

Consultancy Study on Community Care Services for the Elderly

Final Report

Submitted by

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Glossary

Abbreviation code	Description
C&A	Care-and-Attention Homes
C&SD	Census and Statistics Department
CACP	Community Aged Care Packages
CCHSA	Canadian Council on Health Services Accreditation
CCS	Community Care Services
CMS	Centres for Medicare & Medicaid Services
CMS	Contract Management System
CSSA	Comprehensive Social Security Allowance
CWL	Central Waiting List
DE/DCU	Day Care Centre/Unit for the Elderly
DECC	District Elderly Community Centre
DH	Domestic Helper
D of H	Department of Health
EBPS	Enhanced Bought Place Scheme
EC	Elderly Commission
EHC	Elderly Health Centres
EHCCS	Enhanced Home and Community Care Services
ELCSSHK	Evangelical Lutheran Church Social Services of Hong Kong
EN	Enrolled Nurse
ERB	Employee Retraining Board
FDH	Foreign Domestic Helpers
FMAP	Federal Medical Assistance Percentage
FY	Financial Year
HA	Hospital Authority
HACC	Home and Community Care
HC	Home Care
HCA	Home Care Alliance
HCA	Home Care Assistants
HCW	Home Care Workers
HD	Housing Department
HKSARG	Hong Kong Special Administrative Region Government
HPS	Health Protection Scheme
HW	Health Workers
IDSP	Integrated Discharge Support Programme for Elderly Patients
IHC/IHCS	Integrated Home Care Services
IHC/IHCS(FC)	Integrated Home Care Services (Frail Cases)
IHC/IHCS(OC)	Integrated Home Care Service (Ordinary Cases)
IHCST	Integrated Home Care Services Team
ISP	Individual Service Plan
LDH	Local Domestic Helpers
LTC	Long Term Care

LTCI	Long Term Care Insurance
LWB	Labour and Welfare Bureau
M/E	Ex-multi-service Centre
MDS-HC assessment	Minimum Data Set for Home Care Assessment
MFP	Money Follows the Person
NEC	Neighbourhood Elderly Centre
NGO	Non-governmental Organization
NH	Nursing Home
NHS	National Health Service
NOFA	Net Operational Floor Area
OECD	Organisation for Economic Co-operation and Development
OGCIO	Office of the Government Chief Information Officer
OT	Occupational Therapist
PACE	Programme for All Inclusive Care for the Elderly
PCW	Personal Care Worker
PEVS	Pre-primary Education Voucher Scheme
PGB	Personal Budgets
PSG	Planning Standard and Guideline
PT	Physiotherapist
QF	Qualifications Framework
RC	Residential Care
RCHE	Residential Care Home for the Elderly
RCS	Residential Care Services
RUG	Resource Utilization Groups
SCNAMES	Standardized Care Need Assessment Mechanism for Elderly Services
SE	Social Centre for Elderly
SE	Social Enterprise
SPMS	Service Performance Monitoring System
SSI	Supplemental Security Income
SUS	Skills Upgrading Scheme
SWD	Social Welfare Department
UK	United Kingdom
US	United State
USA	United State of America
VHT	Visiting Health Team
VTC	Vocational Training Council

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CHAPTER ONE

EXECUTIVE SUMMARY

1. This study on community care services (CCS) is conducted based on the recommendations of the Elderly Commission's (EC) study in 2009 on residential care services (RCS) for elders, with a view to further encouraging elders to age in place and thus avoiding premature or unnecessary institutionalization. On behalf of EC, the Labour and Welfare Bureau (LWB) has commissioned the University of Hong Kong's research team to conduct the consultancy study.

Objective of the Study

2. In line with the Government's policy of supporting "ageing in place as the core, institutional care as back-up", the objective of the Study is to examine ways to a) strengthen CCS for elders through a more flexible approach and diverse mode of service delivery, and b) to encourage social enterprises (SE) and the private market to develop related services, with a view to facilitating elders to age at home as far as practicable, and avoiding premature or unnecessary institutionalization.

Methodology of the study

3. The research team has adopted multiple methods in collecting both quantitative and qualitative data and in the analysis, including a) review of relevant local and overseas studies; b) questionnaire survey with 2,490 elderly people and carers and 162 employees of operators. The sampling frame includes a wide variety of respondents with different backgrounds grouped under eleven sampling categories; c) 50 key informants interviews with government officials, operators / stakeholders of CCS; and d) secondary analysis of existing data provided by Social Welfare Department and Census & Statistics Department.

Existing CCS provision

4. Currently, the Government's provision of subsidized CCS as Long Term Care (LTC) services include the three aspects of ***Enhanced Home and Community Care Services (EHCCS)***, ***Integrated Home Care Services (IHCS)*** (Frail Case) and ***Day Care Centres (DEs) and Day Care Units (DCUs)***. As of February 2011, there were 24 EHCCS teams, 60 IHCS teams and 59 DEs/DCU in the 18 districts in Hong Kong.

Issues and challenges in Hong Kong's LTC provision

Imbalance between home care and residential care - high institutionalization rates

5. There is currently an imbalance between RCS and CCS in terms of volume and government expenditure on the two types of services (24 746 subsidized RCS vs. 7 089 CCS places; HK\$2 549 million vs. HK\$381 million in 2010-2011 financial year (as estimated based on the figures from Head 170, the Budget of year 2011-12).

Over-reliance on publicly funded provisions - imbalance between public and private LTC services

6. Hong Kong's LTC provision is largely a publicly funded tax-based model provided by the Government. Furthermore, without means-tests, there is no effective mechanism allowing the Government to target subsidized services at elders who are most in need.

Lessons learned from overseas experience

7. International experiences have revealed that effective CCS can reduce or delay institutionalization, improve the physical functions of elderly service users and reduce the decline in cognitive status.
8. A "public" model of CCS provision is either financed by public revenue which would imply a high tax regime (e.g. Nordic countries), or by a social insurance system (e.g. Germany and Japan). There can be "private insurance" model (e.g. USA) in which people purchase health and/or LTC insurance that covers service expenses. Governments in different countries would also support the public in accessing LTC services, either through provider-subsidy or user-subsidy. End-users are also encouraged to share the expenses by co-payment.
9. Overseas experiences reveal that CCS would require a viable system of clinical assessment to ascertain the level of care and scope of services to be provided. The adoption of a "case mix" system based on clinical assessment, further supported by case management model, would help to enhance cost efficiency and service effectiveness and address the diversity in older peoples' needs.

Values and principles in LTC provision in Hong Kong

10. In the development of LTC in Hong Kong there should be the adoption of the following values and principles: firstly, the services should be "***elderly-friendly***"; secondly, "***ageing in place***"; thirdly, "***shared responsibility of care***" among the individual, the family, the community, the market, and the Government; and fourthly, "***equitable allocation of resources***", in which the allocation of public subsidized services should be prioritized to those with most genuine need.

RECOMMENDATIONS

Area 1: Improving the service provision of subsidized CCS and increasing the service volume

1a) Improving service hours, scope of services, and space for operators

11. The service hours of various types of CCS may be extended beyond office hours and to weekend and public holidays to better accommodate service recipients' needs and family caregivers.
12. Additional services could be provided, such as ad hoc escort service for medical appointment, massage at users' home, home visit with rehabilitation service, cognitive training service, traditional Chinese medicine treatment; and more space including kitchen and office space could be provided for the operators.

1b) Increasing support services for family carers

13. Knowledge on community resources, elderly caring skills and techniques, and elderly diseases and symptoms could be conveyed to family caregivers through talks and training courses offered at convenient time for working carers and supplemented with elder-sitter service, mass media and internet.

1c) Providing more transitional care and respite

14. The success of *Integrated Discharge Support Program for Elderly Patients (IDSP)* best illustrates the merit of transitional care. Some NGOs have developed self-financing transitional care services that adopt a “revolving door” concept in which older persons may choose to change the services according to the health condition. It would be desirable to further improve the current provision of residential respite places.

1d) Fine-tuning the existing funding mode and service performance monitoring system

15. There may be the designation of short term cases to serve those acute frail elder discharged from the hospital or those who only need service for a 3-month period.
16. There is a need to strike a good balance in ensuring service continuity and stability with rational allocation of resources by reviewing the mechanism of bidding for service.

1e) Realigning the service boundaries

17. A more “community-based” model of service boundary alignment can be adopted so that smaller teams could be deployed at the estate or street-block or Tertiary Planning Unit level so as to reduce the traveling time of both the elderly and service operators.

1f) Residential Care Homes for the Elderly (RCHes) serving as CCS base

18. The wide geographical spread of the 777 RCHes that are already equipped with kitchen, dining hall and space can be a very penetrative network of base for the provision of CCS. Pilot projects with those private RCHE that have participated in the Enhanced Bought Place Scheme (EBPS) could be launched to increase the supply of self-financing CCS.

1g) Promoting synergy between centre-based (DE) and home-based (EHCCS/IHCCS) services

19. There could be reallocation and thus reshuffling of service providers, or realignment of service boundaries, amongst the various service providers, so that various services could be provided by the same agency to avoid inter-agency referral. Such reshuffling may start with districts in which one agency provides two or all the three types of CCS.
20. The scope of service and function of day care centres may be expanded to be a base for multi-services provision that may offer a continuum of care services, ranging from day care to home care, and even respite residential care.

1h) Promoting interface between LTC and non-LTC services - review of IHCS (Ordinary Case)(OC) service

21. It may be desirable to review the possibility of re-integrating the IHCS(OC) elderly cases into the LTC system by merging the IHCS(OC) team into the existing EHCCS. One possible strategy is to target those applicants assessed by the Standardised Care Need Assessment Mechanism for Elderly Services (SCNAMES) as having “mild” frailty level. Providing necessary supportive services via the IHC(OC) services could help reduce the rate of physical deterioration, and thus postpone their demand for higher level of LTC services.
22. The 211 elderly centres (as of February 2011) i.e. District Elderly Community Centres (DECC), Neighbourhood Elderly Centres and Social Centres for the Elderly, are actually another type of “community support service”, and can serve as the “front-desk” to identify and refer relevant older people who are on the verge of needing CCS.

1i) Promoting interface between hospital and health care and CCS

23. The IDSP has achieved its goals of providing seamless follow-up service for patients discharged from hospitals, but there could be further improvements of the IDSP. There could be better synergy and coordination between Department of Health and SWD in the provision of CCS for community-living older people, in which the 18 EHC may serve as the mechanism of early identification of LTC needs and thus make referrals to the SWD for the allocation of CCS.

1j) Introducing case management in CCS delivery and better utilization of clinical assessment tool data

24. The experience gathered from overseas countries in the adoption of “case management” may shed light on the development of the case management approach in the provision of LTC services in future. That said, these countries have a different financing system in LTC services, mainly a “private insurance” system or “self-contribution” model. Hence, the case manager system adopted in other countries may not be entirely applicable in Hong Kong. Successful implementation of case management in Hong Kong depends on: firstly, the availability of a large number of competent case managers in the frontline, secondly, the effective coordination between the case manager and the various operators; thirdly, the availability of effective clinical assessment of care needs. Thus, there would be merit in reviewing the SCNAMES to identify its potential strengths in contributing to long-term service and resource planning.

Area 2: Introducing CCS voucher based on affordability and shared responsibility and equitable allocation of resources

2a) means test and sliding scale of subsidy

25. Different categories of survey respondents support the principle of equitable allocation of public resources and thus a more targeted provision of subsidized CCS services. A majority was in support of administering means test.
26. There can be a “sliding scale” of varying degrees of provision or fee charged to the subsidized services, so that those of better financial condition would be required to pay higher fee. The

principles of co-payment and affordability may help to address to the varying needs of different sectors of the older population.

2b) voucher of variable amount

27. There could be merit in exploring the CCS voucher scheme that is administered with a means-test with varying amounts of value in accordance with the applicants' frailty and financial conditions.

2c) CCS Voucher as incentive to choose CCS for "dual option" applicants

28. The provision of a CCS voucher, coupled with the anticipated expanded volume of provision by the NGOs with a self-financing mode and the private operators, may serve as an incentive to encourage elderly applicants for subsidized LTC services to opt for CCS under the dual option system.

2d) Implementing monitoring mechanisms on voucher users

29. The success of a voucher system requires an effective mechanism of monitoring and scrutiny to be put in place. On the other hand, it would be better to avoid disbursing cash so as to ensure proper usage of the subsidy on targeted consumption.

30. The success of a CCS voucher system also depends on the availability of a sufficiently large number of service providers and ample supply of staff, the institution of a clinical assessment system that operates independently from the CCS providers and the stipulation of quality assurance mechanisms.

Area 3: Creating an environment for further development of CCS

3a) Promoting the development of non-subsidized CCS with quality assurance mechanism

3ai) Providing support to operators

31. In order to expand the volume of CCS provision in the community, the Government may need to devise strategies to promote the development of self-financing CCS such as the provision of premise, financial support, and the like. There should be the setting up of quality assurance mechanisms to ensure service quality.

3aii) Quality assurance of non-subsidized CCS operators

32. Setting up a licensing or statutory regulation regime for CCS providers may not be practicable in the short run, as it is practically difficult to define the licensing requirement for CCS providers because the range of services covered is too wide, from simple house cleaning, to nursing care. That said, if a CCS voucher was to introduce, in the long run, there should be a separate monitoring mechanism to ensure their service quality. It is imperative to establish service performance standard, independent party audit, and transparent complaint system for developing a viable private sector of service provision.

3b) Strengthening human resources in LTC

3bi) strengthening recruitment and retention of formal carers / paid staff

33. There should be strategies to promote the recruitment of more formal carers, including nurses, occupational therapists (OT) and physiotherapists (PT). Local training institutes may increase the student intake or launch “blister programmes” to increase the overall supply of nurses and OT/PT.
34. The Government should continue its efforts to provide more training for health care workers and personal care workers under various channels to increase their supply. On the other hand, extending the Education Bureau’s Qualifications Framework (QF) to cover elderly care service industry would help facilitate further training in-service personnel and attract more people to join the sector.
35. There is also need to devise strategies to retain existing staff, which relate to employment condition, promotion prospects, salary and working condition, work satisfaction and the like.

3bii) Enhancing the caring skills of Domestic Helpers

36. Efforts should be made to promote awareness amongst the employers of Domestic Helpers (DH) to encourage their DH to attend training on taking care of frail elderly. Furthermore, perhaps Hong Kong may consider stipulating requirement for DH to undertake training and obtain a license for their practice.

3biii) Mobilizing neighbours in providing support

37. Informal caregivers such as neighbours could be an additional “human resource”. The mobilization of neighbours to serve as informal caregivers may also promote local economy, especially in some old urban areas and old PRH estates with high concentration of older people and low-income households, by improving their financial condition. It may be a pool of human resources that can be tapped by SE and the private market in developing their CCS business.

3c): Promoting public awareness of CCS

38. There is need to improve promoting public education in changing people’s conception in the application of subsidized RCS that subsidized CCS (in kind or in voucher) can be a viable alternative of subsidized RCS. There is also need for increasing publicity, public education and provision of readily available information to the public, the older people and their family members.

OTHER PERTINENT ISSUES

Issue 1: Fostering elderly-friendly infrastructure

39. The sustained development of a viable system of CCS in the community actually requires other policy measures in fostering an “elderly friendly” environment, that includes the

availability of premises for the provision of CCS, barrier-free community environment, accessible transportation to enable elderly people's accessibility and thus community engagement; and a sustainable LTC financing system.

Issue 2: Improving services for older people suffering from dementia

40. It might be desirable to extend the provision of the dementia supplements to other CCS services, so that the service operators could have more resources to serve the home-bound elderly people suffering from dementia. It would be desirable to explore if the DECCs can serve as "front desk", to early identify older people suffering from dementia.

