistics Department.

¹ See Census and Statistics Department (2015c).

1.2 An important aspect that distinguishes older population from the younger one is its higher rate of co-occurrence of multiple chronic conditions. Indeed, there has been increased incidence of chronic diseases and physiological deterioration among older people in Hong Kong in recent years. Among all persons aged 60 or above, the percentage share of those having one or more chronic diseases (including stroke and cancer) increased from 48.8% in 2000 to 59.0% in 2007 and further to 61.8% in 2013.² Likewise, disability has become more prevalent among older people in Hong Kong. In 2013, about 28.4% of persons aged 60 or above had one or more disabilities (e.g. restriction in body movement and seeing difficulty), which was higher than the corresponding rate of 15.0% in 2000 and 21.5% in 2007. An increased proportion of older people living with chronic disease(s) and physical deterioration has resulted in rising demand for long term care services for the elderly.

2. Long term care services for the elderly

2.1 In Hong Kong, long term care comprises residential care services ("RCS") and community care services ("CCS"), and it is the Government's policy to promote "ageing in place as the core, institutional care as back-up"³. Through the provision of subsidized CCS for the frail elderly, the Government aims to enable them to age at home as far as practicable, before admitting them to be taken care of in residential care homes for the elderly ("RCHEs").

2.2 Since 2000, the Social Welfare Department ("SWD") has implemented the Standardized Care Need Assessment Mechanism for Elderly Services to ascertain the care needs of the frail elderly, with a view to matching them with appropriate subsidized CCS or RCS.⁴ There is no means test for the allocation of services. If the subsidized CCS or RCS places are not readily available for the eligible elderly applicants, the elderly applicants will be put on SWD's Central Waiting List to wait for their turn of admission. The list allocates the subsidized places on a first-come-first-served basis according to the applicants' registration dates and their preferences.

² See Census and Statistics Department (2014).

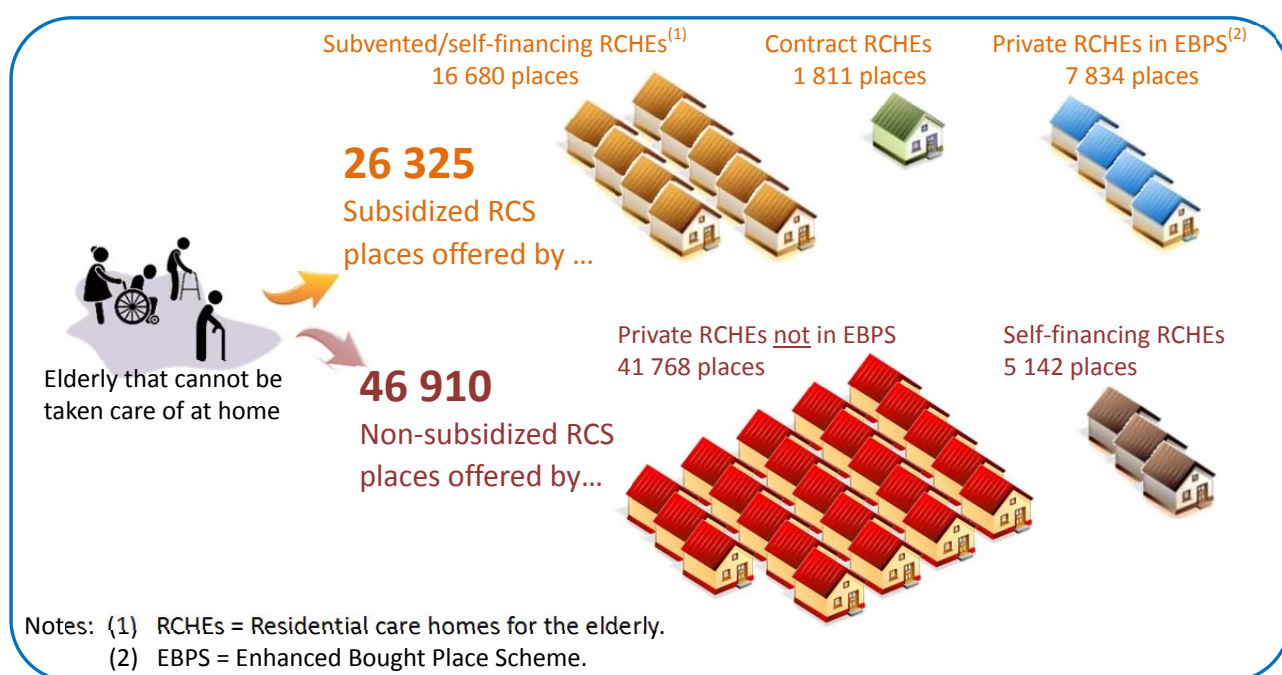
³ See Labour and Welfare Bureau (2014).

⁴ Services allocated include "RCS only", "CCS only" and "dual option" (i.e. either RCS or CCS is equally appropriate for the applicant).

3. Residential care services for the elderly

3.1 RCS are provided for those elderly who cannot be adequately taken care of at home. At present, there is a mix of public and private provision of RCS. While RCS are not directly provided within the administrative structure, subsidized RCS places are offered by (a) subvented/contract RCHes⁵, and (b) private/self-financing RCHes participating in the Government's bought-place schemes.⁶ Alternatively, elders may choose to take up non-subsidized RCS places offered by private/self-financing RCHes (**Figure 2**). Applications for subsidized places are assessed under the Standardized Care Need Assessment Mechanism for Elderly Services, whereas for non-subsidized places there are no such standardized admission criteria.

