For information
on 14 May 2007

**Subcommittee to Study the Subject of Combating Poverty**
**Report on Elderly in Poverty**

## Purpose

This paper summarises our comments on a number of recommendations made by the Subcommittee to Study the Subject of Combating Poverty (the Subcommittee) in its draft Report on Elderly in Poverty (the Report).

## Responses to the Recommendations of the Report

2. Chapter 5 of the Report summarises all the recommendations made by the Subcommittee. Our views on the recommendations (a) – (k), (m) – (o), (u), part of (w), and (y) in Chapter 5 are set out below –

### Financial assistance for the elderly

**Recommendation (a) : "Conduct a comprehensive review of the adequacy of monthly allowances payable under the Comprehensive Social Security Assistance (CSSA) and Social Security Allowance (SSA) Schemes to ensure that they meet the basic living requirements of the elderly recipients"**

3. The standard payment rates of CSSA and SSA Schemes are reviewed annually to take account of price changes in accordance with the movement of the Social Security Assistance Index of Prices (SSAIP). This mechanism is effective in ensuring that CSSA/SSA standard payment rates are adjusted regularly to maintain their purchasing power.

4. The standard payment rates for the CSSA elders are higher than other categories of recipients. They are also entitled to a wide range of special grants and supplements, such as glasses, dentures, removal expenses, transport fares to hospital/clinic, medically recommended diets and appliances, long-term supplement and burial grant. With the provision of higher standard rates,

special grants and supplements for the CSSA elders, the current CSSA payment is sufficient to meet their basic and special needs. In accordance with CSSA rates revised from February 2007, the estimated average monthly CSSA payment for a single elderly is $3,740.

5. As at end-March 2007, 187 225 elders aged 60 or above were on CSSA. The government expenditure on CSSA old age cases in 2006-07 was $8.3 billion.

**Recommendation (b) : "Review the eligibility criteria for Old Age Allowance (OAA) under the SSA Scheme including extending the permissible annual absence limit and raising the asset limit"**

Absence Limit

6. The residence requirement of OAA is to ensure that a non-contributory benefit is paid to Hong Kong residents with strong connection in Hong Kong.

7. We have already relaxed the annual permissible limit of absence from Hong Kong under the SSA Scheme from 180 days to 240 days since 1 October 2005. The measure allows the recipients to spend more time to travel or visit their relatives and friends outside Hong Kong or take up short-term residence, while on the other hand ensures that public funds are spent on Hong Kong residents who regard Hong Kong as a place of permanent residence. We believe that the measure has struck a reasonable balance.

Asset Limit

8. Under the SSA Scheme, only the Normal OAA, which is paid to elders aged between 65-69, is subject to means-test. The current asset limits of Normal OAA are $169,000 for singleton and $254,000 for married couple. As OAA is a non-contributory scheme and is entirely funded by general revenue, we have to ensure that public funds are spent on those most in need.

**Recommendation (c) : "Extend the Portable CSSA (PCSSA) Scheme to all places outside Hong Kong"**

9. At present, the PCSSA Scheme covers Guangdong Province and Fujian Province for the reason that they are the places of origin of the vast majority of elderly CSSA recipients, accounting for about 95% of the total number of CSSA elders. We believe that the existing Scheme has addressed the needs of the vast majority of elderly CSSA recipients.

10. Given the practical difficulties in administering a global-wide PCSSA Scheme, especially in monitoring the continuous eligibility of the recipients overseas, and the significant financial implications involved, we cannot support the suggestion to make the Scheme fully portable to all places outside Hong Kong.

**Recommendation (d) : "Review and relax the requirement for elders to apply for CSSA on a household basis"**

11. Under the CSSA Scheme, any persons, including the elders, if living with family members, should apply for CSSA on a household basis. The total income and assets of all family members in the same household are taken into account in determining the family's eligibility for assistance. To require persons, who are living with family members, to apply for CSSA on a household basis is in line with the policy objective of CSSA that financial assistance funded by general revenue should be provided to those most in need. It also encourages family members to support each other and prevents the avoidance of the duty of care to the elders by resorting to the CSSA.

12. For exceptional cases meriting special consideration, exemptions from the one-household requirement are allowed where justified.