CHAPTER TWO

BACKGROUND OF STUDY

Introduction

41. Following up on the recommendations of the study on residential care services (RCS) for elders, the Elderly Commission (EC) has decided to conduct a more in-depth study on possible enhancement of community care services (CCS), with a view to further encouraging elders to age in place and thus avoiding premature or unnecessary institutionalization. On behalf of EC, the Labour and Welfare Bureau (LWB) has commissioned the University of Hong Kong's research team to conduct a consultancy study on Community Care Services for the Elderly (the Study).
42. Hong Kong is already having an ageing population: the number of people in the population aged 65 and above was 925 900 in 2010, that constituted 13.1% of the territory's 7.1 million people; while those aged over 60 comprised as much as 18.6% (Census and Statistics Department (C&SD)), the Hong Kong Special Administrative Region Government ((HKSARG), 2011). The CADENZA's 2008 study on the international comparison of well-being of seniors revealed that Hong Kong seniors generally live a healthy and active life. Notwithstanding this, there can still be considerable extent of natural physiological deterioration of the human body, which results in a more profound morbidity among the elderly population, especially in the context of increased longevity.
43. From the 2009 RCS Study, it was found that Hong Kong has a relatively higher rate (6.8%) of institutionalization of older people (aged 65 and above), but at the same time there has still been substantial demand for subsidized RCS services, as revealed from the long waiting time. Apparently, there has been a tendency for older people (or their family members) to opt for RCS instead of CCS. It could be attributable to the inadequacy of subsidized CCS and the unavailability of private CCS in the community; that made the older people and their family caregivers to have no alternatives but to choose RCS. In fact, the 2009 Study revealed that there was actually a preference amongst older people to remain living in their own home, instead of in an institution.
44. On the other hand, though there is a substantial private sector provision of residential care homes for the elderly (RCHE), constituting some 70% of the total supply of beds, there has been public concern on the diversity of service quality in such private RCHEs. Yet, due to the fact that a substantial portion of the private RCHE users are recipients of the Government's Comprehensive Social Security Assistance (CSSA), the Government is actually providing RCS directly through provision of subvention to NGOs as operators and indirectly through CSSA payments to users. In view of the possible increased demand from an aging population, the highly subsidized nature of long term care (LTC) services, and the fact that there is no means-test mechanism in the current allocation of subsidized LTC services, it is anticipated that it could incur substantial fiscal pressure on the Government in the long run.
45. The 2009 Study investigated the desirability and feasibility of introducing a means-tested voucher scheme in the provision of subsidized LTC service. Survey results revealed that there could be acceptance amongst the current beneficiaries and the general public to this new mode of financing LTC service provision in Hong Kong. The Study also explored the possibility

of encouraging “dual option” applicants to opt for CCS instead of RCS, so as to promote “ageing in place”.

46. Nonetheless, the 2009 Study also revealed other pertinent issues related to the supply of LTC manpower, quality control of LTC service providers, and recommended the promotion of CCS so as to enable older people to remain living in their familiar community provided with sufficient quality service and support.
47. In fact, the Hong Kong Government has been the main provider of funding to LTC services either directly (through subvention to NGOs) or indirectly (through social security payments). In anticipation of the escalating demand for LTC service due to the ageing population, coupled with the largely publicly funded nature of existing LTC service delivery, there is concern on the sustainability of such a financing mode. Furthermore as the current provision is primarily universal, i.e. provided based on clinical need, but not selective based on means-test, there is also concern as to whether public resources deployed in providing subsidized LTC services are utilized most efficiently and equitably. There is thus the need to explore into the possible development of alternative financing models for providing LTC services for the older people in Hong Kong in the long run.
48. On the other hand, there has been concern in the public that there is still shortage and problems in the current CCS service provision and delivery and that there could be further improvements in various ways to improve efficiency and effectiveness.
49. Against this background, this study ventures to continue exploring the strategies of improving the existing CCS provision, promoting CCS, and the desirability and feasibility of introducing more flexible modes of financing subsidized CCS in Hong Kong.

Objective of the Study

50. In line with the Government’s policy of supporting “ageing in place as the core, institutional care as back-up”, the objective of the Study is to examine ways to a) strengthen CCS for elders through a more flexible approach and diverse mode of service delivery, and b) to encourage social enterprises and the private market to develop related services, with a view to facilitating elders to age at home as far as practicable, and avoiding premature or unnecessary institutionalization.

Review of Existing CCS and present situation

History of development

51. The Hong Kong Government has since 1977 persistently upheld the principle of “ageing in place” in the development of Long Term Care (LTC) services for elderly people. This principle emphasises that elderly people should, as far as possible, live with their families or in a familiar environment as they age. Such a policy direction has also been upheld and further promoted by the SAR Government.

52. CCS constitutes a significant part in Hong Kong's LTC services alongside RCS. Due to escalating demand from the community, and the need to ensure the equitable and efficient deployment of public resources, and that subsidised LTC services are targeted at elders with genuine needs, the Government has since 2000 introduced the Standardised Care Need Assessment Mechanism for Elderly Services (SCNAMES) to assess the care need of applicants for subsidised LTC services and to ascertain their eligibility.
53. In 2000, there were some 400 service units, ranging from the then multi-service centres, day care centres/units for the elderly, social centres for the elderly, and the then home help teams under the administration of more than 100 non-governmental organisations (NGOs), that were in operation throughout the territory. Although these service operators had in the past contributed to fulfilling the needs of the elderly, a number of system problems have been observed, such as service fragmentation, inadequate co-ordination, confusing and complex service boundaries, diseconomy of scale, large service gaps, service duplications, system rigidity, and etc. Based upon the recommendation of a consultancy study by the University of Hong Kong (2003), SWD revamped the Community Support Services for Elders by upgrading Social Centres for the Elderly (SEs) to Neighbourhood Elderly Centres (NECs); the ex-multi-service centres (M/Es) to District Elderly Community Centres (DECCs); and the ex-home help, home care and meal teams to Integrated Home Care Services Teams (IHCSTs).
54. Currently, the Government's provision of subsidized CCS as Long Term Care services include the three aspects of EHCCS, IHCS(Frail Case) and DE/DCU. There are 24 EHCCS teams, 60 IHCS teams and 59 DEs/DCU in the 18 districts in Hong Kong (Table 2.1). In terms of service capacity, as at February 2011, the total number of service users for the three types of CCS are 3 268 EHCCS, 1 056 IHCS(FC) and 3 142 DEs/DCUs (including part-time users, i.e. users who attend DE/DCU for less than 4 days in a week) respectively. The Government has also planned to increase 1 500 places for the EHCCS and about 200 day care places in the 2011-12 Budget.

Table 2.1: Total number of units, service capacity and number of users for EHCCS, IHCS, DE/DCU (as at February 2011)

Service team/Centre District	EHCCS (1st Batch)	EHCCS (2nd Batch*)	IHCS	DE/DCU
Island	1	N.A.	1	2
Central Western	1	1	3	3
Wan Chai	1		2	2
Eastern	1		5	5
Southern	1		2	2
Wong Tai Sin	1		6	6
Sai Kung	1	1	3	2
Kwun Tong	1		4	7
Yau Tsim Mong	1		3	3
Kowloon City	1		3	3
Sham Shui Po	1		7	5
Shatin	1	1	4	4
Tai Po	1		3	1
Northern	1		3	1
Yuen Long	1		4	3
Tsuen Wan	1		2	2

Kwai Tsing	1		3	5
Tuen Mun	1		2	3
Total	24		60	59
Service Capacity	3 579		1 120 (frail cases)	2 314
			no service capacity for ordinary cases #	
Total no. of users	3 268		1 056 (frail cases)	3 142
			20 311 (ordinary cases)#	
Remarks:				
# Figure as at December 2010. According to SWD, the provision of IHCS(OCs) is not part of long term care service				
**“EHCCS (2nd Batch)” denotes the same EHCCS team shared by several districts.				

55. In order to further supplement and enhance the effectiveness of CCS services, the Government has deployed resources to introduce various pilot schemes. For instance, since 2007 the Government has provided block grants to NGOs in launching the **“District-based Trial Scheme on Carer Training”**, which has helped to train carers and develop paid carer services. Two-thirds of the Trial Scheme participants completing the training program have joined the pool of carer-helpers in providing services to frail elders living nearby.
56. In 2008 the Government launched a pilot project called the **“Integrated Discharge Support Program for Elderly Patients” (IDSP)** that would provide elderly patients discharged from hospital with six to eight weeks of follow-up home support services. The initial results reveal that the pilot project has effectively reduced unplanned readmission to hospitals of these elderly patients. The Evangelical Lutheran Church Social Services of Hong Kong (ELCSSHK) is one of the NGOs which is implementing IDSP, and has conducted an opinion survey on the users’ satisfaction of the programme. The elders or the family members agreed that the program could provide emergency and enquiry services and acted as a bridge between the patient and the hospital. Also the family members agreed that the program could encourage the elders to do exercises during the critical period for rehabilitation and the information provided to the carers was useful and could release carer burden (ELCSSHK, 2010).
57. Most recently, the Government has set aside \$55 million to introduce the **“Pilot Scheme on Home Care Services for Frail Elders”** in early 2011 to provide tailor-made service packages for elders waiting for nursing home places but are still living at home. The pilot scheme will last for 3 years in 6 selected areas, including Kwun Tong, Wong Tai Sin, Sai Kung, Kowloon City, Yau Tsim Mong and Sham Shui Po. The number of beneficiaries will be 510 elders. The scheme will apply case management approach and the case manager will be nurse, social worker, physiotherapist or occupational therapist. Each case manager will handle about 25 cases.

Scope of services

58. According to the service contract or Funding and Service Agreement between the SWD and the operating NGOs, the EHCCS, IHCS and DEs/DCUs operators have to meet some specific service targets or requirement. The specific scopes of services of the three types of services are as follows:

59. **Enhanced Home and Community Care Services (EHCCS)** is designed to actualize the concepts of “Ageing in Place” and “Continuum of Care”, which serve as an integrated form of services to meet the nursing and care needs of frail older people (aged 65 or above; and those aged 60-64 with proven needs) with the aim of enabling them to age at home in a familiar environment, as well as to provide support to carers and to strengthen family cohesion. Elders assessed to be of moderate or severe level of impairment by the SCNAMES would be provided with home and community support services according to their assessed needs including care management, basic and special nursing care, rehabilitation exercises, day care service, carer support services, day respite service, 24-hour emergency support,
60. **Integrated Home Care Services (IHCS)** provide a range of community support services to the older people, people with disabilities and needy families living in the community with a pool of experienced and professionally trained staff, and via a network of service units in the community with its collaboration and support. The Integrated Home Care Services Teams (IHCSTs) provide care and support to the target service users according to their individual needs and actualize the concepts of “Ageing in Place” and “Continuum of Care” to enable the service users to continue living in the community. Older people (aged 60 or above) who suffer from moderate to severe impairment ascertained by the SCNAMES and require a comprehensive package of services would be provided with IHCS as “frail case” (IHCS(FC)) category. The scope of IHCS(FC) service is basically the same as that of the EHCCS.
61. **Day Care Centres (DEs) and Day Care Units (DCUs):** DEs or DCUs provide a range of centre-based care and support services during daytime to enable the frail and demented older people (aged 60 or above) suffering from moderate or severe level of impairment to maintain their optimal level of functioning, develop their potential, improve their quality of life and to live in their own homes wherever feasible and possible. DE and DCU provide the following services: personal care, nursing care, rehabilitation exercise, health education, carer support services, counselling and referral services, meals, social and recreational activities, and transportation service to and from the centre. Besides, DEs and DCUs also provide various kinds of support and assistance to the carers in order to enable them to continue to assume their responsibilities as a carer.
62. Most CCS teams would provide home services at regular operating hours, Monday to Saturday and only meal delivery on Sunday. The SWD also requires that CCS operators should deliver services on Sundays, public holidays and outside the regular operating hours of the organisation, that is to be pre-arranged and agreed between the operator and service users. Some EHCCS team would provide “holiday services” including buying meal for the elders and other simple care services, based on special request but not on a regular schedule.
63. For DEs/DCUs, it should operate 12 sessions per week with 10 hours per day from Mondays to Saturdays excluding public holidays, and provide extension of service hours for needy cases. About 22% of DEs/DCUs provide extended services hours on regular basis and another 32% provide extended services hours upon request from users and their family members. There should be enrolled/registered nurses in DE or DCU at all times during the service. For most of the DEs, the average enrolment rate within one year is set at 105%

(part-time users, ie. users who attend DE/DCU for less than 4 days in a week, are included) and the average daily attendance rate (Monday to Saturday) within one year at 90% of capacity.

64. However, it suffices to add that there is another type of services that is not included in the Government's LTC service allocation system, i.e. the Integrated Home Care Services (Ordinary Cases) (IHCS(OC)). This service caters to service users who suffer from no to mild impairment or disability. Priority will be given to individual and families with no or poor support from friends or the community and are financially disadvantaged, or discharged cases from EHCCS or IHCS(FC). The services include: personal care, simple nursing care, general household or domestic duties, escort service, child minding, home respite service, environmental risk and health assessment, purchase and delivery of daily necessities, provision of meals and laundry services. For service users who are assessed to be of moderate or severe level of impairment but require only personal care, simple nursing care and/or other support services (e.g. general household or domestic duties, escort, meals delivery, etc.), IHCS(OC) should be arranged. According to service users statistics of SWD and NGO providers, the great majority of the users of IHCS(OC) services are elderly people.
65. The waiting time for subsidised CCS, as compared to subsidised RCS, is a lot shorter, with an average of about 7 months for day care services and about 2 months for home-based services (frail cases). There is also higher flexibility in the provision of CCS (especially home-based services) as it is less prone to physical constraints such as accommodation.
66. With the introduction of the Lump Sum Grant subvention system since 2001, NGOs operating the two types of CCS (i.e. IHCS and DE/DCU) can have flexibility in deploying their subvention in setting up different staff establishments for their services. Table 2.2 provides a sample, based on interviews with operating NGOs, of the staff establishment of the three services.

Table 2.2: A Sample of staff establishments of three types of CCS at the same district			
	EHCCS	DEs/DCUs	IHCS
Service capacity	216	44	10(FCs) max.250(OCs)
Cases served	216	57 (including part-time users)	10(FCs) 222(OCs)
1. Social worker	2	0	2
2. Nurse	4	2.5	0
3. Physiotherapist	2	1	0
4. Physiotherapist assistant	0	0	0
5. Occupational therapist	2	1	0
6. Occupational therapy assistant	0	0	0
7. Personal care worker	18	7	19
8. Clerk	1	1	2
9. Worker	0	1	2
10. Driver	1	2	2
11. Chef	0	1	2
12. Others		2 (care assistants)	
total :	30	18.5	29

Elderly Centres

67. Besides the above mentioned CCS, District Elderly Community Centre (DECC), Neighbourhood Elderly Centre (NEC) and Social Centre for the Elderly (SE) also play an important part of community support services for the elderly. As at February 2011, there are 41 DECC, 117 NEC, and 53 SE in the territory, serving 190 000 elders. Services provided by DECC and NEC include: carer support, counselling, drop-in, educational and developmental activities, health education, meal and laundry, provision of information on community resources and referral, reaching out and networking, social and recreational activities and volunteer development. DECC further provide case management, community education and support team for the elderly. SE services include providing recreational, social, or educational / developmental groups or activities, giving information and making referral to appropriate services or organizations, encouraging members to organize mutual help activities and participate in community affairs, providing a drop-in area providing a place for social contact.
68. The DECC should aim at early identification of service needs of individual elders whom they come across through daily activities, programmes, and drop-in service, and provide appropriate services and/or referrals. DECCs and NECs also provide carer support service to those family carers who provide family care to their frail elderly family members, provide information on community resources and referral services for community-living older people. These elderly centres operate on a membership basis and the annual fee charged is set at a low level that makes the service accessible to most older people; but at the same time also reflects that the Government has been highly subsidizing the service.

Financing of CCS

69. Due to the fact that there is still a relatively less developed market of private providers of CCS in Hong Kong, the provision of CCS is characterised by a predominance of a “public” model in which services are provided by NGOs which receive funding from the Government. The funding mode is basically tax-based supplemented by a very minor portion of user fees. The Government now subsidises about 80% of the service cost.
70. There is no means-tested administered to the provision of CCS, and eligibility for receiving subsidized CCS is based on the level of impairment of the elder, his/her other health problems, coping and/or environmental risks as assessed by the HDS-HC. The Government is actually providing the CCS (through NGO operators) with a high degree of subsidy and charge the users only a nominal fee. Tables 2.3, 2.4, 2.5 and 2.6 show the respective fee schedules of the various types of services delivered by the EHCCS, IHCS, DCC and the Pilot Scheme on Home Care Services for Frail Elders services. The level of Government subsidy on the respective CCS services is shown in Table 2.7 and the total Government expenditure on CCS service provision in 2010/11 financial year amounted to HK\$752 Million.