Figure 2 – Subsidized and non-subsidized RCS places, 2014-2015



Data source: Social Welfare Department.

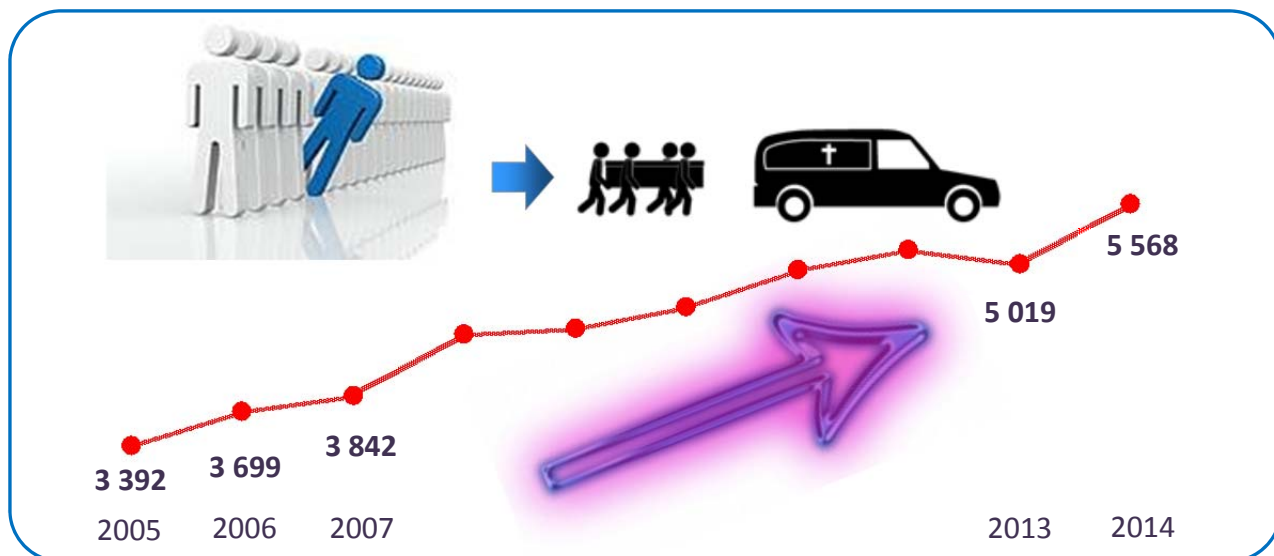
3.2 The number of subsidized RCS places has only shown a modest increase of 1 457, from 24 868 in 2010-2011 to 26 325 in 2014-2015, while the number of elderly applicants on the Central Waiting List for subsidized RCS places has grown by

⁵ Subvented RCHes are operated by non-governmental organizations and funded by the Government under the Lump Sum Grant subventions. Meanwhile, contract RCHes are purpose-built premises set up by the Government. Once built, they are awarded to be operated by non-governmental organizations/private home operators through competitive bidding.

⁶ Currently, the Government purchases (a) care and attention home places from private RCHes under the Enhanced Bought Place Scheme, and (b) nursing home places from self-financing RCHes under the Nursing Home Place Purchase Scheme.

4 598, from 26 751 to 31 349 over the same period.⁷ Many elderly applicants on the waiting list passed away before being offered a place. The number reached 5 568 in 2014, an all-time high over the last decade (**Figure 3**).

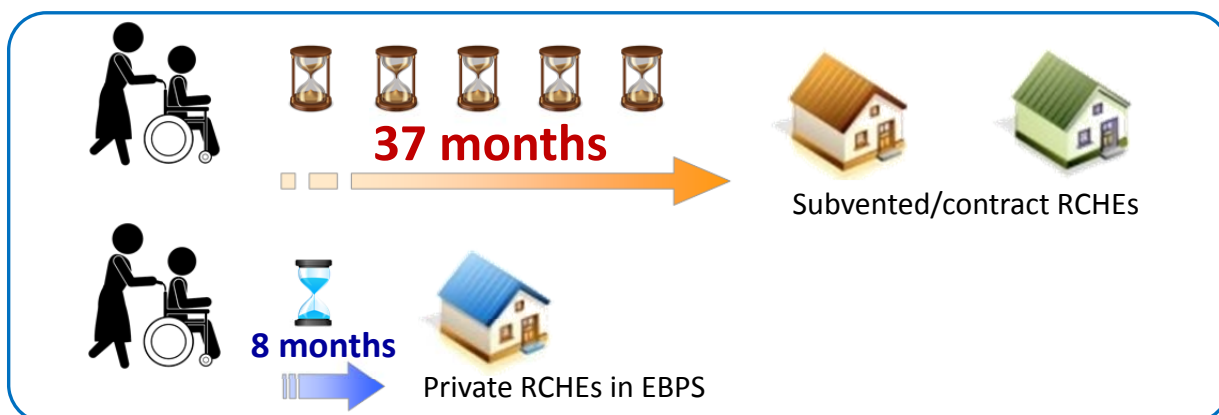
Figure 3 – Number of elderly applicants passed away while waiting for subsidized RCS places, 2005-2014



Data source: Social Welfare Department.