**<u>Medical services for the elderly</u>**

**Recommendation (e) : "Streamline the application procedures for medical fee waiver, and extend the waiver to Chinese medicine consultation and medication charges"**

13. Elderly persons are one of the major beneficiary groups of the medical fee waiver mechanism. In the first ten months in 2006-07, elderly patients accounted for $186.6 million of waived fees, or 45.6% of the total amount waived in that period. To make the medical fee waiver mechanism more accessible to elderly patients, we have already made a number of improvements to the fee waiver mechanism in the past few years, which include an extension of the maximum validity period of waivers from six months to 12 months for non-CSSA elderly patients who require frequent use of medical services.

14. The public Chinese medicine clinics have adopted a tripartite model where the Hospital Authority collaborates with a non-governmental organisation (NGO) and a local university in each of the clinic. The NGOs are responsible for running the clinics and are required to provide fee waiver for

CSSA recipients. As for non-CSSA low income elders, we encourage the NGOs to provide assistance for them. There are also a number of NGOs running other Chinese medicine clinics and many of them do offer Chinese medicine services free of charge or at low fees.

**Recommendation (f) : "Consider providing medical treatment at public hospitals and clinics to all elderly at half-price"**

15. Public healthcare is over 95% subsidised by the Government. Our limited public resources should be used efficiently, and targeted at the areas of greatest needs, which include, amongst others, services for low income groups and the under-privileged. Those who have the means should, therefore, bear an affordable share of the medical expenses they have incurred. This overriding principle should continue to apply to all users of our public healthcare system, irrespective of their age. For this reason, we cannot support the proposal to provide medical treatment to all elderly at half-price.

**Recommendation (g) : "Expedite the setting up of public Chinese Medicine Clinics (CMCs) and dental clinics in all 18 districts in Hong Kong, particularly in those districts with a high proportion of elderly population"; and**

**Recommendation (h) : "Consider providing subsidies for elderly for receiving treatment from registered private Chinese medicine practitioners and dentists, prior to setting up CMCs and dental clinics in all 18 districts in Hong Kong"**

16. Since late 2003, we have set up a total of nine Chinese medicine clinics (CMCs) in Kwun Tong, Kwai Tsing, Yuen Long, Tuen Mun, Sai Kung, Tsuen Wan, Central and Western, Tai Po and Wan Chai districts. We are actively planning another five CMCs and aim to seek funding approval from the Public Works Subcommittee and Finance Committee in mid 2007. The new clinics are located in districts with a relatively high proportion of elderly population, namely, Eastern, Shatin, Sham Shui Po, Wong Tai Sin, and North districts. As for the remaining four CMCs, we shall continue to search for suitable sites taking into account the needs of the population including the elderly.

17. The Government's policy is to improve the oral health of the population by promoting oral hygiene and oral health awareness in the community. Curative dental services for the public are mainly provided by the private sector and non-government organizations.

18. Emergency dental services are provided free of charge at 11 government dental clinics. Besides, specialized oral health care service for in-patients and special needs group are provided at the Hospital Dental Units of seven public hospitals. At present, the average utilization rate of the emergency dental services at the 11 government dental clinics is around 85%. The government has no plan to expand public dental service.

19. For elderly who are on CSSA Scheme, they can apply for dental grant to cover actual expenses for dental treatment, subject to a ceiling. In 2005-06, the dental grant approved amounted to about $15 million.

**Recommendation (i) : "Review the public healthcare services (including the provision of a manually operated telephone booking system and the allocation of a number of consultation slots for walk-in elderly patients in addition to the implementation of an automated phone booking system) to ensure that elderly patients can receive timely treatment"**

20. The general out-patient clinics (GOPCs) under the Hospital Authority (HA) serve primarily the low-income and vulnerable groups including chronic patients and poor and frail elderly. Improving access to GOPC services by needy patients especially elderly is thus part of the on-going initiative by HA to improve GOPC services. Since October 2006, HA has introduced an automated telephone booking system for its GOPCs with a view to improving the crowded queuing and waiting conditions in GOPCs, and has also enhanced the consultation scheduling arrangement for chronic patients, many of whom are elders. In this connection, HA has promoted the use of the telephone booking service to elderly patients, and enhanced the booking system to make it more user-friendly for elders. For elderly patients with special needs or genuine difficulty in using the telephone booking service, help desks have also been set up in clinics and staff designated to render appropriate assistance in individual cases.