Table 2.3: Fee schedule of Integrated Home and Community Care Services, Enhanced Home and Community Care Services and Home Help Services			
Income level	CSSA level or below	Between CSSA to 1.5 CSSA level	Above 1.5 CSSA level
Meal delivery	\$12.6	\$15.4	\$18.6
Laundry	Light	\$0.7	
	Medium	\$0.9	
	Heavy	\$1.8	
Direct care, home making and escort services per hour	\$5.4	\$11.7	\$19.0

Table 2.4: Fee schedule of Day Care Centre/Unit for the Elderly		
Type of service	Monthly fee	Daily fee
Day Care Services with provision of meal service	\$901* \$988**	\$36* \$39.5**
Day respite service (include transport service)	N.A.	\$40
Part-time service*** (include transport service)	N.A.	\$40
Transportation	\$30	N.A.
<p>* The rate is for 50% disabled or single elders. ** The rate is for 100% disabled elders/elders receiving Disability Allowance. ***Attend DE/DCU for less than 4 days in a week</p>		

Table 2.5: Fee schedule for Day Care Unit for the Elderly attached to Contract Home		
Service	Monthly Fee	Daily fee
Day Care Services	\$1,000	N.A.
Day Care Services (for Service User requiring less than three meals a day)	\$900	N.A.
Transportation	\$30	N.A.
Daily fee for part-time Service User (inclusive of transportation)	N.A.	\$40

Income level	CSSA level or below	Between 1 - 1.5 CSSA level	Above 1.5 - 3 CSSA level	Above 3 - 4 CSSA level	Above 4 - 5 CSSA level	Above 5 - 6 CSSA level	Above 6 CSSA level	
Meal delivery	\$12.6	\$15.4	\$18.6	\$25.0	\$30.0	\$30.0	\$30.0	
Laundry	Light	\$0.7			\$5.5 (per lb)	\$11.0 (per lb)	\$14.0 (per lb)	\$14.0 (per lb)
	Medium	\$0.9						
	Heavy	\$1.8						
Direct service provided by nursing staff (per hour)	\$5.4	\$11.7	\$19.0	\$25.0	\$30.0	\$40.0	\$60.0	
Direct service provided by professional staff (per hour)	\$5.4	\$11.7	\$19.0	\$30.0	\$85.0	\$120.0	\$150.0	

	EHCCS	IHCS (FCs) and (OCs)*	DEs/DCUs
Cost per case served per month (2010-11 Estimate)	\$3,227	\$1,296 (Average of frail cases and ordinary cases)	\$6,078
Annual expenditure (2010-11 Estimate)	\$126.8M	\$452.8M	\$172.8M
* For ordinary cases, the applicants are not required to pass the care need assessment under SCNAMES.			

Self-financing and private CCS

71. With increased awareness of the potential great demand for CCS in the community, there has recently been some emerging trend of increased interest from amongst the NGOs and private operators in providing self-financing CCS. Table 2.8 presents the current situation of the availability of CCS provided by NGOs by means of self-financing mode and private operators.

Self-financing / Private CCS (Organisation)	Service Scope
Bamboos	Medical services and personalized nursing care
Centre of Wellness (Hong Kong Sheng Kung Hui Welfare Council)	A variety of medical care services, e.g. Western and Chinese medical consultation, physiotherapy, etc. Tailor-made health promotion plans available for groups and organisations

EasyHome Services (Senior Citizen Home Safety Association)	Housekeeping service includes home help, clean-up, home care for the elderly, patient escort service, infant and child care, post-natal care, health massage, occupational therapy and physiotherapy, etc.
Extra-ordinary Human Resource Market (The Neighbourhood Advice-Action Council)	Patient escort service, occasional child care, domiciliary support, cleaning, babysitting, post-natal care, gardening and hairdressing, etc.
Home Assistant (Hong Kong Employment Development Service)	Services targets on community elders included escort from hospital, clinics, and other social activities
Home Care Services for Discharged Patients (The Tsung Tsin Mission of Hong Kong Social Service Company Limited)	Patient escort and home care services for discharged patients and people with chronic illness
Live Health Project (Tung Wah Group of Hospitals)	Rehabilitation, domestic cleaning and patient escort services, and sale of rehabilitation products
OK Link (Baptist Oi Kwan Social Service)	Indoor safety alarm, mobile phone with multi-functions (e.g. emergency calling function), and domiciliary support service
Professional Escort Service for the Elderly (SAGE Quan Chuen Home for the Elderly)	Patient escort service for the elderly in need and accompanying the elderly out for shopping and outdoor activities
Quality Health Care Company Limited	Integrated healthcare services
Smart Living (Employees Retraining Board)	Elderly care, escort services, discharge care, hospitalized care
Trustease (Hong Kong Single Parents Association)	Personal care, patient escort, child care, post-natal care and cleaning services, etc.
Versatile Home Services (Tung Wah Group of Hospitals Jockey Club Shatin Integrated Services Centre)	Home help service, patient escort service, child care service as well as one-stop home support service for Shatin district
Women's Healthy Living Workers Co-operative Society Limited (Hong Kong Federation of Women's Centres)	Patient escort service and domestic service for the elderly in need
Yuen Yuen Cheerful Family Service Company Limited (The Yuen Yuen Institute)	Elderly home care service and professional home help service
Baptist Oi Kwan Social Service - Integrated Health Care service (Baptist Oi Kwan Social Service)	Day care
Evangelical Lutheran Church Social Service - Hong Kong	Escort services, and personal care
Evangelical Lutheran Church Social Service Tuen Mun Day Care Centre (Evangelical Lutheran Church Social Service - Hong Kong)	Day care
Haven of Hope Christian Service	Domiciliary care services

HKCWC Madam Wong Chan Sook Ying Memorial Care and Attention Home for the Aged (Hong Kong Chinese Women's Club)	Day care
Hong Kong Alzheimer's Disease Association	Day care and domiciliary care
Hong Kong Sheng Kung Hui Cyril and Amy Cheung Aged Care Complex (Hong Kong Sheng Kung Hui Welfare Council)	Day care
Jockey Club CADENZA Hub (Hong Kong Jockey Club)	Day care, health assessment, service management, and health service for the poor
Jockey Club Centre for Positive Ageing	Day care and day respite at holiday
St. James' Settlement Kin Chi Dementia Care Support Service Centre (St. James' Settlement)	Day care and domiciliary care
Yan Oi Tong	Domiciliary care services

72. Among the present self-financing and private CCS, most of them operate during weekdays and Saturday before 6pm while some may open until 9pm. Very few Day Care or Respite service centre operate during Sunday and public holiday. This is not much different from the subvented services. However, due to differences in district profile and thus demand, some operators may have waiting list due to high demand, and some operators would set a maximum weekly utilization limit (e.g. 2 days of Day Care Centre service per week) for their users.
73. Regarding the service fees, charges for day care service of private / self-financing services range from \$2,300 to \$7,200 per month and \$100 to \$200 per day. The charges for professional care service, such as Nurse/ OT/ PT, range from \$160 to \$200 per 45 minutes and \$50 to \$100 per hour for PCW or Health worker service. Miscellaneous domiciliary care services such as home cleaning, home attending, home care, meal delivery, escort service, and etc. are charged at a range of \$25 to \$100 while some operators would provide concessionary charge for CSSA recipients (Table 2.9).

Table 2.9 Comparison of fees level between subsidized and private / self-financing CCS		
	Subsidized	Private / self-financing
EHCCS / IHCS (Direct care, home making and escort services)	\$5.4 – 19 / hr	\$50-100 / hr
Day Care	For a DCU attached to a contract home: the fee charged is \$1,000 per month/ \$900 per month for users requiring less than 3 meals a day. For a subvented DE / DCU: \$901 for 50% disabled/single elders /\$988 for 100% disabled / elders receiving disability allowance	\$2,300-2,700 / month

74. While the private and self-financing CCS services serve a supplementary role in providing much needed community services to community-living frail older people and their family members, due to unavailability of data provided by the operators, it is not entirely sure how far such non-subsidized CCS services could meet the public demand. Furthermore, while the self-financing services are mostly provided by NGOs and thus the service quality could largely be ascertained, the private operators are not yet under scrutiny in their quality of service and fee schedule. There might be concern as to how best to ensure the rights of the service users as consumers of these private services.

Issues and challenges

Imbalance between home care and residential care - high institutionalization rates

75. There is a predominance of residential-care services over community-care services, thus contravening the Government’s principle of “ageing in place”. Hong Kong currently has a higher institutionalization rate (nearly 7% of elders aged 65 or above) than many other countries in the East and West (Table 2.10).

	Institutionalisation rate
Hong Kong	6.8% (2009)
Japan	3.0% (2006)
Singapore	2.3% (2006)
Taiwan	2.0% (2009)
China	1.0% (2008)
Australia	5.4% (2006)
UK	4.2% (2004)
Canada	4.2% (2003)
USA	3.9% (2004)

Source: Chui, E.W.T. et al. (2009) *Elderly Commission’s Study on Residential Care Services for the Elderly Final Report*. Hong Kong: Elderly Commission.

76. There is currently an imbalance between RCS and CCS in terms of volume and government expenditure on the two types of services (24 746 subsidized RCS vs. 7 089 CCS places; HK\$2 549 million vs. HK\$381 million in 2010-2011 financial year as estimated based on the figures from Head 170 of the Budget of year 2011-12). The imbalance between residential and community care can be further illustrated by the following figures (Table 2.11, Figure 2.1): over the period 2003-04¹ to 2010-11, the ratios of government expenditure on and number of places of subsidized RCS to CCS (excluding IHC(OC) which is not regarded as part of Long Term Care as it does not involve clinical screening by the SCNAMES) is consistently above 5 and above 3 respectively. Nonetheless, such ratios have been decreasing over the years,

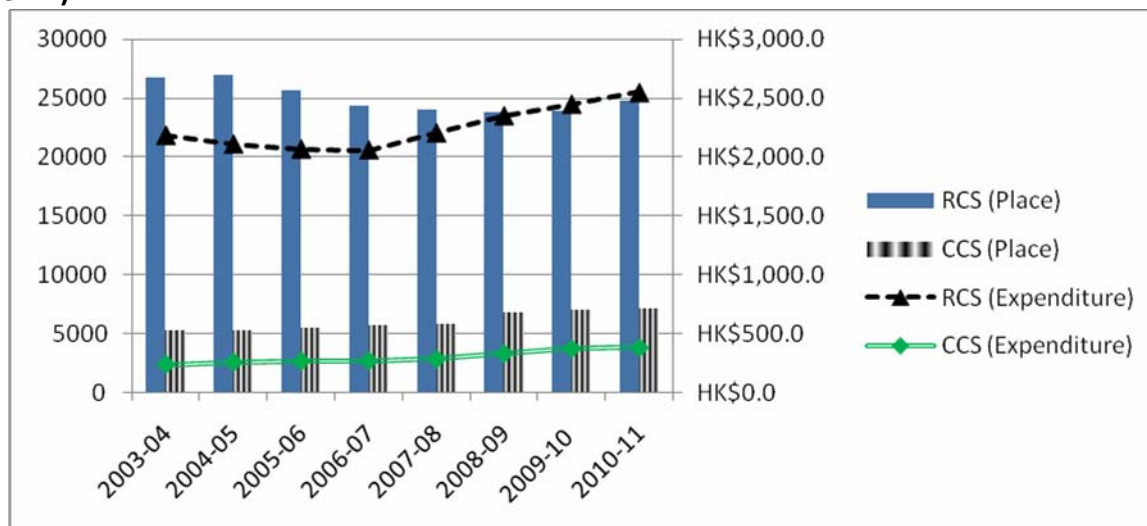
¹ The choice of the year 2003/04 is based on the consideration that the IHC service was started in that year.

indicating that the relative importance of subsidized CCS has been increasing in the overall LTC service provision.

Table 2.11 Provision of subsidized RCS and CCS 2003-2011

	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
Subsidized places								
RCS ¹	26,763	26,985	25,705	24,375	23,969	23,778	23,858	24,746
CCS ²	5,264	5,264	5,508	5,731	5,833	6,820	7,013	7,089
Ratio	5.1	5.1	4.7	4.3	4.1	3.5	3.4	3.5
total	32,027	32,249	31,213	30,106	29,802	30,598	30,871	31,937
DE ³	1,955	1,955	1,955	1,975	2,057	2,234	2,314	2,390
EHCCS	2,189	2,189	2,433	2,636	2,656	3,466	3,579	3,579
IHCS(FC)	1,120	1,120	1,120	1,120	1,120	1,120	1,120	1,120
Government expenditure (HK\$ million)⁴								
RCS	2,183.6	2,107.5	2,064.3	2,056.7	2,205.3	2,350.8	2,450.6	2,549.5
CCS	237.0	256.4	264.7	267.1	282.5	329.6	372.1	381.1
Ratio	9.2	8.2	7.8	7.7	7.8	7.1	6.6	6.7
Total	2,420.6	2,363.9	2,329.0	2,323.8	2,487.8	2,680.4	2,822.7	2,930.6
1 includes EBPS places								
2 includes DE, EHCCS and IHC(FC), but not IHC(OC)								
3 numbers for DE here denote 'places' but not 'users'								
4 government expenditures were estimated based on the figures from Head 170, The Budget of year 2003-04 to 2011-12.								

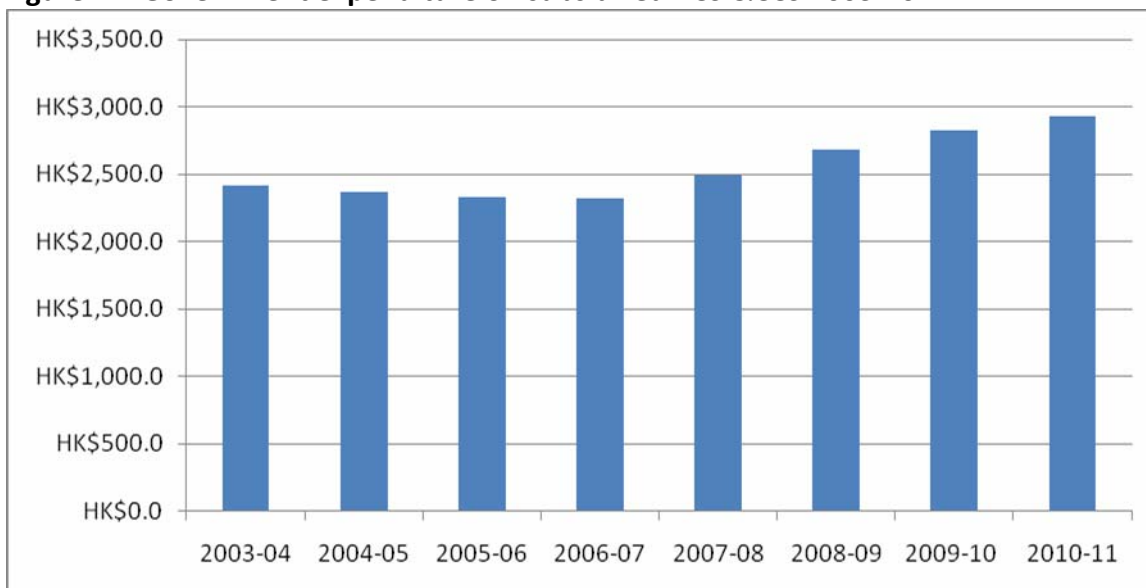
Figure 2.1 Government expenditure (\$ in millions) and number of places of RCS and CCS (2003-11)



Over-reliance on publicly funded provisions - imbalance between public and private LTC services

77. Overall, although a private market exists for residential care, the provision of LTC services in Hong Kong is largely a publicly funded model in which the Government provides highly subsidized services (both residential and community care) through financial subsidies to NGOs or private operators. Furthermore, the provision of such subsidized residential and community care services is not means-tested; that is, there is no effective mechanism allowing the Government to target subsidized services at elders who are most in need. As detailed later, the Government subsidizes virtually all community care services, and largely subsidizes residential care services either directly through subsidies to NGOs or indirectly through Comprehensive Social Security Assistance (CSSA) to users of private residential care services.
78. In the CCS domain, there are virtually no private sector community care and support services, or they are minimal at best. Thus, their provision is essentially a “public” model. The funding mode is basically tax-based, supplemented by a very minor portion of user fees. The Government provides subsidies to NGOs ranging from HK\$3,300+ for a home-based service user per month, while the user pays \$227 per month on average for EHCCS (for the period from April to Sept 2010). The subsidy from the Government constitutes about 90% of the service cost. On the other hand, while the Government provides subsidies to NGOs to operate day care services at a unit cost of HK\$6,000 per user per month, the user pays only about HK\$1,000 per month, which again represents about an 83% subsidy by the Government.
79. It is anticipated that, with the highly subsidized nature of services and the non-means-tested provision, the Government’s fiscal burden could become immense with the increasing ageing population. As revealed from government statistics, the total government expenditure on long term care (including residential and community care) services has been on an increasing trend since 2006/07: increasing from HK\$2,323.8 million in 2006/07 to HK\$2,816.8 million in 2009/10 (HKSAR Government Social Welfare Department, 2010). (Figure 2.2)

Figure 2.2 Government expenditure on subsidized RCS & CCS 2003-2011



80. As revealed from Table 2.12, there is also a considerable portion of users of subsidized CCS who are concurrently receiving government subsidy through the CSSA: 23% of EHCS, 33% of IHCS(FC) and 17% of DCC. Furthermore, there is also a sizable proportion of waitlisted applicants who are CSSA recipients: 44% of EHCS and IHCS(FC) and 21% of Day Care Centre.