3.3 For those elderly applicants who were finally allocated a subsidized RCS place, they had to wait for a long time for the place. In 2014-2015, the average waiting time reached 37 months for admission to subvented/contract RCHes. The average waiting time for purchased home places provided by private RCHes was relatively short at just eight months⁸ (**Figure 4**).

Figure 4 – Average waiting time for admission to subsidized RCHes, 2014-2015



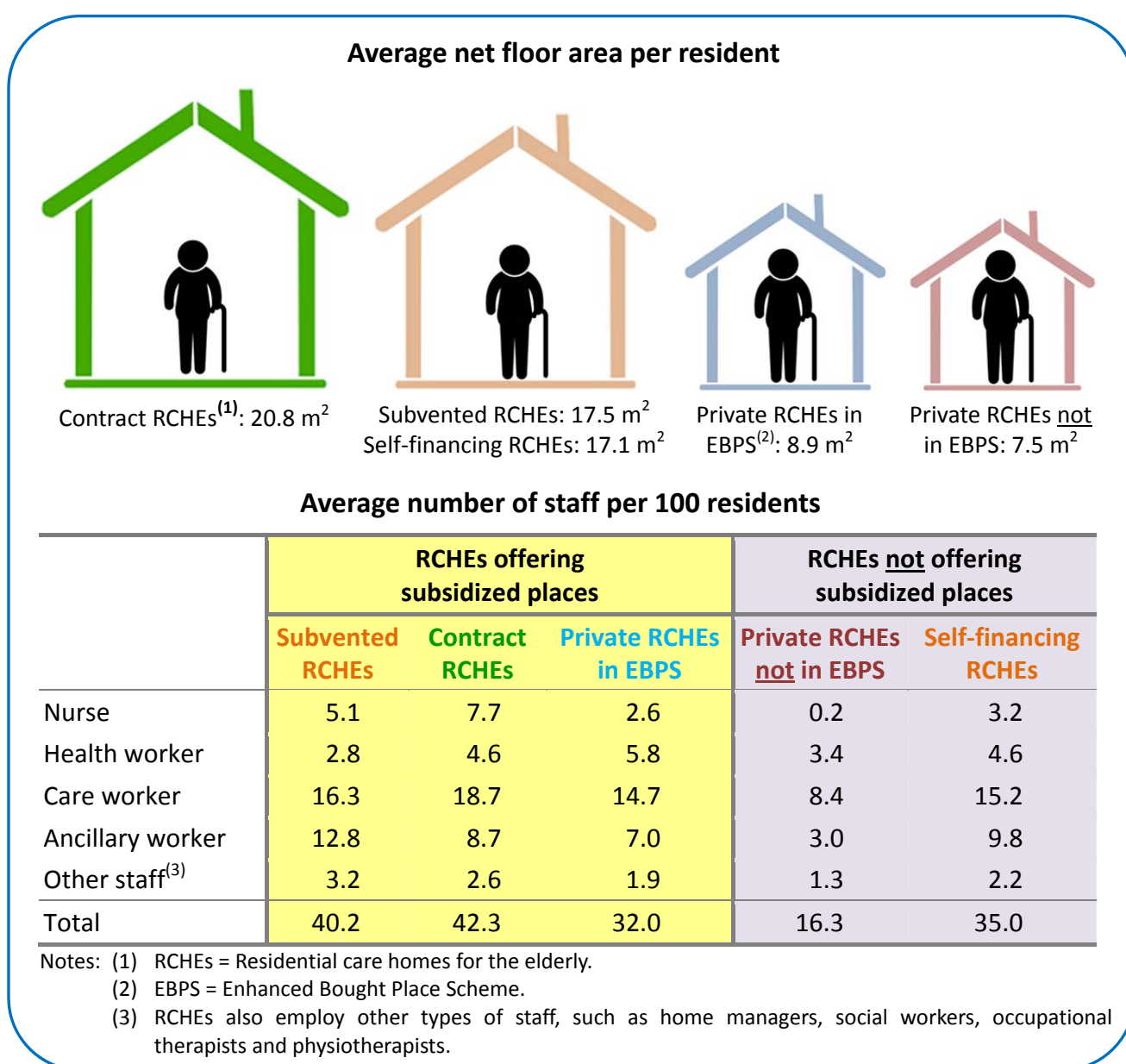
Data source: Social Welfare Department.

⁷ According to the Elderly Commission, contributory factors to this increase in demand for subsidized RCS places include faster ageing population, better confidence in the quality of subsidized RCHes and lower service fees charged for the subsidized places. See Elderly Commission (2009).

⁸ As shown in Figure 5 on next page, private RCHes participating in the bought-place scheme differ from subvented/contracted RCHes in terms of spacing and staffing provisions.

3.4 The long waiting list and waiting time for subsidized RCS places have contributed to the increasing role played by private RCHEs in meeting the rising demand for RCS. This is particularly the case when there is an urgent need for a family to find an elderly home. While private RCHEs not participating in the bought-place scheme form the majority of RCHEs⁹, their services quality varies among themselves. The obvious disparities, as unveiled in the *Director of Audit's Report No. 63* released in October 2014, were reflected in their spacing and staffing provision, in particular when comparing with those offering subsidized places (Figure 5).

Figure 5 – Spacing and staffing provision among RCHEs



Data source: Audit Commission.

⁹ At end-September 2015, more than half of RCHEs (55%) operating in Hong Kong were private RCHEs which did not participate in the bought-place scheme.