21. As possible improvements, HA has considered the suggestions of adding a manually-operated telephone booking service, and re-opening queues for walk-in elderly patients. Practically, these suggestions would lengthen the time required for each telephone booking and make it even more difficult for users to dial into the system. Adding manually-operated telephone booking service would also require substantial changes to the existing system and would have significant resources and manpower implications for GOPCs. Similarly, re-opening queuing as an alternative to telephone booking will cause long waiting queues outside clinics to re-appear. Shared quotas between telephone booking and queuing would also make it much more difficult for needy patients to get an appointment with GOPCs. To further improve access by elderly

patients to GOPC services, HA is planning to establish on a trial basis in selected clinics dedicated booking hotline for the elderly with reserved telephone booking quota.

**Care and support services for the elderly**

**Recommendation (j) : "Formulate a comprehensive long-term care policy, establish a mechanism for the planning of long-term care services for the elderly and review the Standardised Care Need Assessment Mechanism for Elderly Services";**

**Recommendation (m) : "Strengthen the provision of day care support services for the elderly and provide direct subsidies to the elderly"; and**

**Recommendation (n) : "Expedite the provision of subsidised RCHE places to shorten the waiting time to less than one year and increase the amount of subsidy for private RCHE places, pending the completion of the review of the Standardised Care Need Assessment Mechanism for Elderly Services"**

22. "Active ageing", "ageing in the community", "continuum of care" and "targeting resources at elders most in need" are the underlying principles of our elderly policy. To enhance the quality of life of elders, we promote active ageing. For elders in need, we provide both non-contributory financial assistance through social security and a range of highly subsidised services. To assist elders to age in the community, we provide them with subsidised home-based and centre-based community care services. For those who have long term care (LTC) needs and cannot be adequately taken care of at home, we provide them with subsidised residential care services.

23. To ensure that public resources are targeted at those elders most in need and to enhance consistency and transparency, we have introduced the Standardised Care Needs Assessment Mechanism. The mechanism has been designed on the basis of an internationally-recognised assessment tool known as Minimum Data Set-Home Care to assess the LTC needs of elders who wish to apply for subsidised LTC services. The mechanism has proven to be effective in assessing the frailty level and LTC needs of elders.

24. The Government has invested heavily on elderly services in the past ten years or so. The number of subsidised residential care places has increased by 60% from 1997 (16 000) to now (26 000). Community-based care and support services have also been enhanced. Also, we have been upgrading subsidised residential care places to provide continuum of care. Taking stock of the utilisation of the services :

- over 170 000 elders in the community are members of the elderly centres;

- over 22 000 elders in the community are using various types of home-based and centre-based community care and support services; and

- about 26 000 elders are staying in the subsidised residential care places of various care level for elders in need. Another 23 000 elders are using the CSSA payment to stay in non-subsidised residential care places. The majority (70%) of the elders staying in the subsidised residential care places are receiving CSSA. As such, about 90% of the elders living in residential care homes for the elderly (RCHEs) are receiving some form of Government subsidy and/or subsidised services.

25. In 2007-08, Government's estimated expenditure on elderly services, excluding public housing and public health services, will amount to $3.25 billion, representing a 5.5% increase when compared to that of 2006-07. Of note is that the Government has allocated an additional $150 million for 2007-08 to strengthen elderly care and support services, which include enhancing the efforts to outreach singleton and hidden elders ($38 million), enhancing the support for elderly hospital discharges ($96 million) and increasing the number of subsidised residential care places in new purpose-built premises ($16 million).

26. As the population ages, there will be increasing demand for subsidised elderly services. We are making early planning to address the demand. Among other increases in the next two years, there will be :

- an additional 800 plus subsidised places available in 2007-08 and 2008-09, which include the additional 150 places for 2008-09 making use of the $16 million additional resources earmarked in the 2007-08 Budget. Of the additional 800 plus subsidised places, about 500 will be purchased places in private RCHEs. With the additional purchased places, more elders will be admitted to subsidised places with a shorter waiting time (i.e. about nine months);

- an additional 80 day care places in 2007-08; and

- further increase in the service capacity of the home-based community care services for elders in the community as appropriate.