	EHCS ¹	IHCS (FC) ²	Day Care Centre ³
No of CSSA recipient users aged 60 / 65+	823 (23%)	372 (33%)	397 (17%)
Total no. of places	3579	1120	2314
No of CSSA recipients on waiting list	421 (44%)		296 (21%)
Waitlisted	957		1431
** excluding IHC(OC)/HH and respite care; 1,2 = aged 65+; 3 = aged 60+			

81. It is to be reckoned that the Government has devoted more resources in the 2011-12 Budget to further substantiate its pursuit of the policy objective of “ageing in place”. It was proposed to increase annual recurrent funding by \$76 million to provide about 1 700 additional places for community care services for elders, including 1 500 places for the Enhanced Home and Community Care Services and about 200 day care places for the elderly, and to increase annual recurrent funding for the IDSP by \$148 million to make it a regular service and extend its coverage from the current three districts to all districts, so that the number of elders benefited each year is expected to increase from the current 8 000 to around 33 000. Furthermore, it was proposed to increase annual recurrent funding by \$45 million to raise the supplements for subsidised RCHE to provide better services for the demented or infirm elders, and the coverage of the Dementia Supplements will also be extended to all subsidised day care centres for the provision of more targeted services to patients residing in the community (The 2011-12 Budget, paras 144, 147).

82. Given the above review of the existing CCS and their limitations, further coupled by the fact that “Ageing in place” should be realized in policy and actual practice, there is indeed need to study the possible directions for further improvement in the provision of CCS in Hong Kong. It is especially true for Chinese people in Hong Kong who prefer to age in a familiar environment and to continue enjoying the support of their family members, friends and neighbours. Both overseas and local studies (Gott, Seymour, Bellamy, Clark and Ahmedzai, 2004; Lou, Chui, Leung, Tang, Chi, Leung et al., 2009) substantiate this preference amongst elderly people to remain living in their own home instead of an institution. For instance, the 2008 Thematic Household Survey of the Census and Statistics Department revealed that 96.4% of elderly respondents had no intention to move to a residential care home for the elderly and 81.4% of them would like to remain living in their own home even when health deteriorated (C&SD, 2008).
83. The present study therefore ventures to explore the possible directions for developing a viable CCS financing and delivery system that best serve the policy direction of promoting “Ageing in Place” for older people in Hong Kong.

METHODOLOGY

84. The study covers a wide range of issues that requires the collection of a wide range of data (both quantitative and qualitative). The research team thus has to adopt multiple methods in collecting data and in the analysis.

Literature review

85. The research team had reviewed relevant previous and ongoing studies, both local and overseas, to provide reference for the present study. Specifically the research team collected a huge amount of information about the LTC policy and practices, including the financing mode and the service scope and variations, in seven countries and regions, namely Australia, the United Kingdom, the United States, the Netherlands, Singapore, Mainland China and Taiwan. Reference was also made to 19 member countries of the Organisation for Economic Co-operation and Development (OECD) and Asian countries / economies, which provided reference for Hong Kong.

Interviews

(a) Questionnaire survey

86. A total of 2,490 elderly people and carers were interviewed face-to-face and 162 employees of operators returned their self-administrated questionnaires in the study period. Also, 50 in-depth interviews with some cases of some categories were conducted to get more detailed information about the specific situations of those groups of stakeholders. The sampling frame includes a wide variety of respondents with different backgrounds grouped under eleven sampling categories as detailed below (Table 2.13):

Table 2.13: Sampling frame of the questionnaire survey

	Category	Sample size # [Actual no. of cases conducted]
1	Non-users of community care services (CCS) living in domestic household but waiting for subsidised residential care services (RCS)	600 [506]
2	Existing frail users of subsidised CCS (note i)	500 [493]
3	Existing non-frail users of subsidised CCS (note ii)	400 [329]
4	Existing users of non-subsidised CCS (note iii)	100 [31]
5	Non-users of CCS with no long-term care (LTC) needs (note iv)	400 [409]
6	Middle-class elders such as residents of the Senior Citizens Residence Scheme (SEN) and retired civil servants	150 @ [154 @]
7	Participants of the Integrated Discharge Support Programme for Elderly Patients (IDSP)	100 @ [91 @]
8	Carers	400 @ [363 @]
9	Employees of CCS operators providing direct services to elders	150 [162]
10	Elderly patients of day hospitals	100 @ [82 @]
11	Recent applicants undergone Minimum Data Set - Home Care (MDS-HC) assessment with LTC needs	100 @ [82 @]
	Total	3000 [2702]

Notes:

- i. Existing frail users of subsidised CCS refer to existing Integrated Home Care Services (Frail), Enhanced Home and Community Care Services and day care users.
- ii. Existing non-frail users of subsidised CCS refer to the existing Integrated Home Care Services (Ordinary) users.
- iii. Existing users of non-subsidised CCS refer to the existing users of self-financing CCS provided by NGOs.
- iv. Since we are unable to identify elders without LTC need, non-users of CCS with no LTC needs refer to those living in the community, not using and applying for any CCS (both subsidized and non-subsidized) and is not applying for any RCS.

There may be duplication of membership across the categories but since there is currently no available data to cross-check the magnitude of such overlapping membership, it is therefore assumed that this will not significantly affect the relative proportion of samples selected.

@ 10 in-depth interviews were conducted in such categories

(b) Informant interviews

87. In order to have a fruitful review of the existing service provision and explore into the possible directions for improvement and future development of CCS in Hong Kong, it is imperative to solicit views from these NGOs operators. Furthermore, in view of the potential demand for CCS and thus the possible development of CCS provision by non-subsided operators, including the NGOs operating on self-financing mode and private operators, it is also necessary to interview some of the potential providers of CCS. A total of 26 key informants were interviewed and they were made up of government officials, operators / stakeholders of CCS.
88. The interviews were guided by detailed interview schedules (Appendix I) specifically designed for different groups of stakeholders. The scope of questions include the current problems and challenges in operating / providing the CCS, the impact of the possible changes in policy on operation and finance, as well as the possible impact of implementing a voucher system for subsidised LTC services (including both CCS and RCS).

Secondary analysis of existing data

89. The research team analysed data archives provided by relevant government departments which include the following:

(a) Social Welfare Department The SWD maintains data archive of Long Term Care Service and other relevant data, which include:

- i. Aggregated data of the SCNAMES from 2004-2011;
- ii. Number of places of DE, EHCCS and IHCS(FC)];
- iii. Percentage of CSSA recipients in CCS users.

(b) Census & Statistics Department

- i. 2006 Population By-census
- ii. 2010 population figures
- iii. Data of the 2004 and 2008 THSs on socio-demographic profile, health status and long-term care needs of older persons

Limitations

90. There are a number of limitations that have to be acknowledged in the present study. Firstly, as there were no readily available name lists in some categories of targeted samples, it was not feasible to conduct random sampling for these categories. Secondly, the categories of respondents may not be entirely discrete as there could be overlapping membership e.g. a respondent may at the same time be current users of subsidized and self-financed CCS. Thirdly, in case the selected elderly was cognitively and/or physical unfit to respond (upon screening by clinical assessment), the proxies had to answer on behalf of the elderly.

CHAPTER THREE

INTERNATIONAL EXPERIENCES IN CCS PROVISION

Introduction

91. The current study reviews the experiences of other countries in the provision of CCS services, so as to shed light on the improvement of CCS provision in Hong Kong.
92. As revealed in the Elderly Commission's 2009 study on residential care services (RCS) for the elderly, there is an international trend of promoting "ageing in place" through the provision of community care services. In this regard, governments worldwide (at federal, provincial or municipal levels) provide a wide variety of in-kind services and subsidies (in the form of cash or voucher) to the service users and/or their family members to enable them to exercise choice in using long-term care (LTC) services, and to encourage elders to age at home or their family caregivers to take care of elders in their own homes. In some countries/regions, the elders can even choose a combination of both types of support.
93. Through literature review, the consultant team has examined the provision of community care services in seven countries and regions, namely Australia, the United Kingdom, the United States, the Netherlands, Singapore, Mainland China and Taiwan. Nonetheless, reference to Organisation for Economic Co-operation and Development (OECD) countries is also made when and if appropriate.

Highlights of Community Care Services in the International Scene

94. As revealed from OECD statistics, most of the countries put stronger emphasis on promoting CCS rather than RCS. Table 3.1 shows a general trend of having more elderly receiving CCS than RCS. However Table 3.2 shows that the expenditure on RCS is higher than that on CCS as a percentage of GDP of those countries. This apparently shows that the average cost of RCS is higher than CCS (Chappell, Dlitt, Hollander, Miller and McWilliam, 2004). There are a variety of policy tools and services that can promote "ageing in place" of older people.

Table 3.1 International scene in the distribution of recipients of RCS and CCS as a percentage of population aged 65+

	Year	%65+ receiving RCS	Year	%65+ receiving CCS*
Australia	2007	6.0	2008	2.5 ¹
Austria	2003	3.6	2000	14.8
Canada	2007	3.5	2003	15.0
China	2008	1.73	2009	19 (in Shenzhen)
Germany	2008	3.7	2003	7.1
Hong Kong	2008	6.8	2010	0.8#
Ireland	2008	4.0	2000	5.0
Japan	2009	2.9	2000	5.5
Korea	2009	1.1	2000	0.2
Luxembourg	2007	4.7 (estimated)	2003	4.8
Netherlands	2008	6.7	2008	12.9
New Zealand	2009	3.6	2000	5.2
Norway	2008	5.5	2000	18.0
Singapore	2008	2.9	n.a.	n.a.
Sweden	2008	5.9	2000	9.1
Switzerland	2008	6.4	2000	5.4
Taiwan	2009	1.9	2006	1.0 (day care)
United Kingdom	2004	4.2 (estimated)	2002	20.3
United States	2004	3.9 (estimated)	2007	2.8 ²

*CCS includes “home-care” and “community care” services and monetary “benefits”

EHCCS serves people aged 65+; IHC(FC) and Day Care serve people aged 60+

¹ receiving Community Age Care Packages in Australia

² receiving Home Help in US

Source: Huber, M. (2005b), “Long-term Care: Services, Eligibility, and Recipients”, OECD Health Working Papers, OECD (2005). Long Term Care for Older People, “OECD Health Data 2010”, OECD, Paris; Australia: Australian Institute of Health and Welfare. Aged Care Packages in the community 2007-08. A statistical overview. Canada: Rotemann, M. (2003). Seniors’ health care use. Supplement to Health Reports, 16, 33-45; Hong Kong: Chui, E. et al. (2009). Elderly Commission Study on RCS; Taiwan: Ministry of the Interior, Taiwan. (2010). 10th Week of Interior News of Statistics 2010; Singapore: Integrated Health Services Division and Healthcare Finance Division.

Table 3.2 Public and private expenditure on long-term care as a percentage of GDP, 2000

	Total expenditure			Public expenditure			Private expenditure		
	HC	RC	Total	HC	RC	Total	HC	RC	Total
Australia	0.38	0.81	1.19	0.30	0.56	0.86	0.08	0.25	0.33
Canada	0.17	1.06	1.23	0.17	0.82	0.99	n.a.	0.24	0.24
Germany	0.47	0.88	1.35	0.43	0.52	0.95	0.04	0.36	0.40
Ireland	0.19	0.43	0.62	0.19	0.33	0.52	n.a.	0.10	0.10
Japan	0.25	0.58	0.83	0.25	0.51	0.76	0.00	0.07	0.07
Netherlands	0.60	0.83	1.44	0.56	0.75	1.31	0.05	0.08	0.13
New Zealand	0.12	0.56	0.68	0.11	0.34	0.45	0.01	0.22	0.23
Norway	0.69	1.45	2.15	0.66	1.19	1.85	0.03	0.26	0.29
Poland	0.35	0.03	0.38	0.35	0.03	0.37	n.a.	0.00	0.00
Spain	0.23	0.37	0.61	0.05	0.11	0.16	0.18	0.26	0.44
Sweden	0.82	2.07	2.89	0.78	1.96	2.74	0.04	0.10	0.14
UK Kingdom	0.41	0.96	1.37	0.32	0.58	0.89	0.09	0.38	0.48
USA	0.33	0.96	1.29	0.17	0.58	0.74	0.16	0.39	0.54

HC = home care, RC = residential/institutional care

Note: Data for Poland are only rough indications of magnitude; Data for Australia, Norway, Spain and Sweden are for age group 65+; n.a. = not available.

The notion of “long-term care” used in a national context can be substantially broader, e.g., by including residential homes for older people (e.g. the Netherlands, Nordic countries).

Source: Canada, Germany, Norway: *OECD Health Data 2004*; Australia: Productivity Commission (2003); Ireland: estimates based on O’Shea (2003) and Mercer Limited (2003); Poland: Kawiorska (2004); Spain: Marin and Casanovas (2001); United States: *OECD Health Data 2004* and GAO (2002); Austria, Japan, Norway, New Zealand, Sweden, United Kingdom: Secretariat estimates based on replies to the OECD’s questionnaire on long-term care. (See Huber, 2005a, for a more detailed documentation of sources and methods.)

OECD (2005) Long Term Care for Older People

Policy tools for promoting “ageing in place” against institutionalization

95. In Australia, there is a “Transition Care Programme” that provides a sufficient period of transitional care for patients discharged from hospital to avoid them go directly to nursing home. The “Retirement Villages Care Packages” is focused on residents of retirement villages who require additional aged care services. “Customer Direct Packaged Care” embraces all the existing Home and Community Care (HACC) services based on the user’s preference. The shares paid by the elders who participate in community care (Community Aged Care packages) are less than those who opt for residential care. People are provided with funds from “personal budgets”, which is used for home and community services. There is a whole array of carer support provisions, such as Calamity leave, Ten-day care leave, Leave to care for a dying person, Career interruption, Saved-up leave and Long-term care leave.
96. In the UK, different levels of governments provide different types of publicly funded home care services, depending on whether the services are health services or social services. Nationally, the Central government, through the National Health Service (NHS), is responsible for administering health services including home health services (Dalley, 2000). “Direct Payments” is payable to older people who need home-based long-term care to the value of their assessed need for services and these can be used to pay relatives and friends as care assistants who are not living together (OECD, 2005:55). Various alternatives to residential care,

which include sheltered housing and extra care housing schemes that offer independence with an increased level of care and support, would be suggested by social services agencies.

97. In the USA, the Congress established the “Money Follows the Person (MFP) Demonstration” in 2005 to provide states with an enhanced Federal Medical Assistance Percentage (FMAP) for a one-year period for each individual when they transit from an institution to a qualified home and community-based programme. In 2007, the US government’s Centres for Medicare & Medicaid Services (CMS) awarded grants to 31 states.
98. In China, there is also the emphasis on community care over residential care. The government encourages the use of the CCS for elderly. For instance, the Ministry of Civil Affairs suggested a “9064” planning model in the provision of elderly service, i.e. 90% of elderly should be receiving home care, 6% could live in elderly community and only 4% should be living in institutions. Due to China’s vast territory, there are variations amongst the various provinces and municipalities in their respective policies and provisions. For instance, the Shanghai municipal government started from 2000 onwards subsidizing CCS in the form of buying service for low income elderly who have difficulties in caring themselves. In 2004, it adopted voucher system in CCS for those elderly who are covered by the Minimum Living Standard scheme and those who have low income. The Shanghai municipal Government subsidizes those aged 80 and over, who are either living alone or living in pure elderly household and passed the assessment of self-care, 50% of the standard allowance for elderly service.
99. In Singapore, according to the government’s Eldercare Master Plan (FY2001 to FY2005), the Singapore government only set S\$2.6 million on residential care compared with S\$14.9 million on home care for frail elderly and S\$30.6 million on programmes for healthy elderly. As the NGO sector in Singapore is heavily subsidized by the government, such a policy of promoting more CCS than RCS is reflected in the fact that the number of centres and voluntary welfare organisations providing community-based care service in 2005 was nearly double of that in 1998 while the number of nursing homes and sheltered homes only increased by a small percent.

Provision of CCS in other countries/regions

100. The provision of CCS in the countries/regions reviewed are further examined in the following aspects: 1) financing model of service provision, 2) form of government subsidized service, 3) issues related to the implementation of financial subsidy, 4) quality assurance of CCS providers, 5) care needs assessment and service scope, 6) case management, and 7) manpower issues.

(a) Financing model of service provision

101. Similar to the 2009 study on RCS, the present review also shows that CCS in various countries may be provided by a variety of financing models (Table 3.3 on page 47). Scandinavian countries like Norway and Sweden provide services by a publicly (tax) funded model; whereas the USA, is having private insurance supplemented by some publicly funded programmes. In terms of the scope of provision, the Nordic tax-based model and the insurance model in Germany, Luxemburg and Netherlands provide “universal” coverage; while other tax-based

systems in Australia, Canada and UK provide in-kind services on a “selective” (usually based on means-test) basis.

102. Even under universal public programmes, there is usually the requirement for private cost-sharing by means of co-payment or user-pay mechanisms (Table 3.3). Cost-sharing in universal systems either comes as a fixed percentage of cost, or as the difference between the benefit and actual spending (OECD, 2005:25). Even in the case of the Netherlands which adopts the insurance model and where no means-test is in place, pensioners are required to contribute premium in the form of deductions from their pensions or out-of-pocket contributions to share part of the costs. Nonetheless, as revealed in Table 3.4, cost-sharing (by user-pay or co-payment) constitutes a relatively minor portion in the provision of publicly funded CCS, as reflected from the situation where private expenditure on home / community care is consistently lower than public expenditure. The USA is an exception in which public and private expenditures on home care are somewhat similar.