3.5 The disparities in services quality among RCHEs can be partly explained by the regulatory framework governing the operation and management of RCHEs in Hong Kong.¹⁰ All RCHEs, be they subvented, contract, self-financing or private, are licensed under the *Residential Care Homes (Elderly Persons) Ordinance* (Cap. 459) ("*RCHE Ordinance*") which came into operation in 1996. In addition to fulfilling the statutory licensing requirements stipulated in the *RCHE Ordinance* and its subsidiary legislation, subvented/contract RCHEs and RCHEs participating in the bought-place schemes are also required to meet enhanced standards set out in the *Funding and Service Agreements* or service contracts signed between the concerned operators and SWD. In contrast, private RCHEs not participating in the bought-place scheme are only required to comply with the statutory minimum standards.

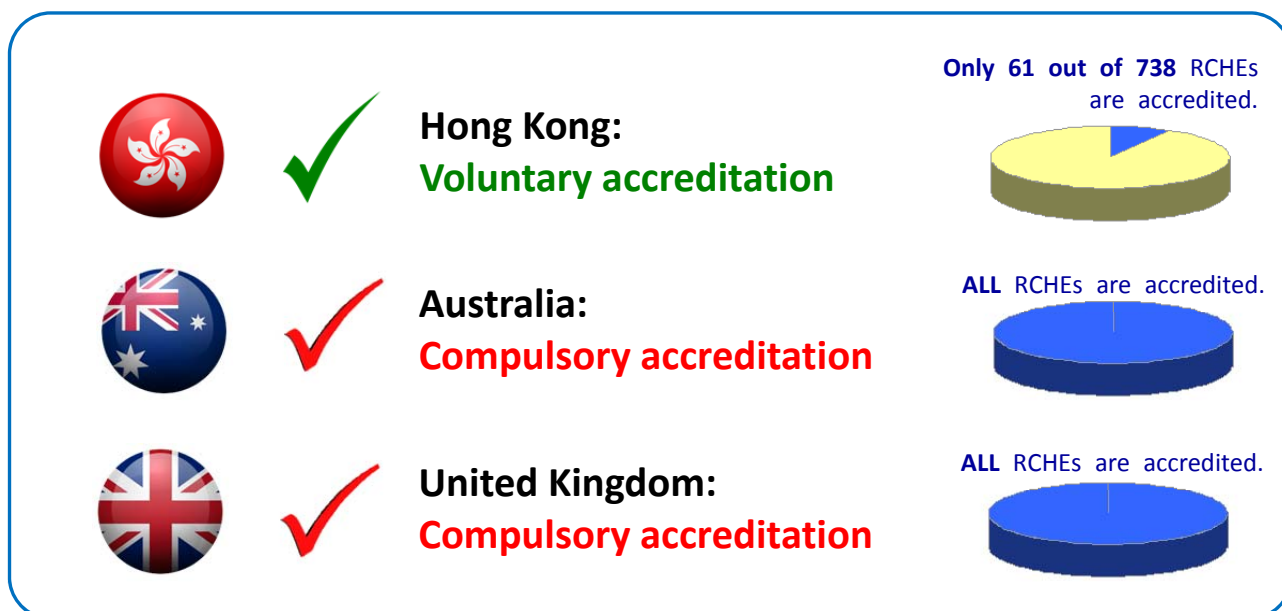
3.6 As the *RCHE Ordinance* only covers the statutory minimum standards to operate an RCHE, the Government has all along been encouraging RCHEs to actively join independent services quality accreditation scheme.¹¹ However, there has been no universally agreed or accepted accreditation scheme in Hong Kong so far. Different RCHE operators resort to different schemes. There are currently three separate schemes each providing accreditation services for voluntary participation of RCHEs, and only 61 out of a total of 738 RCHEs have been accredited in one or more of these schemes.

3.7 Similar to Hong Kong, many overseas places have adopted accreditation schemes to enhance the services quality of RCS. Yet, some of them have made accreditation a compulsory requirement for licensing of RCHEs. For example, RCHE operators in the United Kingdom and Australia must meet compulsory accreditation standards and show continuous improvement in terms of the quality of care and services provided to residents within the facility (**Figure 6**).

¹⁰ According to the Audit Commission, high rental is also one of the factors affecting the services quality of private RCHEs. Unlike subvented/contract RCHEs which are set up in areas located in public housing estates or purpose-built complex provided by the Government, many private RCHEs are located in commercial or residential buildings which are relatively less spacious but more expensive in rental cost. See Audit Commission (2014).

¹¹ Accreditation is used to assess conformity against a standard, a code of practice or regulatory requirements. It provides quality assurance, as well as leading to quality improvement as accreditation is usually reviewed after a period of time.

Figure 6 – Accreditation systems for RCHEs in Hong Kong, Australia and the United Kingdom



Data sources: Australian Aged Care Quality Agency, Care Quality Commission, Hong Kong Association of Gerontology, Hong Kong Health Care Federation and Hong Kong Quality Assurance Agency.

3.8 Against the above concerns about the provision of RCS, there have been calls for the Government to improve the services quality of private RCHEs not participating in the bought-place scheme.¹² Recently, the Government has planned to launch a pilot RCS voucher scheme for the elderly which aims to, among other things, promote further development of quality private RCHEs. It also issued in 2013 an updated *Code of Practice for Residential Care Homes (Elderly Persons)*¹³ to strengthen the services quality of RCHEs. Yet, there is a view that the most effective way to improve the services quality of private RCHEs is to upgrade the statutory minimum requirements in the *RCHE Ordinance* (particularly the spacing and staffing provision) which have not been revised in the past 19 years.