27. We place great emphasis on the quality of RCHEs. The Social Welfare Department (SWD) will continue to ensure that RCHEs fully comply with the licensing requirements through the licensing regime, unannounced inspections and enforcement, and by providing training and education in collaboration with other relevant departments to enhance the professionalism of RCHEs. Through the Enhanced Bought Place Scheme, we have provided incentives to private RCHEs to enhance their quality. With effect from 15 December 2005, SWD has introduced a new arrangement whereby it will make public on its website information about RCHEs successfully prosecuted under the Residential Care Homes (Elderly Persons) Ordinance and/or Regulation on or after that date. Under this arrangement, SWD has made public the particulars of eight convicted RCHEs.

28. Nursing manpower of RCHEs has a bearing on their service quality. We are concerned about the difficulties of RCHEs in recruiting and retaining nurses. SWD has, in collaboration with the Hospital Authority (HA), launched two batches of Enrolled Nurse (EN) Training Programme for the Welfare Sector (the Programme) in 2006 to provide 220 EN training places. The third batch will be launched in 2007 to provide an additional 110 EN training places. Tuition fees of the Programme are fully subsidised by SWD. Graduates have to undertake to work in the welfare sector for at least a consecutive two years after graduation. This will help retain the graduates in the welfare sector, in particular RCHEs, and alleviate the shortage of nurses in the sector. HA has secured funding for two additional EN programmes in 2008 and 2009, which will provide another 220 EN training places.

**Recommendation (k) : "Develop community-based healthcare services for the elderly at district level"**

29. The Community Geriatric Assessment Teams and the Community Nurses of the Hospital Authority, the Elderly Health Centres and the Visiting Health Teams of the Department of Health, and the Government-subsidised home-based community care services and day care places for the elderly operated by the non-governmental organizations, are part and parcel of our community-based care services for elders. Private medical practitioners are also key providers of primary health care for elders in the community.

## Residential care services for the elderly

**Recommendation (o) : "Provide direct subsidies to the elderly and allow them to choose the types of residential institutions which best suit their needs"**

30. In face of an ageing population, any support system for the elderly has to be financially sustainable in the long term. Increasing continuously the supply of subsidised community care and residential care services alone will not be sufficient to meet the range of their needs which vary according to their background. We will continue to promote shared responsibility of individuals, their families and the society in meeting the needs of elders, and encourage a balanced mix of public and private elderly care services to widen the choices for quality self-financing and private residential care places providing differential services. In consultation with the Elderly Commission, we will continue to explore ways of responding to the challenges of an ageing population effectively, including considering how to further target resources at elders most in need, how to increase the choices for quality residential care places, and how to put in place a sustainable LTC financing, cost-sharing and subsidy allocation model taking into account the development and outcome of the study on health care financing.

## Financial security for the elderly

**Recommendation (u) : "Consider providing a universal retirement protection for the elderly"**

31. In Hong Kong, the retirement protection for the elderly is based on three pillars, namely the CSSA Scheme and OAA, the Mandatory Provident Fund (MPF) Scheme and voluntary private savings. The Government has also built up a vast safety net, providing special care and heavily subsidized services to the elderly in medical and housing policies. The elderly also enjoy various transport concessions.

32. The Government has launched a study on "Sustainability of the Three Pillars of Retirement Protection in Hong Kong", which is expected to be completed in 2007. The Government will consider the findings of the study in deciding on the future course of action.

**Promoting positive ageing in the community**

**Recommendation (w) : "including step up public education on the concept of "ageing in the community""**

33. In consultation with the Elderly Commission, the Government has been stepping up the promotion of the concept of "ageing in the community". In November 2006, we organised a seminar with the participation of overseas and local experts to exchange views on how to further promote "ageing in the community". Frontline medical social workers in public hospitals and staff of the elderly service agencies will also continue to promote the concept of "ageing in the community" to elders and their carers. The carer support services provided by the elderly centres and the home-based community care teams are also conducive to promoting and facilitating "ageing in the community".

**Recommendation (y) : "Draw up specific measures to enhance the capability of the elderly to integrate into the community"**

34. In 2007-08, an additional $38 million has been earmarked to enhance the manpower provision of the existing elderly centres to strengthen their outreach and support services to singleton and hidden elders. After locating the singleton and hidden elders, the elderly centres will establish contact with them, bring them out of isolation, identify their needs, and provide them with the necessary support and services.

35. Members are invited to note the content of this paper.

Health, Welfare and Food Bureau
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