Table 3.4 Public vs. private expenditure (as a % of GDP) on home care – international scene		
	Public expenditure	Private expenditure@
Australia	0.30	0.08
Germany	0.43	0.04
Japan	0.25	0.00
Netherlands	0.56	0.05
New Zealand	0.11	0.01
Norway	0.66	0.03
Spain	0.05	0.18
Sweden	0.78	0.04
United Kingdom	0.32	0.09
United States	0.17	0.16
@ “private expenditure” refers to user-fees, co-payments		
Source: OECD (2005) Long Term Care for Older People		

103. Actually the USA exhibits another model of financing the LTC services with a public-private mix. Given that the USA has a federal government structure there is no nation-wide publicly funded LTC programme, unlike many European countries. On the other hand, the USA has adopted a “private” model of health insurance which to a certain extent covers and/or overlaps with LTC service. However, several federal and state government programmes provide funding to support home care including Medicare, Medicaid, Older Americans Act, Social Services Block Grant, Supplemental Security Income (SSI), and a range of supportive arrangements (Kassner, 2006). The USA’s Medicaid system, which is publicly funded, is restricted to the poor; while the Medicare, as a public health system for those 65 and older, provides only limited coverage for home health and skilled care (Handy, 2006).

104. In publicly funded models like those of Australia and UK that are financed by tax, there would be some mechanism of selection. Such selective provision is usually implemented by administering a means-test mechanism on the recipients’ assets and incomes on LTC service provision (including community care services). The administration of a means-test mechanism

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

105. Apart from general tax revenue, a number of countries/regions including the Netherlands, Singapore, USA and Taiwan have also established different forms of regulatory contributory social insurance mechanism, aimed at the working population, to cater for the LTC needs (including community care needs) of their frail elders. On the other hand, private insurance for LTC services is rather uncommon².

(b) Forms of government subsidized service

106. Most publicly-funded CCS services are provided in-kind. However, there is an emergent trend that governments have gradually adopted cash subsidies or "in-cash" provision as a supplement or alternative to in-kind provision. In countries that provide both in-kind (services) and cash support, the elderly may choose between the two alternatives, or in the case of Germany, can even choose a combination of both types of support. But in most cases the cash alternative is set at a lower level than the value of the services.

107. As a special note, it should be reckoned that most countries would only provide cash subsidy for home-care but not residential service. According to the OECD's (2005) review of the 19 OECD countries,

the other countries

only have in-kind provision in the form of RCS placement. This reflects the preference of the government (and people) of these countries to home-care, instead of institutional care for their elderly population. Such preference is grounded upon the fact that community-based home care services have been demonstrated comparative merits in promoting "ageing in place" for elderly people.

108. As revealed from Table 3.5, in many of the western countries (and Japan being the only Asian country), there is a variety of financial subsidies (with such names as "Personal budgets" or "consumer-directed care and payments") provided by governments (at federal, provincial or municipal levels) payable to elderly in purchasing LTC services, including CCS. This serves to enable them to exercise choice in using LTC services, and to encourage elderly to age in place or their family caregivers to take care of elderly in their own homes.

109. it is to be reckoned that the provision of financial subsidy, in the forms of cash allowance to elderly users and/or their informal carers (including relatives who are either co-residing with the user or not), is provided either with a universal or wide coverage in countries that are either having a high tax regime or having established a social insurance on LTC; or provided on a selective basis in other countries that administer some form of means-test on the users (and sometimes also their co-residing spouse/ relatives).

² Even in the US where private insurance is more common, it only constitutes about 4% of the total expenses on LTC services (Congress of The United States Congressional Budget Office 2004).

110. Countries such as the Netherlands operate a *Personal Budget* scheme similar in nature to a voucher scheme such that individual elders may use the amount allocated to purchase services from independent service providers or agencies. The Netherlands' scheme is the biggest in scale in the provision of personal budgets (Lundsgaard, 2005).
111. In the UK, the *Direct Payments* scheme, which was originally provided for people with disability, was extended to older people in 2000. Older people who are assessed to have genuine need for services and need home-based long-term care would be provided with direct payments to the value of their needed services. Such payments can be used to pay relatives and friends as care assistants provided that they are not living together. Yet in Austria, such cash allowances can be paid to co-habiting relatives. Austria and Germany commenced implementing the *Cash Allowances for Care* scheme in the 1990s, in which such cash subsidy is covered by LTC insurance in Germany where in Austria all public support for LTC home care service is given as cash.
112. The USA has the longest experience of developing consumer-directed care, in which some programmes have been developed for over 20 years. The "Cash & Counselling" programme also provides a "budget" to Medicaid recipients so that they could exercise their own choices about the personal assistance services they receive, to hire their own caregivers and even to purchase care equipment. The programme has a built-in "counselling" element in which elders are provided with advice in managing their budget though the services are limited to skilled nursing care and home health-aid services (Cash and Counselling homepage, 2009).
113. Apart from the provision of carer subsidy, there can also be other supports rendered to family carers. For instance, in Sweden, many municipal governments appoint a special public officer as consultant for informal care givers and established contact points (Lundsgaard, 2005), so as to provide support to informal carers. Furthermore, there is also the availability of a support system of professional home-care services that can help reduce the workload on family caregivers (OECD 2005:30).

(c) Issues related to the implementation of a voucher scheme

114. There is a whole array of issues pertinent to the consideration of implementing a voucher system (Steuerle, 2000). Such issues, including the merit of a voucher system in enhancing consumers' purchasing power and consumer choice, its impact on increasing services prices, issue of "equity", of co-payment, the level of subsidy and scope of application, issue of regulation and availability of information to consumers, sustained implementation and fiscal burden of government, have been dealt with in the Report of the 2009 Study on RCS (para 93-114).
115. To recapitulate but a few crucial ones, such issues pertain to three major concerns: **equity**, **effectiveness** and **efficiency**. Equity boils down to the fair allocation of voucher or financial subsidy to those with genuine and most urgent need. This may relate to the choice between universal versus selective provision: while universal provision may appear to be equitable to all people, it might not achieve target specificity and there might be the problem that resources would be committed to those who can afford to pay the cost even without the government's subsidization. Selective provision may be targeted to the most in need but

might incur stigmatization on the user and considerable administrative cost in implementing a selection mechanism.

116. Effectiveness of a voucher system relates to the institution of effective mechanisms, including appropriate care need assessment, availability of ample number of service providers staffed with adequately trained care personnel, and regulatory mechanisms on both voucher beneficiaries or end-users and service providers.
117. Efficiency of a voucher scheme is concerned about minimising the various administrative procedures pertaining to ascertaining the eligibility of voucher beneficiaries; for instance administering clinical assessment and means-test, determining the voucher value, and other relevant monitoring mechanisms on users and providers mentioned above.

(d) The regulation on voucher users

118. As the introduction of voucher to users and their family carers has significant implications on public resources, there is need to ensure equitable, efficient and effective implementation. A viable system of implementation with effective monitoring and scrutiny has to be put in place to ensure that such financial subsidies are used specifically on LTC aspects and that measures have to be stipulated accordingly.
119. Review of overseas experiences shows that there can be various policy tools that could serve this purpose. In some countries, especially those with Long Term Care Insurance (LTCI), the provision of cash payment is administered on a rather loose or less restrictive manner in which the user may have high discretion on the use of the cash subsidy, without having to report to the administering authority. Nonetheless, as in the case of Germany that practices LTCI, the health condition and wellbeing of recipients of the *Cash Allowance for Care* is reviewed every three or six months. If the older people concerned are found to be receiving insufficient care, the authorities must provide some in-kind services, in which case the cash allowance will be withdrawn (OCED, 2005). In the Netherlands that uses a *Personal Budgets* (PGB's) system, the user has to be held accountable for the budget by filling in a form that reports the content of services provided and the people involved, within a designated period after the end of each advance payment period and returning to the care liaison office. The care administration office also carries out random checks accordingly. In the USA, recipients of cash support are required to sign undertakings to ensure the money is to be spent on home care services, and violation of such would result in prosecution by the government.
120. The provision of cash subsidy to family caregivers may turn out to be a disincentive for people to join the workforce and thus would adversely affect the labour market. The experience of USA reveals that "the combination of taxation, unemployment benefits, social assistance and cash allowances for care redirected informally to the informal care giver negates the incentives for some unemployed persons to actively search for employment while providing informal care" (OECD 2005:36). To tackle such disincentive problems, the Netherlands government requires a formal contract between the older person and the caregiver who is his/her relative or friend. In this regard, the payments received by the caregiver would be regarded as "income" by tax and unemployment benefit authorities. As a result, only when the payment is high enough to exceed income generated from gainful employment would the disincentive sets in.

121. In most cases when carer subsidy is provided, such income support is not meant to fully compensate the value of the care-givers' work. Such support is only meant to sustain a minimum level of income for persons who are unable to have a normal full-time job due to providing care to the frail elders. In some countries, such income support schemes are only available for low-income carers and thus means-test is to be administered. These include the Australian *Carer Payment*, the Japanese *Allowance for Families Caring for an Elderly Person*, and the UK *Carer's Allowance*. In the case of the UK *Carer's Allowance*, the means-test is administered to take into account the income and assets of the carer's spouse or partner, which practically would exclude those carers from middle- or high-income families, so as to ensure the provision of such subsidy to the most needy. There can also be some other schemes that provide an option for the carer to have a temporary leave from work. As in the case of Norway, such a carer leave scheme is available to persons at all income levels. Some carer allowance schemes, such as the one in Australia, are meant to reward or recognise the work of informal care givers caring for persons with less severe needs, so as to provide an extra incentive for the family not to seek institutionalization which would incur higher public expenses on LTC (OECD, 2005).

(e) Quality assurance of CCS providers

122. The administration of a voucher system requires the availability of a wide network of accessible service providers so that the users can actually use their voucher to "purchase" the services they need. Such providers could either be non-profit making NGOs or for-profit private operators. In any case, there is need to ensure that such operators can provide quality services to the users. In this connection, there is need to put in place service quality assurance mechanisms.

123. In the international scene, various countries have adopted different strategies in achieving this. In Japan there are nationally-set standards on structure and process measures, such as on qualification and training of staff, stipulated for the service providers in the NGO and private sectors. The prefectural authorities serve to monitor the service providers by either deducting the long-term care fees payable to the provider, or cancelling the providers' designation.

124. In Canada, the Home Care Reporting System requires national reporting that has contributed to conducting comparative analysis of home care clients and services across Canada to identify trends in resource use and establishments of benchmarks for monitoring (Canadian Home Care Association, 2008). Currently, eight of the 13 provinces / territories have achieved or are planning to achieve accreditation through the Canadian Council on Health Services Accreditation (CCHSA).

125. In USA, the Federal government requires the states to certify that they have methods for assuring quality of home and community-based services. Although there is variation in the actual monitoring of quality of home care across different states, there is generally an emphasis on ensuring the availability of qualified caring personnel, which can be seen as "input" standards in the form of "provider qualification". Specific reference could be made to the Home Care Alliance (HCA) of Massachusetts, a non-profit trade association, that has created a *Home Care Agency Accreditation Programme* to establish operational and quality

standards equivalent to licensure in most other states. In evaluating home care agencies for elderly, the programme includes 14 standards relating to: client rights, privacy, and complaint procedures; protections against abuse; fair employment practices; caregiver criminal background screening; competency, training and supervision; insurance coverage; and compliance with all applicable federal, state and local laws (Home Care Alliance, 2010). As at 2011, over 1,000 of private-pay home care service providers had been accredited by the HCA.

(f) Care needs assessment and service scope

126. Most countries/regions that provide publicly-funded LTC services (including community care services) require some degree of care needs assessment of the elders prior to service provision. Such assessment serves the purpose of targeting the publicly-funded services to those with genuine care needs. There appears to be an international trend in adopting a standardised care needs assessment mechanism on a national/regional level which is already in place in Australia, the Netherlands as well as Hong Kong. In UK, the Government has planned to introduce a national system of care need assessment in 2010, which is part and parcel of its national care service reform. Japan is the only Asian country that has administered a national assessment mechanism in its LTC insurance system.
127. As regards service scope, both centre-based and home-based services are provided to their elders in these countries/regions. Centre-based services cover day-care, respite care and even night-care services where the rehabilitation and social needs of the elders can be catered for. For home-care services, these services range from low-end services such as elder sitting, housekeeping and transport services with little professional input to high-end professional services such as nursing, personal and medical services, with a view to helping elders to avoid unnecessary or pre-mature institutionalisation.
128. In more detail, the scope of services for home and community care in the various countries/regions would normally include the following services: Day/Respite-care, Night-care, Home-care, Domestic assistance, Home maintenance, Transport, Social needs, Elder sitting, Emergency Response, Case management, Meal delivery/ preparations, Nursing/ Personal care, and Special dementia programmes.
129. Table 3.6 provides a review of the mechanism of care need assessment and scope of CCS services provided in the different countries/regions under study. As revealed from the comparative analysis, currently Hong Kong has basically put in place appropriate care need assessment mechanism and provided quite a wide range of services that can be comparable to advanced economies.

(g) Case management

130. In many of the countries/regions reviewed, it is revealed that CCS delivery is usually coupled with the implementation of “case management” or “care management”.
131. There can be many different understandings and practical strategies in the implementation of case management. For instance, it has been defined as “an intervention using a human service professional (typically a nurse or social worker) to arrange and monitor an optimum

package of long-term care services” (Applebaum and Austin 1990:5). It can also be conceived as being multi-faceted in terms of functions, goals, core tasks, differentiating features, and multi-level responses (Challis et al., 1995: 2002). It involves the functions of co-ordination and linkage; having the goals of maintaining vulnerable people at home and their independence; involving core tasks of case finding and assessment; serving specific target groups; having differentiating features in terms of intensity of involvement, breadth of services overseen, duration of involvement; finally having multi-level responses at the client level and system-level. The Case Management Society of America in USA defines case management as a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.

132. Case management as practiced in the UK and USA capitalizes on the practice of a “case manager” who is vested with the authority to “manage” the services that a service user obtains. As aptly exemplified by the Case Management Society of America in USA, “[t]he case manager helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the client and the reimbursement source. Case management services are best offered in a climate that allows direct communication between the case manager, the client, and appropriate service personnel, in order to optimize the outcome for all concerned” (see <http://www.cmsa.org>).
133. In the famous *Cash and Counselling* Programme in the USA, case management is to be implemented with the provision of cash subsidy or voucher to the LTC users (and/or their family caregivers) to allow them more user control and choice. The issues related to the merits and prerequisites in implementing a voucher system have been dealt with above.
134. One of the key features of case management is the adoption of a "case-mix" system which is a system that sets standard prices for operations and treatments for the service users, based on an accurate clinical assessment of the service needs. This “case-mix” approach in an effective means to promote cost efficiency and service effectiveness in the LTC service delivery and even in hospital services.
135. Notwithstanding the potential merits of case management, however, it is noteworthy to cast a critical look at the concept of “case management” that is advocated by the service providers and even academics. The very term of “case management” apparently debases the user as a “case” to be “managed” by someone, i.e. the professional service providers, in a dominating role. This would result in the undesirable disempowerment of the users.³
136. The success of case management hinges on a number of critical factors. Reilly, Hughes and Challis (2010) suggested three of these: programme fidelity, caseload size, and case-management practice. “Programme fidelity” refers to the degree to which a particular service follows or is consistent with a programme model and has a well-defined set of interventions and procedures to help individuals achieve the desired goal.

³ In a national symposium on consumer-direction and self-determination for older persons and those with disabilities organised by the U.S. Department of Health and Human Services in June 2001, there was one paper presented with the title: “I’m Not a Case and I Don’t Want to Be Managed!” (OECD 2005:25)

137. The issue of caseload size is related to the appropriate use of mechanisms to determine entry to and exit from the CCS. This also relates to the screening mechanism and on-going review of the care need of the cases. The caseload of case managers would definitely determine the level and quality of care they provide to the service users.
138. The issue of case-management practice involves those relating to the continuity of care, the intensity and breadth of involvement, and control over resources (Challis et al. 1995; cited in Reilly, Hughes and Challis, 2010). This relates to the “authority” or mandate of the case manager in his/her working with other service providers within and/or without the immediate agency that s/he is working.