3.9 Apart from upgrading the services quality of private RCHEs, the Government has also been urged to increase the number of subsidized RCS places to keep pace with rising demand. Indeed, the Government has recently put in place the Special Scheme on Privately Owned Sites for Welfare Uses to better utilize the sites granted to non-governmental organizations, with a view to providing around 7 000 RCS places.¹⁴ The Government has also earmarked sites in 11 development

¹² See Audit Commission (2014), Elderly Commission (2009) and University of Hong Kong (2011).

¹³ The Code, issued by the Director of Social Welfare under the *RCHE Ordinance*, sets out the principles, procedures, guidelines and standards for the management and operation of RCHEs.

¹⁴ SWD has received 63 preliminary proposals submitted by 43 applicant organizations, and five of them have entered the implementation stage as at end-March 2015. Based on the rough estimation of the applicant organizations, if all the 63 proposals received under the Special Scheme could be implemented smoothly, the additional RCS places would be provided in the coming five to 10 years.

projects for the construction of new RCHEs to provide another 1 200 RCS places. Yet, past development projects indicate that it took at least five years to open a new contract RCHE from the time when the project received funding approval from the Legislative Council (**Figure 7**). Manpower shortage also adds to the concerns over the feasibility of increasing the number of subsidized RCS places in the years ahead.

Figure 7 – Number of years required for opening a new contract RCHE



Data source: Social Welfare Department.

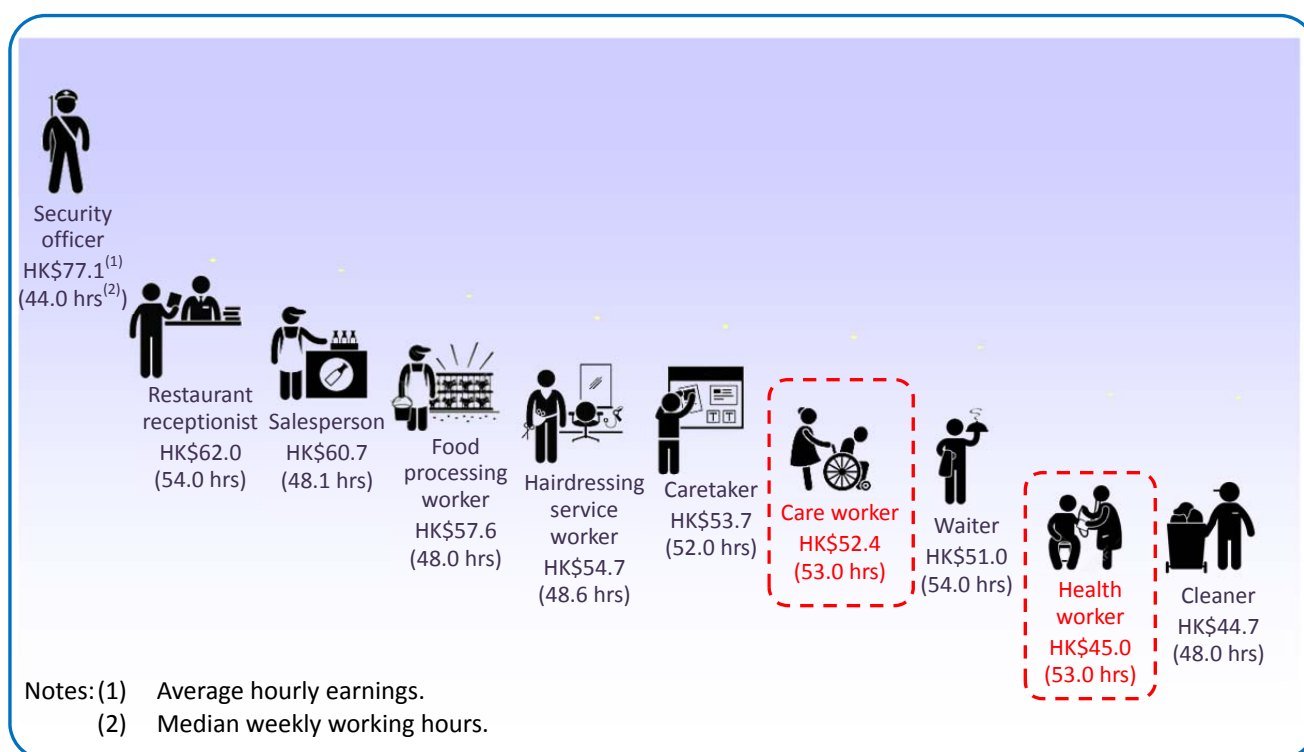
3.10 For RCHEs, non-professional or general frontline workers such as cleaning workers and personal care workers are often deemed to be the most difficult to recruit with a high turnover rate^{15,16}. Unattractive working conditions, such as long working hours and low salary, have resulted in many experienced frontline workers leaving the elderly care industry. Indeed, elderly homes have been identified by the Minimum Wage Commission¹⁷ as one of the low-paying sectors in Hong Kong. Health workers and care workers compare less favourably than many other low-paying workers in terms of average hourly earnings and/or median weekly working hours (**Figure 8**).

¹⁵ According to the Hong Kong Council of Social Service, which surveyed 174 elderly service units in January 2013, there was a high turnover rate of over 20% for personal care workers. See 香港社會服務聯會 (2013).

¹⁶ Professional staff members like nurses are also difficult to recruit for large elderly homes; however much of these professional services such as nursing, physiotherapy and occupational therapy can be offered through outsourcing to external private service providers. See Wong and Kwok (2014).

¹⁷ The Minimum Wage Commission is an independent statutory body tasked with reporting to the Chief Executive in Council its recommendation about the statutory minimum wage rate.

Figure 8 – Average hourly earnings and median weekly working hours of selected low-paying workers, 2015



Data sources: Labour Department, and Census and Statistics Department.

3.11 On attracting people to enter the elderly care industry, the Employees Retraining Board has offered courses such as Foundation Certificate in Care Worker Training and Certificate in Health Worker Training. While these two training courses aim to provide a potential pool of manpower for RCHEs, the number of graduates reduced by half in recent years from 2 470 in 2010-2011 to 1 220 in 2014-2015.

4. Community care services for the elderly

4.1 Amid the time required and manpower constraint for increasing the number of RCS places, enhancement of CCS could help delay or even reduce institutionalization of the elderly.¹⁸ Indeed, international experiences have revealed that effective CCS can avoid pre-mature or unnecessary institutionalization, improve the physical functions of elderly service users and reduce their decline in cognitive status.¹⁹

4.2 Various studies have also revealed that across the world, there has been a general preference amongst elderly people to remain living in their own home,

¹⁸ Hong Kong had a relatively high institutionalization rate of 5.7% among people aged 65 or above in 2014, which was more than double that of Singapore, South Korea and Japan, and more than three times of Taiwan.

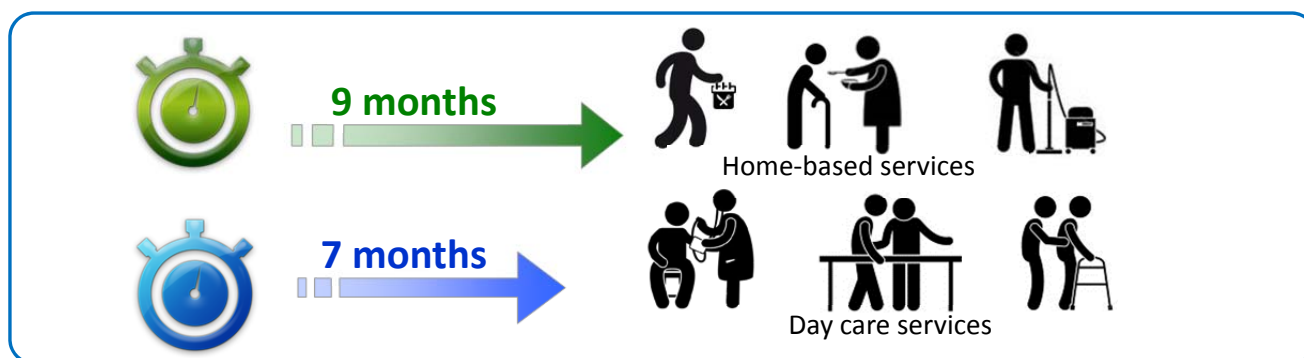
¹⁹ See University of Hong Kong (2011).

instead of entering an institution.²⁰ According to a survey conducted in 2008²¹, among the elderly persons residing in domestic households, most of them (81.4%) preferred to remain living at home instead of moving into RCHE even if their health conditions deteriorated.

4.3 The Government has provided a variety of subsidized CCS to assist the elderly suffering from moderate or severe level of impairment to age in the community.²² These CCS are mainly provided by day care centres/units or at the elderly's homes. Over the last decade, the Government almost doubled the recurrent expenditure on various subsidized CCS from HK\$574 million in 2005-2006 to HK\$1.1 billion in 2014-2015. Yet, it is observed that there is an imbalance between RCS and CCS in terms of the number of places provided and the amount of money spent by the Government on these two types of subsidized services.

4.4 In 2014-2015, the Government spent HK\$1.1 billion on providing 9 680 CCS places, but HK\$3.9 billion for 26 325 RCS places. The small provision of CCS places does not tally with the Government's long-stated policy of "ageing in place as the core, institutional care as back-up". It also increases the number of elderly people on the Central Waiting List for subsidized CCS from 3 310 in 2010-2011 to 4 981 in 2014-2015. In 2014-2015, the average waiting time was nine months for home-based services²³ and seven months for day care services²⁴ (Figure 9).

Figure 9 – Average waiting time for subsidized CCS, 2014-2015



Data source: Social Welfare Department.

²⁰ See Elderly Commission (2009).

²¹ In 2008, the Census and Statistics Department conducted a survey on the socio-demographic profile, health status and self-care capability of older persons. Similar surveys were conducted in 2000 and 2004.

²² There is another type of CCS catering to the elderly who suffer no to mild impairment. The service does not form part of the Government's subsidized CCS, and the non-governmental organizations which operate it keep their own waiting list for the applicants.

²³ Home-based services include personal care, nursing care, rehabilitation exercise, home-making and meals delivery services, as well as transportation and escort services.

²⁴ Day care services aim at providing support to those frail elders whose family members are unable to take care of them during daytime. They include personal care, nursing care, rehabilitation exercise, health education, meals, social and recreational activities, transportation service to and from the day care centre, and escort service in case of emergency.