(h) Manpower issues in LTC provision

139. Research findings in various advanced economies reveal some common problems contributing to the difficulty of recruiting and retaining direct care workers, which ultimately precipitates into the shortage of manpower in LTC service (including CCS) provision. These problems include low wages, poor benefits, limited advancement opportunities, inadequate job preparation, continuing education, and training to prepare workers for caring for people with increasingly complex needs. Direct care workers often do not feel valued or respected by their employers and supervisors, as well as the public (Wilner, 1998; Stone, 2000; Hussein and Manthorpe, 2006).
140. The shortage of manpower entering the elder care industry and high wastage might probably be a result of the incidence of subtle ageism. Overseas studies reveal that there are negative stereotypes about older persons prevalent in society at large (Minichiello, Browne and Kendig, 2000; Mchugh, 2003; Ray and Sharp, 2006; Cuddy, Norton and Fiske, 2005). Such social misunderstanding or prejudices might have affected the human service professionals to a certain extent (Allen, Cherry and Palmore, 2009). It is observed that young graduates in various human service disciplines, like social work and nursing, are less inclined to start a career that serves older persons (Curl, Simons and Larkin, 2005; Centre for Policy on Aging, 2009). For instance, in the United States, there have been concerns that there are insufficient programs, resources or interested students for expanding specialization opportunities (Rosen, Zlotnik and Singer, 2002), and that there has been a decline in the number of aging specialties and courses offered by schools of social work (Tompkins and Rosen, 2007).
141. It is to be understood that services for older persons are actually labour-intensive or “high-touch” (Wilber, Schneider and Thorstenson, 1997) in nature, and that some of the tasks involved in personal care and hygiene might appear to some young practitioners as somewhat disgusting and generate low intrinsic job satisfaction. This is further worsened by the fact that many of the positions of personal care are usually low-paid and provide not much career prospect, and thus could not attract people joining the workforce; which explains the sustained shortage of manpower in the elderly service field.
142. The labour intensive nature of personal care for elderly may result in various kinds of strain in the emotional, physical, and material domains amongst the care providers. It is particularly significant if and when their services are not appreciated by their service recipients (Hooyman, 1990; cited in Cheung and Chow, 2006).

143. Furthermore as many of the care providers work at the domestic setting of the elderly patients or users, they are likely to be working in isolation, without support and companionship from peer colleagues. This would lead to their alienation and jeopardize their mental health, eventually leading to fatigue, frustration and burnout (George, 1987; Guttman, 1991; cited in Cheung and Chow, 2006), and some might even quit their job, thus resulting in manpower shortage in the caring industry.
144. Even in Japan which has the highest incidence of ageing population in the world and has developed strategies to face the related challenges, problems exist in the elder care industry (Japan Institute of Labour, 2003). Studies reveal that home helpers were dissatisfied with their wages: while full-time home helpers viewed their pay as insufficient, part-time or on-call home helpers complained about unstable salary. This has made many trained workers do not enter the industry, thus resulting in wastage of qualified manpower.
145. In response to the challenges of manpower shortage, various countries have tried to devise different strategies to tackle the problem. Review of international human resource management practices in the LTC sector reveals that the provision of “real advantage”, career paths, and opportunities for promotion are important measures to attract and retain care workers; while training and opportunities to learn new skills are conducive to higher job satisfaction and thus better retention (Kane, 2003; Nakhnikian and Kahn, 2004).
146. There can be other strategies to help retain care staff. For instance, the Government of Western Australia encourages employers to adopt flexible working hours, flexible leave arrangements, and temporary part-time work or home-based work arrangements (Department of Consumer and Employment Protection, Labour Relations, Western Australia, 2001; cited in OECD 2005).
147. In the USA, the Greenhouse retirement communities require their staff to wear colourful clothing instead of standardized uniforms so as to engender a cheerful rather than dull outlook. They take multiple roles, including cooking, cleaning, playing with and taking care of the older residents, instead of merely working as a “care worker”. This is to avoid segmentation of roles and creating a fixated image of a “caretaker”. All these help to foster a positive image for the staff, which might serve to attract young people to join and work in the care industry.
148. Furthermore, there could be more innovative approaches adopted for attracting some “unconventional” pool of workforce to join the personal care industry. Reference could be made to a campaign in the USA that targeted four special groups, i.e. the newly retired or recently widowed adults looking to fill empty hours; college students looking for part-time or other job options; retail or food-service workers looking for more “meaningful” jobs; and homemakers looking to be paid for their caregiving skills (Stone, 2000). Also some states and cities in the USA, e.g. New York City, are experimenting with initiatives such as recruiting high school students to the home care sector by training and upgrading their skills in order for them to qualify to provide Medicare services and enhance their employability (Hussein and Manthorpe, 2006).
149. In Taiwan, the government devised a ten-year plan of long-term care in 2007 that attended to the need for training not only professionals and para-professionals, but also care workers. The government implemented a national examination system in which some 44,000 received

training and 11,000 passed the examination (Qian, 2010). This helped to increase the manpower supply of care workers for the LTC services.

Implications / lessons for Hong Kong

150. Based on the review of international experiences, there can be references for Hong Kong in developing a viable CCS system in the long run, in the following aspects.

Merits of CCS

151. International experiences have supported the postulation that effective home and community care can effectively reduce or delay institutionalization (Eleazer and Fretwell, 1999; Mai and Eng, 2007; Beland et al., 2006), improve the physical functions of elderly service users and reduce the decline in cognitive status (Bemabei et al., 1998). Specifically, frail elders are susceptible to being hospitalized on account of stroke, bone fractures caused by falls and other chronic illnesses. If sufficient rehabilitation supports were available after hospital discharge, perhaps coupled further with support to family carers, some elderly patients may be able to remain living in the community. In this regard, the various disciplines ranging from medical social workers, medical professionals and community-care providers should seek better coordination in designing a viable discharge plan that ensures the provision of community- and home-care services upon discharge from hospital.
152. The potential merit of an effective CCS in delaying or avoiding institutionalization can be substantiated in some empirical studies and projects. In USA, the Estates Nurse-Managed Wellness Centre assisted the elders, with close partnership with the nurse who “outreach” to the elders living in the community, to (1) identify problematic health-related behaviours, giving priority to behavioural deficits most likely to lead to nursing home admission; (2) improve skills and encourage positive, beneficial behaviours; (3) engage in collaborative problem solving and decision making; and (4) capitalize on inherent strengths, coping and survival skills, assets, and behaviours that promote independence. This would effectively promote self-care capacity of community-living elders and thus avoid admission to nursing homes, as they provide services in the homes of the client before the point of crisis (Collins, Butler, Gueldner and Palmer, 1997: 61).
153. The success of such CCS programmes can be seen in the Social Health Maintenance Organisation and the Programme for All Inclusive Care for the Elderly (PACE) in the US; the Community Aged Care Packages (CACP) in Australia, the Integrated System of Care for the Frail Elderly(SIPA) in Canada, and the integrated social and medical care and case management in Italy.
154. Currently, although the Hong Kong Government has been promoting Community Care and Ageing in Place as principles of LTC provision, there apparently is an imbalance of resources devoted to RCS and CCS respectively. The volumes of and public resources committed to RCS are much higher than those to CCS, as revealed in Chapter 2 earlier. There might be the need to review how Hong Kong could reshuffle this imbalance towards giving more emphasis on CCS.

Financing and beneficiary of provision

155. If CCS is to be provided with a “public” model, it would either be financed by public revenue which would imply a high tax regime (as in the case of Nordic countries), or by means of a social insurance system (as in the case of Germany and Japan) in which people have to pay premium. Alternatively, there can be the “private insurance” model as in the case of USA in which people purchase health and/or LTC insurance that covers service expenses. In publicly funded model, there can also be “universal” provision that provides equal access to all citizens; or “selective” provision that target to specific beneficiary groups, in which the selection is usually by means of a means-test mechanism.
156. Governments in different countries would also provide support to the public in accessing LTC services, which could either take the form of provider-subsidy or user-subsidy. In the former case, the government provides funding to NGOs and private operators which then provide in-kind services to the end-users; in the latter case, governments provide subsidy in the form of voucher or “personal budgets”. In various countries, end-users are also encouraged to share partly the expenses by means of co-payment to cover the difference between insurance coverage and the actual cost.
157. As Hong Kong is currently adopting a low tax regime and has not yet developed any health and/or LTC insurance scheme, there might be considerable challenge in sustaining a LTC service provision system in the long run in view of the ageing population trend. Various issues related to the implementation of LTCI (including both a “social” or “private” model) were discussed in the 2009 RCS Study (para.83-86).
158. On the other hand, the Government has been adopting a provider-subsidy approach i.e. providing subvention to NGOs in providing services; rather than a user-subsidy approach. As compared to the overseas practice of using financial subsidy to users or their family carers, there is relatively less users’ choice in Hong Kong’s LTC system.

Service delivery system

159. Overseas experiences reveal that CCS as a part of LTC services would require a viable system of clinical assessment to ascertain the level of care and scope of services to be provided to the older people. Moreover, as there is considerable diversity in the needs of the older people, especially with the involvement of a multidisciplinary professional team of practitioners or care providers, there would inevitably be wide variation in the resources required among the population of users. Thus, the adoption of a “case mix” system would help to enhance cost efficiency and service effectiveness.
160. It should also be reckoned that the success of case management model practised in the overseas countries is based upon the context of the respective specific LTC financing models of those countries; for instance, one that is based on a contributory insurance system. As currently Hong Kong’s LTC provision is largely a publicly-funded model without user contributions, it might not be entirely feasible to adopt the full-fledge case management model of the overseas countries into Hong Kong; or there is need to adjust its application in the local context.

161. In order to best serve the need of the older people, it would be desirable to have a flexible system of service delivery in which the user is provided with sufficient advice and assistance in accessing different types and intensities of services in accordance with the care plan generated from the clinical assessment mechanism. However, the viability of such a system requires the concerted interface between service delivery system (i.e. the existence of a plurality of service providers that avail the users with choices) and the financing model (i.e. whether a “provider-directed” or a “user-directed” system).
162. Currently, Hong Kong’s LTC system (including the provision of CCS) is largely provided through the provision of in-kind services by NGOs funded by the Government to older people whose eligibility is assessed by the SCNAMES. The government is adopting a “provider-subsidy” model rather than a “user-subsidy” model in which public revenue is channelled to a multitude of service providers; in the current situation, all being non-profit making NGOs. The users are provided with services by designated agencies the professional staff of which would assess and design the care plan and provide the services. The users are not provided with much choice.
163. Similar to the case of overseas countries, Hong Kong is also facing the critical problem of manpower shortage in LTC. There is also need to gear up the human resource development in LTC, and in the present context, in CCS in particular, in view of developing a sustainable and viable CCS delivery.
164. All in all, making reference to the overseas experiences in the provision of CCS, Hong Kong may need to critically review the financing model, service delivery system and other pertinent issues in preparing Hong Kong for facing the challenges of an ageing population.

Table 3.3 Major public programmes of home care [*] in selected OECD countries 2003

	Programme	Source of fund	Type of benefits	Eligibility criteria ^{1,2}	Private cost-sharing
Australia	Community Aged Care Packages (CACP)	General taxation	In-kind	Generally 70+ Means-tested	Users are charged according to ability to pay
	Home and community care	General taxation	In-kind	All ages Means-tested	Users are charged according to ability to pay
	Care payment	General taxation	Cash	All ages Means-tested	-
	Carer allowance	General taxation	Cash	All ages Universal	-
Austria	Long-term care allowance	General taxation	Cash	All ages Universal	Users are expected to pay the difference between the benefit and the actual cost.
Canada	Provincial programmes	General taxation	In-kind	All ages Usually means-tested	Means-tests vary between provinces.
Germany	Social Long-Term Care Insurance	Insurance contribution	In-kind and cash	All ages Universal	No cost-sharing required but out-of-pocket to pay for additional or more expensive services than covered by public insurance was on average EUR 130 per month
Hungary	Social protection and social care provision programme	General taxation	In-kind and cash	All ages Means-tested	User payment is set by the institution within the range defined by the local governments.
Ireland	Community-based care	General taxation	In-kind	Partly means-tested	Community nursing services are not means-tested and are free of charge, but home helps are means-tested
Japan	Long-term Care	Insurance contribution	In-kind	Aged 40-64: disabled by 15 ageing-related	Users pay 10% of the cost as co-payment
Korea	Social services for the elderly	General taxation	In-kind	65 and over Means-tested	Recipients of social assistance: free of charge Others: charge varies according to the level of income.
Luxembourg	Dependency insurance	Insurance contribution	In-kind and cash	All ages Universal	Users are to pay the difference between the benefit and the actual cost of care
Mexico	Day centres for pensioners and retired	General taxation	In-kind	Insured pensioners and retired people	
Netherlands	AWBZ	Insurance contributions	Consumer-directed budget ³	All ages Universal	Income-related co-payments are required
New Zealand	Carer Support	General taxation	In-kind	All ages, means-tested	
	Home Support: Home help	General taxation	In-kind	All ages, income-tested	
	Home Support: Personal care	General taxation		All ages, universal	
Norway	Public long term care	General taxation	In-kind	All ages Universal	Home nursing care is free of charge. Home help is based on an optional user-payment

Poland	Social services	General taxation	Cash/ In-kind	All ages Means-tested	(usually NOK 60 per time).
Spain	Social care programmes at Autonomous Community level	General taxation	In-kind	Means-tested	73% of total long-term care cost was met privately in 1998 according to an estimate.
Sweden	Public long term care	General taxation	In-kind	All ages Universal	Users pay moderate amount of fee set by local government.
Switzerland	Programmes at Canton level; health promotion for the elderly by Old Age Insurance	Sickness/ Old Age Insurance funds and general taxation	Mix of in-kind benefits and benefits in cash	Means-tested for institutional care	High
United Kingdom	NHS	General taxation	In-kind (nursing at home and in nursing home)	All ages Universal	Free of charge
	Social services	General taxation	In-kind	All ages Means-tested	Users are charged according to ability to pay.
	Social Security Benefits	General taxation	Cash benefit	All ages Means-tested	
United States	Medicare	Insurance contributions	In-kind (skilled care only)	Disabled and aged 65+ Universal	Home nursing care: free of charge. Skilled nursing care: up to 20 days USD 0, 20-100 days USD 105 per day, after 101 days 100%
	Medicaid	General taxation	In-kind	All ages Means-tested	Co-payment can be charged depending on financial status of the recipient.

[*] although many of the countries provide home care to beneficiaries of 'all ages', 80% of the actual users are older people aged 65 or above.

1. "Means-tested" refers to a test of user's income and/or assets in relation to receipt of personal care (at home) or home care allowance. Generosity of testes varies widely between countries.
2. "Universal" refers to programmes with no income and/or asset test as defined in note 1 above.
3. By 1 April 2003, the consumer-directed budget has been changed in a cash payment.

Source: OECD's questionnaire on long-term care. OECD (2005:22-26).