5. Active ageing

5.1 Amid increased incidence of chronic diseases and physiological deterioration among the elderly population in recent years, there are many older people who are still healthy and living in the community. The diverse population of older people necessitates support measures catering to their diverse needs in different age ranges. For able-bodied elderly, they should live in an age-friendly environment conducive to active ageing where they can stay healthy, active and independent.

5.2 The Government has taken various measures to encourage active ageing, including the establishment of elder academies, launch of "\$2 Public Transport Fare Concession Scheme", and improvement of physical accessibility to buildings and public facilities. As shown in **Figure 10**, there is no guiding policy for active ageing in Hong Kong. The provision of support services for the able-bodied elderly follows more of an incremental approach with the delivery of the services straddling across various bureaux/departments.

Figure 10 – Active ageing measures implemented by the Government over the years

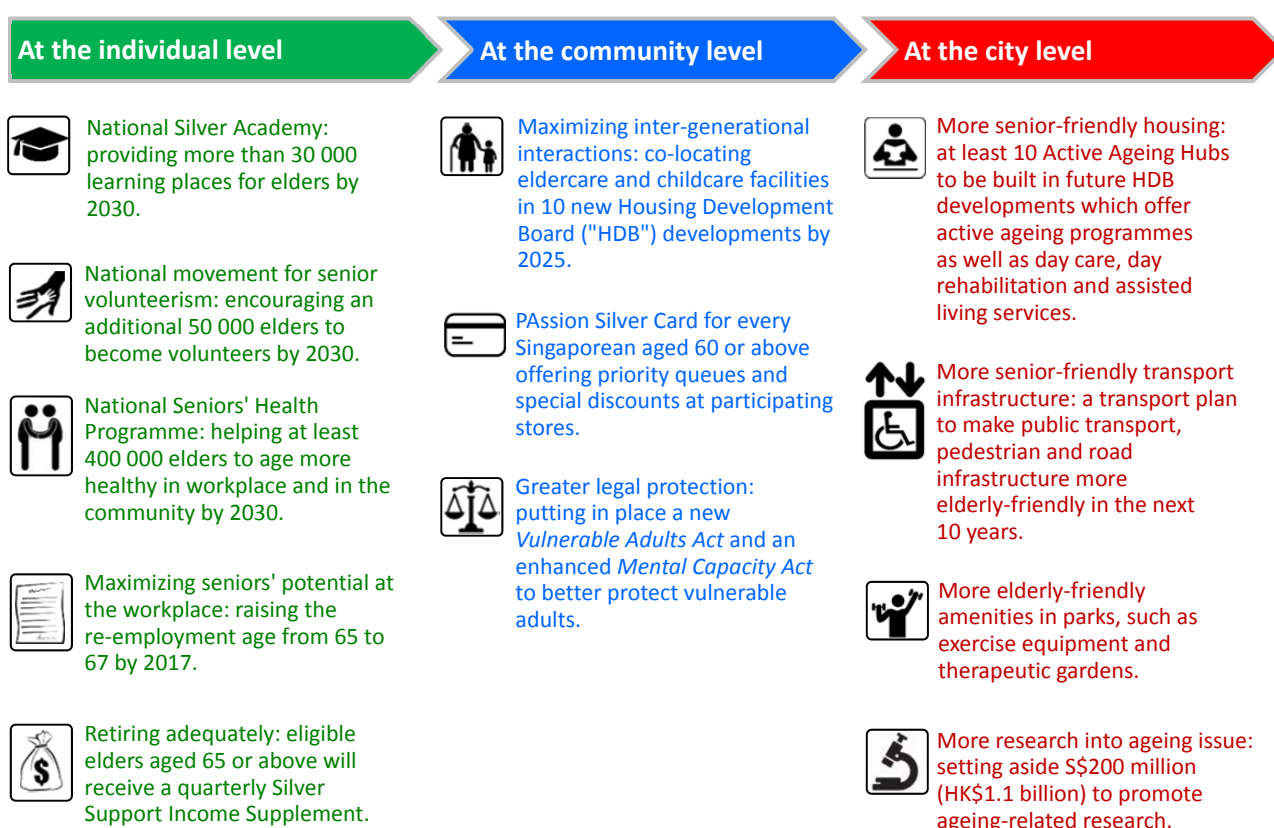
1970s
1979: Elderly Persons Priority Scheme (Hong Kong Housing Authority)
1980s
1982: Families with Elderly Persons Priority Scheme (Hong Kong Housing Authority)
1984: Design Manual: Barrier Free Access (Buildings Department)
1985: Single Elderly Persons Priority Scheme (Hong Kong Housing Authority)
1990s
1990: Special Scheme for Families with Elderly Persons (Hong Kong Housing Authority)
1994: Senior Citizen Card Scheme (Social Welfare Department)
1998: Opportunities for the Elderly Project (Social Welfare Department)
2000s
2003: Senior Citizen Residence Scheme (Hong Kong Housing Society)
2005: Universal Design Guidebook for Residential Development (Hong Kong Housing Society)
2007: Elder Academy Scheme (Labour and Welfare Bureau jointly with Elderly Commission)
2008: Neighbourhood Active Ageing Project (Labour and Welfare Bureau jointly with Elderly Commission)
2009: Harmonious Families Priority Scheme* (Hong Kong Housing Authority)
Recent years
2012: \$2 Public Transport Fare Concession Scheme (Labour and Welfare Bureau jointly with Transport Department)
2015: Joyous Living Scheme (Hong Kong Housing Society)

Note: (*) Families with Elderly Persons Priority Scheme and Special Scheme for Families with Elderly Persons were merged to become the Harmonious Families Priority Scheme.

Data sources: Buildings Department, Elderly Commission, Hong Kong Housing Authority, Hong Kong Housing Society, Labour and Welfare Bureau, Social Welfare Department, and Transport Department.

5.3 Other Asian economies such as Japan, South Korea, Malaysia and Singapore have also promoted active ageing to optimize opportunities for health, participation and security of the elderly in order to enhance the quality of life as people age. Most recently, Singapore's Ministerial Committee on Ageing²⁵ announced a massive and holistic plan – the Action Plan for Successful Ageing – in August 2015 to establish a coordinated national response to the challenges of an ageing society²⁶. The S\$3 billion (HK\$16.5 billion) plan includes about 60 initiatives covering 12 areas, namely health and wellness, learning, volunteerism, employment, housing, transport, public spaces, respect and social inclusion, retirement adequacy, healthcare and aged care, protection for vulnerable seniors and research (Figure 11).

Figure 11 – Action Plan for Successful Ageing in Singapore



Data source: Ministerial Committee on Ageing.

²⁵ The Committee is an inter-ministerial committee including the Ministry of Health, the Ministry of Manpower, the Ministry of the National Development, and the Ministry of Social and Family Development.

²⁶ Singapore is one of the fastest ageing cities in the world. The number of persons aged 65 or above will more than double from 442 000 in mid-2015 to over 900 000 by 2030. By then, about one in five Singaporeans will be aged 65 or above as compared with one in eight in mid-2015.

6. Observations

6.1 The following observations are made based on the findings above:

- (a) the population of Hong Kong is ageing fast. Apart from increasing number and proportion of older people in the total population, there is also a higher incidence rate of chronic diseases and physical deterioration among the older people. The ensuing increase in the number of the frail elderly would result in rising demand for RCS and CCS;
- (b) amid increased demand for RCS, the number of subsidized RCS places remained virtually unchanged over the last decade. This has resulted in the long waiting list and long waiting time for subsidized RCS. Many elderly people on the Central Waiting List had passed away while waiting for the subsidized RCS places. The number reached some 5 600 in 2014, an all-time high over the last decade;
- (c) private RCHes not participating in the bought-place scheme are currently performing as a key provider of non-subsidized RCS places for the elderly. Yet, many of them compare less favourably than other types of RCHes offering subsidized RCS places in terms of spacing and staffing provision. These discrepancies can be partly explained by the existing regulatory framework, under which private RCHes not participating in the bought-place scheme are only required to comply with the statutory minimum standards. While SWD has issued an updated *Code of Practice* to strengthen the services quality of RCHes, there is still a view that the Government should upgrade the statutory minimum requirements in the *RCH Ordinance* as they have not been revised in the past 19 years;
- (d) the Government has all along been encouraging RCHes to actively join independent services quality accreditation schemes. However, there has been no universally agreed or accepted accreditation scheme in Hong Kong so far. At present, there are three separate schemes each providing accreditation services for voluntary participation of RCHes, and only 61 out of a total of 738 RCHes have been accredited in one or more of these schemes. Nonetheless, it is common for overseas places to implement accreditation schemes to improve the services quality of their RCS, and some of them have made accreditation a compulsory licensing requirement for RCHes;

- (e) there have been calls for the Government to increase the number of subsidized RCS places to keep pace with rising demand. In response, the Government has adopted measures such as identifying suitable sites for new RCHEs to increase the provision of subsidized RCS places. Yet, past development projects indicate that it took at least five years to open a new contract RCHE from the time when the project received funding approval from the Legislative Council. Manpower shortage also adds to the concerns over the feasibility of increasing the number of subsidized RCS places in the future. Long working hours and low salary have resulted in a high turnover rate of experienced frontline workers and reduced number of people entering the elderly care industry;
- (f) enhancement of CCS could help delay or even reduce institutionalization of the elderly. The Government almost doubled the amount of recurrent expenditure spent on various subsidized CCS over the last decade. Yet, there is still an imbalance between CCS and RCS in terms of the number of places provided and the money spent by the Government on these two types of services. In 2014-2015, the Government spent HK\$1.1 billion on providing 9 680 CCS places, but HK\$3.9 billion for 26 325 RCS places. The small provision of CCS places does not tally with the Government's long-stated policy of "ageing in place as the core, institutional care as back-up". It also increases the waiting time for centre- and home-based CCS;
- (g) in Hong Kong, there are also many elderly people who are still healthy and living in the community. For these able-bodied elderly, they should live in an age-friendly environment conducive to active ageing. However, there is no guiding policy for active ageing in Hong Kong. The provision of support services for the able-bodied elderly follows more of an incremental approach with the delivery of the services straddling across various bureaux/departments; and
- (h) other Asian economies have promoted an active ageing policy to enable the elderly to stay healthy, active and independent. Most recently, Singapore's Ministerial Committee on Ageing announced a massive and holistic plan – the Action Plan for Successful Ageing – in August 2015. The S\$3 billion (HK\$16.5 billion) plan contains about 60 initiatives covering 12 areas, namely, health and wellness, learning, volunteerism, employment, housing, transport, public spaces, respect and social inclusion, retirement adequacy, healthcare and aged care, protection for vulnerable seniors and research.

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Research Office
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15 December 2015
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