Table 3.5 Personal budgets, consumer-directed care and payments for informal care

Information refers to most recent year available, often 2004 for rules and payment levels, but typically 2002 or 2003 for the number of users

	Programme	Description	Can relatives be employed or supported?
A. Personal budgets and consumer-directed and employment of care assistants			
Netherlands	Personal Budget for Care and Nursing Persoonsgebonden budget	Personal budgets can purchase agency care, directly employ a care assistant and also pay some cash for appliances and informal care.	Yes ¹ But not if living together
Norway	Care Wage Omsorgslønn	Pays relatives or others for caring when this is considered better than agency care. Typically 3-10 hrs/week.	Yes
Sweden	Carer's Salary Antälda anhörige	The person giving care is treated as employed by the public agency. Scheme used in remote areas.	Yes But not if older than 65 years.
United Kingdom	Direct Payments	New scheme. Older persons eligible for care can now choose a direct payment for purchase of care.	Yes ² But not if living together
United States	Consumer-directed Home Care	Consumers can hire and supervise a personal care assistant who will be paid by Medicaid for a specific number of hours.	Most programmes allow relatives but not spouses.
United States ³	Cash and Counseling	Demonstration and Evaluation programmes in Arkansas, Florida and New Jersey. Budget can pay also for home adaptation etc.	Yes
B. Payments to the person needing care who can spend it as she/he likes, but has to acquire sufficient care			
Austria ⁴	Cash Allowance for Care Pflegegeld	All public support for home care is through this allowance. Recipients can purchase formal care if they wish.	Yes
Germany	Cash Allowance for Care Pflegegeld	Under the long-term care insurance, recipients can choose between care in-kind and this allowance.	Yes
Luxembourg	Cash Allowance Prestations en espèces	Under the long-term care insurance, recipients can choose between care in-kind and this allowance.	Yes
Sweden	Attendance Allowance Anhörig bidrag	Cash payment to the dependent who can then pay informal caregivers. Minimum care need of 17hrs/week	Yes
United Kingdom	Attendance Allowance	A cash benefit to persons aged 65+ who have been needing care for at least six months	Yes
C. Payments to informal caregivers as income support			
Australia ⁵	Carer Payment	For people who cannot support themselves because of caring responsibilities	Yes Yes
Australia ⁵	Carer Allowance	For people who live with and care for somebody at home.	No Yes
Canada	Compassionate Care Benefit	A short-term benefit for persons caring for somebody with a terminal condition	No ⁶ Yes
Ireland ⁷	Carer's Allowance	For carer with low income who live with and look after people needing full-time care.	Yes Yes
Ireland ⁸	Carer's Benefit	A payment to insured persons leaving work temporarily to care for	No Yes

		someone needing full-time care.	
Japan ⁹	Allowance for Families, Caring for Elderly	Only if low-income family, heavy care needs and not receiving support from the long-term care insurance.	Yes Yes
Sweden	Care Leave	Statutory right to take leave from work for up to 60 days when caring for a terminally ill relative.	No Must be a relatives or close friend
United Kingdom	Carer's Allowance	For person with low income caring 35+ hrs/week for someone receiving Attendance Allowance. ¹⁰	Yes Yes

1. If the person needing care lives together with healthy adult relatives then they are obliged to do the necessary housekeeping tasks irrespective of whether they are in working age or have retired. Relatives living in the same household can therefore only be employed to provide care beyond these functions. In practice, employment of relatives living in the same household is seen mostly for adult disabled and only rarely for care provided to older persons.
2. With an adjustment of legislation from April 2002, people can use their direct payment to pay a relative who lives with them, but only in exceptional circumstances where they and their local council consider that this is the only satisfactory way of meeting their care needs.
3. The average monthly payment levels differ in the three states involved, from USD 400 in Arkansas, and USD 723 in Florida to USD 1 400 in New Jersey.
4. Based on Nemeth and Pochobradsky (2002), it is estimated that only around 7% of the persons aged 65+ use part of their Cash Allowance to purchase formal care at home, while very few spend all on formal services.
5. The Carer Payment will under most circumstances be liable for taxation when caring for an older person.
6. As the level of payments is calculated as a percentage of normal employment income, it will grow with income in the interval below the ceiling. For persons with low income and children there is, however, a family supplement.
7. The maximum amount of EUR 683 applies for a person aged 66 or over and with very little income giving care to one person. If caring for more than one person, the maximum is EUR1026 per month. For caregivers aged under 66 years the allowance is reduced by EUR79-118, while for each dependent child it is raised by EUR36-73 per month
8. The amount of benefits doesn't take income and assets of a person giving care to one person into account. If caring for more than one person, the benefit is EUR 973 per month, and for each dependent child the benefit is raised by EUR 36-73 per month.
9. This scheme plays a limited role in the overall long-term care provision.
10. In 2002, the Carer's Allowance has been made available also for care-givers aged 65 and over. The payment is only available for persons with disposable income below GBP342; EUR536 a month where disposable income is calculated net of spending on respite care, etc. The benefit is taxable.

Source: OECD (2005). Long Term Care for Older People

Table 3.6 Assessment and scope of CCS in the international scene

	Care needs Assessment	Day/Respite-care	Night-care	Home-care									Special dementia programmes
				Domestic assistance	Home maintenance	Transport	Social needs	Elder sitting	Emergency Response	Case management	Meal delivery/preparations	Nursing/Personal care	
Hong Kong	Standardised Care Need Assessment Mechanism	Yes		Yes	Yes	Yes				Yes	Yes	Yes	-
Australia	Conducted by the Aged Care Assessment Teams[2]	Yes		Yes	Yes	Yes				Yes	Yes	Yes	Extended Aged Care at Home Dementia
UK	Local government adopts own criteria in assessing the service needs based on guidelines from the Department of Health	Yes		Yes	Yes		Yes	Yes			Yes	Yes	-
US	Functional eligibility requirements for Medicaid frail users only and varies across states	Yes		Yes			Yes			Yes	Yes	Yes	A national dementia strategy (covering, among others, home care services) has been published in Feb 2009 and is being implemented.
The Netherlands	Assessed by an organization called CIZ that determines how much and what kind of care a person is entitled to receive	Yes	Yes	Yes			Yes				Yes	Yes	a range of coordinated dementia care options for purchase. Dementia care best practices
Singapore	assessed by medical professionals, social workers on service needs	Yes		Yes		Yes[3]	Yes[4]			Yes	Yes	Yes	Dementia Day Care Centres
Taiwan	Each service agency has its own criteria in care assessment	Yes		Yes		Yes	Yes		Yes		Yes		-
Mainland China[1]	No	Yes		Yes			Yes				Yes		-

[1] Different provinces/cities tend to adopt different models in providing community care services for their elders and there exist significant discrepancies across different parts of the country. [2] Based on a set of criteria including health conditions, physical capability, cognitive/behavioural aspects, social factors, physical environmental factors and personal preference, etc. [3] For medical appointments only. [4] Through volunteer.

CHAPTER FOUR

ANALYSIS OF FINDINGS

165. This chapter reports the findings of the Study, which include firstly, an analysis of the problems existing in the current service delivery system of CCS, and secondly, the financing model of CCS provision in Hong Kong. Reference would be made to firstly, findings from the survey with some 2,702 respondents who are grouped under 11 categories, including current users and family carers of subsidized and self-financing CCS, waitlisted applicants for subsidized CCS, users of IDSP, community members and some 150 team leaders and frontline workers of the CCS operators; secondly, in-depth interviews with users, operators and key informants, for the purpose of collecting views on the existing CCS and the possible improvements to be made in the future. Thus both quantitative and qualitative data have been collected and analysed. The classification of the 11 categories is stated below:

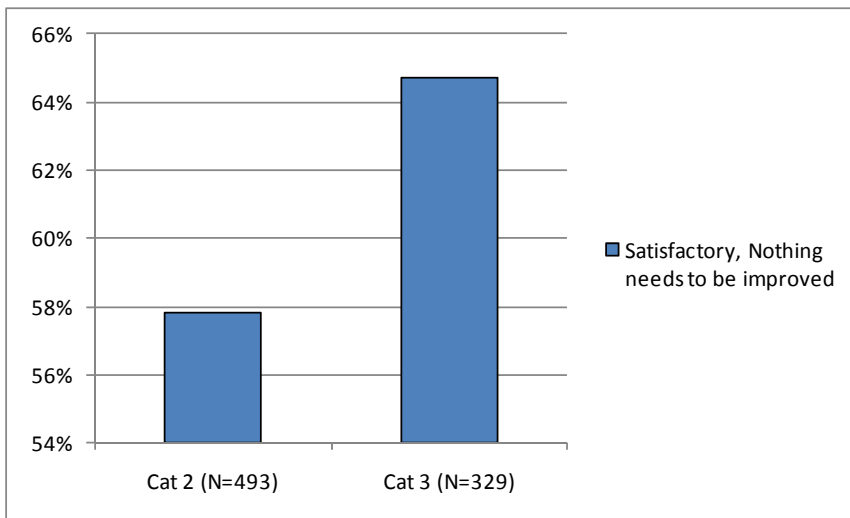
Table 4.1 The classification of the 11 categories

	Categories	No. of cases (N)
1	Non-users of subsidised CCS but wait for subsidised RCS	506
2	Existing users of EHCS, DEs/DCU and IHCS (FCs)	493
3	Existing users of IHCS (OCs)	329
4	Existing users of self-financed CCS	31
5	Non-users of CCS	409
6	Middle class elders	154
7	Participants of IDSP	91
8	Carers	363
9	Employees of CCS operators providing direct services to elder	162
10	Elderly patients of day hospitals	82
11	Recent applicants of MDS-HC assessment with LTC needs	82

Part I. Existing problems of the current delivery mode of CCS and suggested improvements

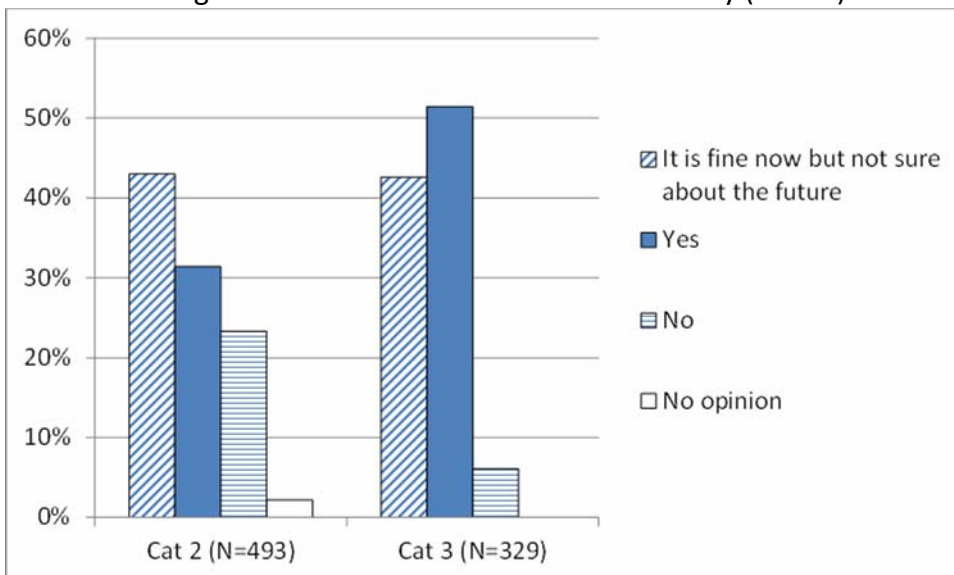
166. In the first instance, it should be pointed out that a sizeable portion of current users of subsidized CCS (57.8% were Enhanced Home and Community Care Service (EHCCS) and Day Care Centre (DE) service [Cat 2] and 64.7% were Integrated Home Care (Ordinary Cases) (IHC(OC) users [Cat 3]) were satisfied with the existing service. Yet, there are also some specific recommendations for the improvement of existing CCS.

Graph 4.1 “What improvement can be made to the existing community care services subsidized by the government?”



167. However, it should also be noted that only some 30% to 50% of the current users of subsidized CCS [Cat 2, 3] and their family carers opined that the CCS that they were using could enable the elder to age in place instead of living at residential care homes for the elderly (RCHEs), while quite a substantial portion (ranging from 42.6% to 43%) thought that “It is fine now but not sure about the future”. Thus, it apparently reflects the need to further enhance the service quantity and quality in various aspects to boost the users and the family members’ confidence and their sustained utilization of CCS rather than shifting to RCS. The following are some of the areas that are of concern.

Graph 4.2 Do you think the existing community care services can enable you to age in place instead of living at residential care homes for the elderly (RCHEs)?

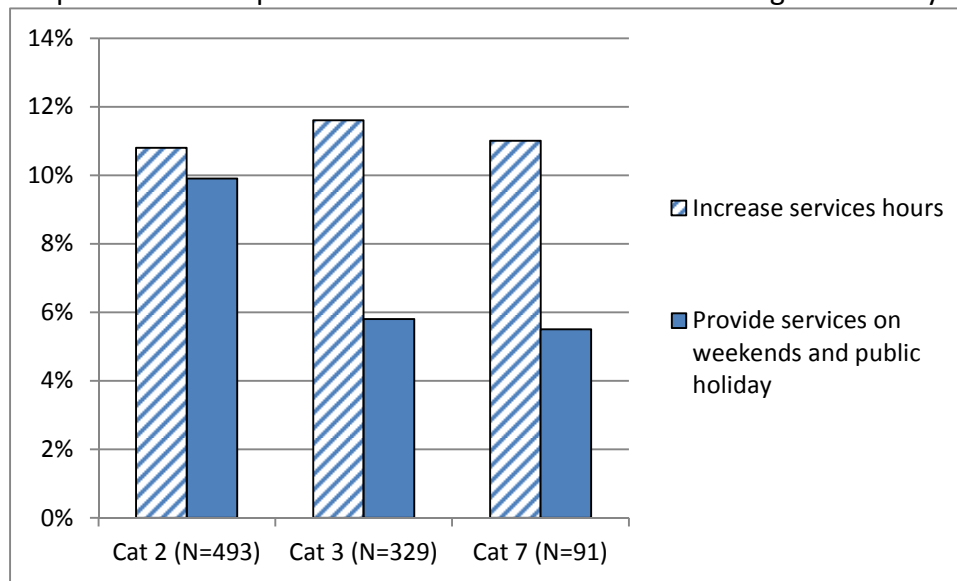


Service hours

168. Some 10.8% of subsidized CCS users [Cat 2], 11.6% of IHC(OC) users [Cat 3], and 11% of IDSP users [Cat 7] suggested increasing service hour; 9.9%, 5.8% and 5.5% respectively suggested providing services on weekend and public holiday. From the in-depth interviews with service

providers, there are also suggestions on extending the service hour to 9pm and Sunday for both home-based and centre-based services.

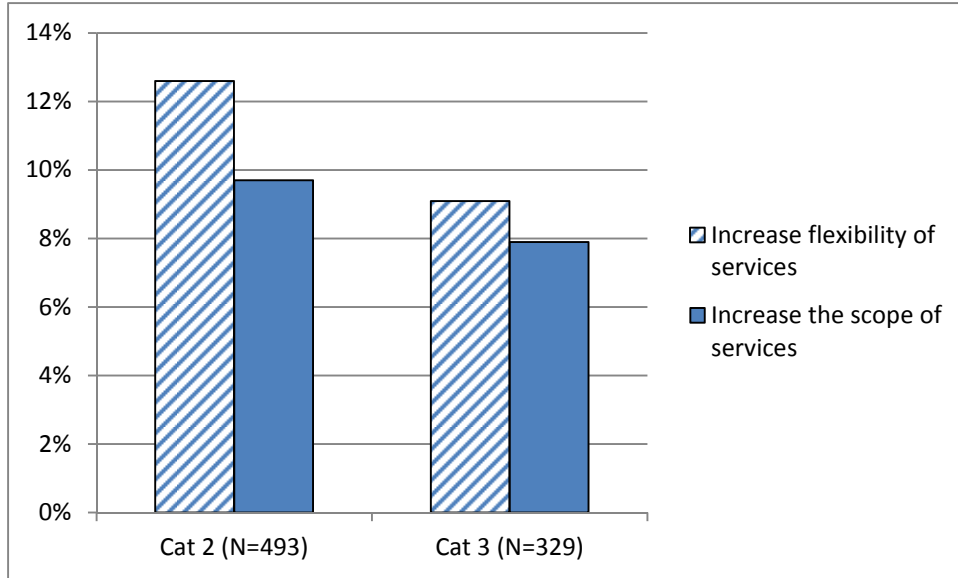
Graph 4.3 What improvements can be made on the existing community care services?



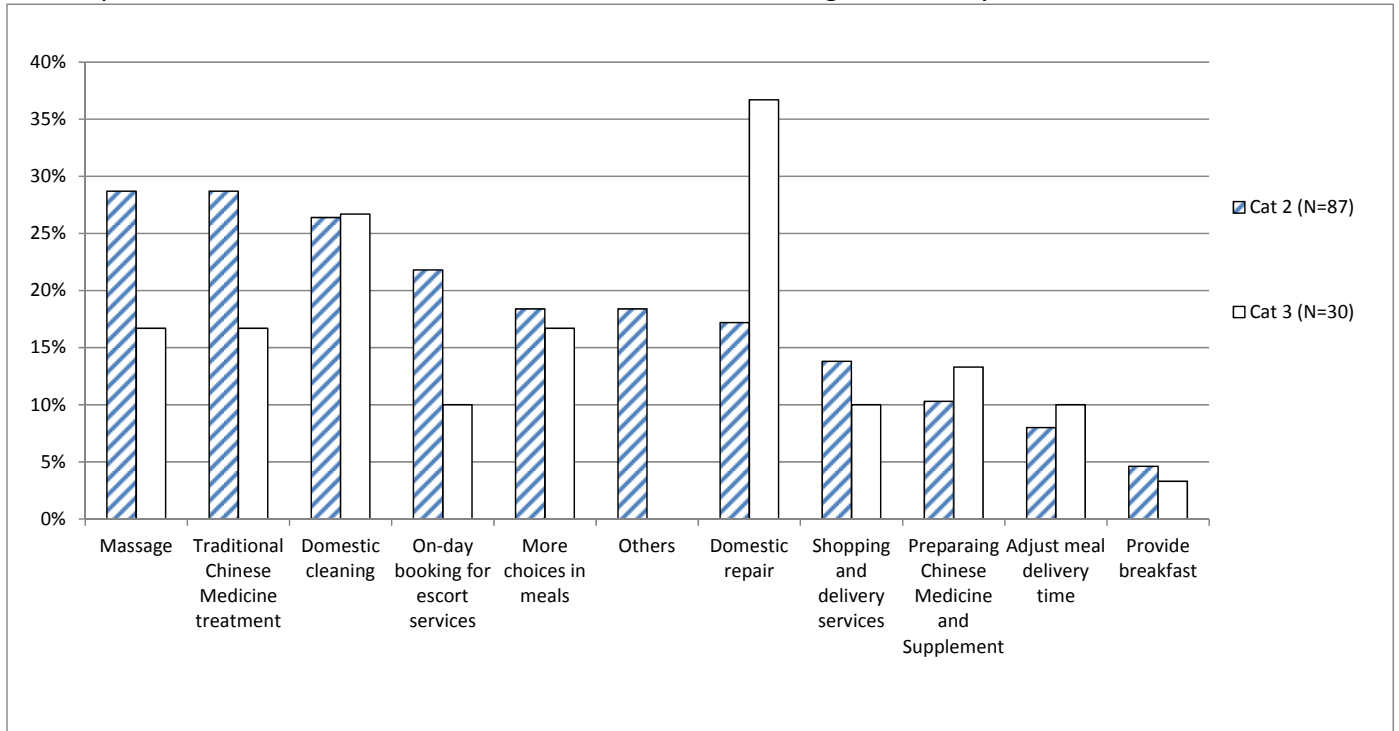
Scope of service

169.9.7% of CCS users [Cat 2] suggested increasing service item and 12.6% increasing service flexibility; the items of which actually are also related to increasing the scope of services (e.g. adding new items such as massage, traditional Chinese Medicine Treatment; and increasing the number of household cleaning, ad hoc escort service for medical appointment). Some 7.9% IHC(OC) users [Cat 3] would like to have a wider scope of service and more flexibility (9.1%). More specifically they would suggest increasing the number of domestic cleaning and adding some household services like home repair, personal care services like massage, Traditional Chinese Medicine Treatment and more choices in meals.

Graph 4.4 What improvements can be made on the existing community care services?

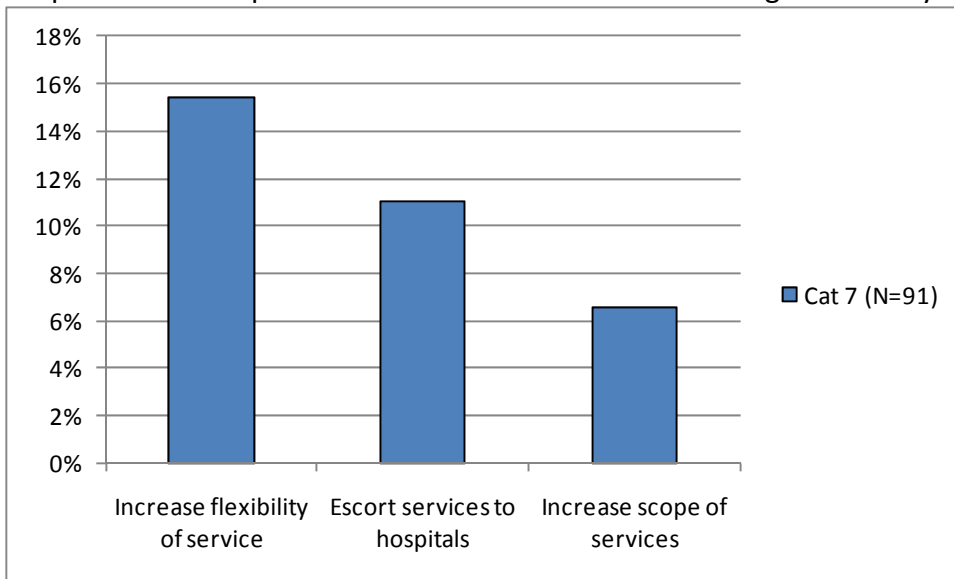


Graph 4.5 What kind of services can be added to the existing community care services?



170. There are some (11%) IDSP users [Cat 7] who demanded escort services to assist elderly patients to attend medical appointments at clinic and/or hospitals; another 15.4% and 6.6% suggested increasing service flexibility and scope of service respectively. Through in-depth interviews, it was revealed that most IDSP users would hope that the service could be extended for a longer period as they would need a longer time to recover from their illness or heal their wound and thus resume their daily self-care activities like going to the market, cooking and personal hygiene.

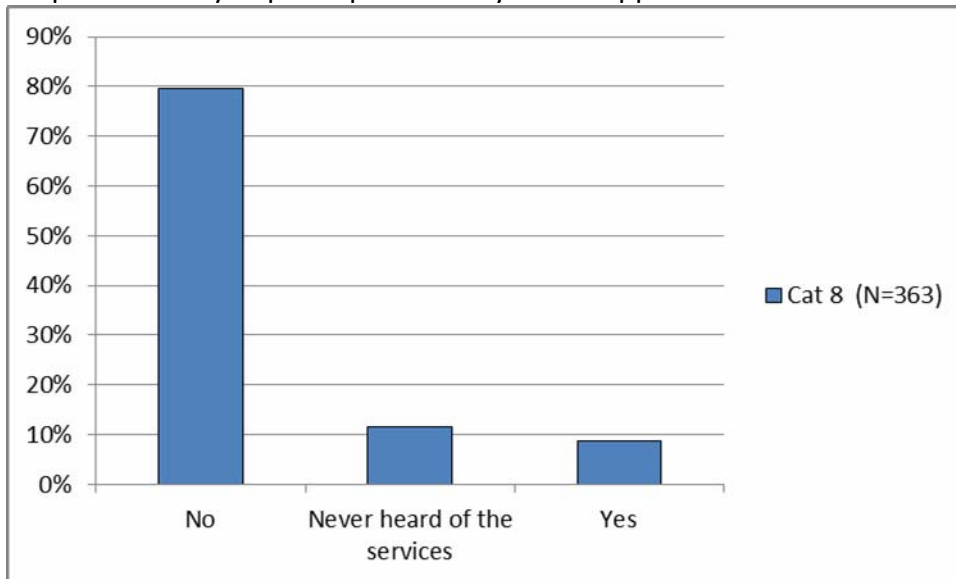
Graph 4.6 What improvements can be made on the existing community care services?



Services for family carers

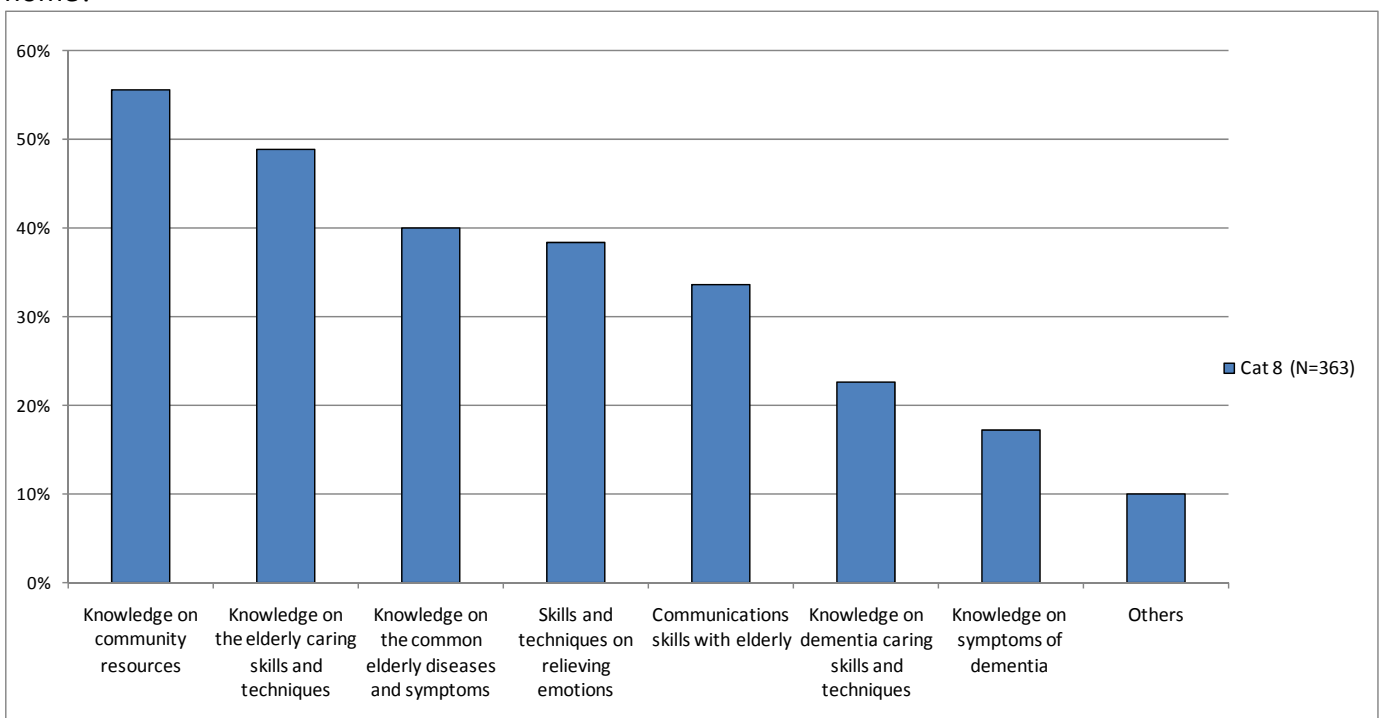
171. The study interviewed some 363 family carers [Cat 8] who provide care to their older family members at home, and who are users of current subsidized CCS. Results reveal that only a very small portion (8.8%) of the interviewed family caregivers had participated in any of the carer support services, while a great majority of 79.6% of them had not, and 11.6% had never heard of those services. Although the survey of the present study had not explored the reasons for the family carer’s low participation, it was supplemented by informant interviews that this might be due to firstly, the service hours of such service cannot fit the carers who are working during the daytime, and secondly the location of such services, in which the family carer cannot leave their frail elderly family members at home to attend the centre-based support services.

Graph 4.7 Have you participated in any carer support services?



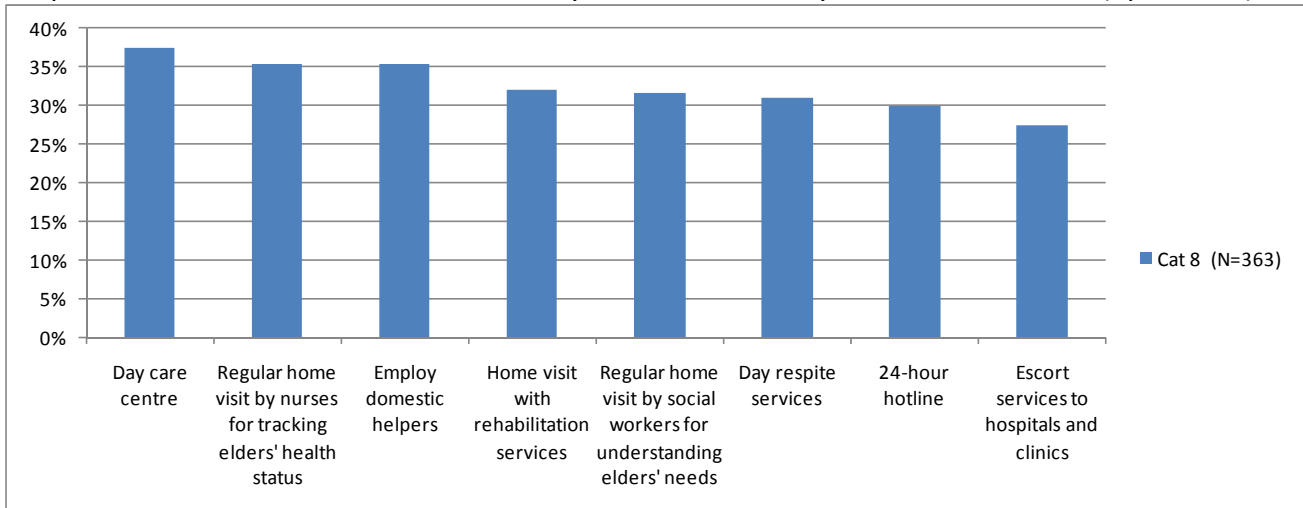
172. The study also shows that family caregivers would like to be provided with more knowledge on community resources (55.6%), knowledge on the elderly caring skills and techniques (48.8%), and knowledge on the common elderly diseases and symptoms (39.9%), so that they can be better prepared in taking care of their elderly family members at home.

Graph 4.8 What kind of trainings can equip you with better skills to take care of the elderly at home?

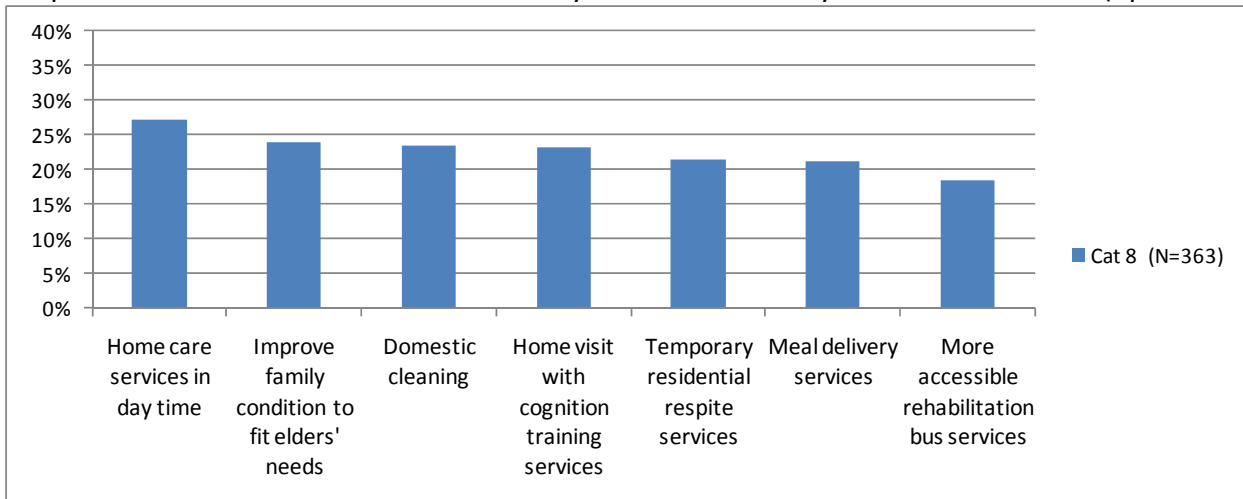


173. The family carers expressed their expectations on the following community services that they thought could facilitate them in taking care of their elders at home: regular home visit by nurse in order to keep track of the elders' health status (35.3%), day care centre (37.5%), day respite service (30.9%), home visit with rehabilitation service (32.0%), and 24-hour hotline (30.0%). Nonetheless, there are still some (35.3%) who might resort to employing DH who can provide 24-hour care to the older people at home.

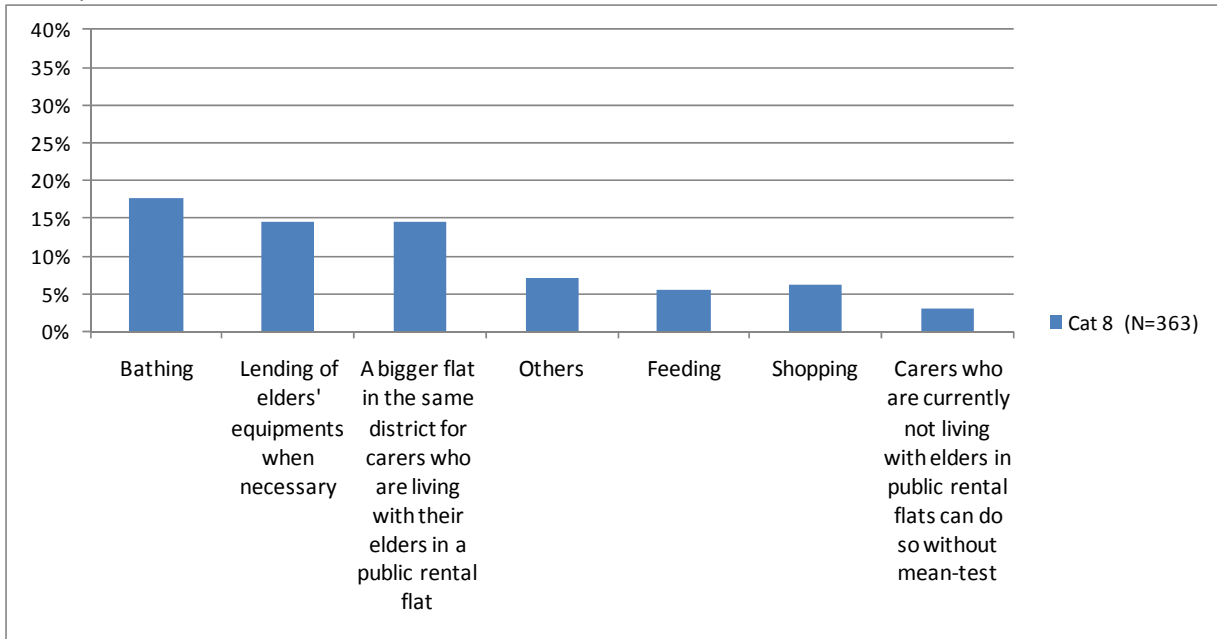
Graph 4.9a What kind of services can assist you to take care of your elders at home? (option 1-8)



Graph 4.9b What kind of services can assist you to take care of your elders at home? (option 9-15)

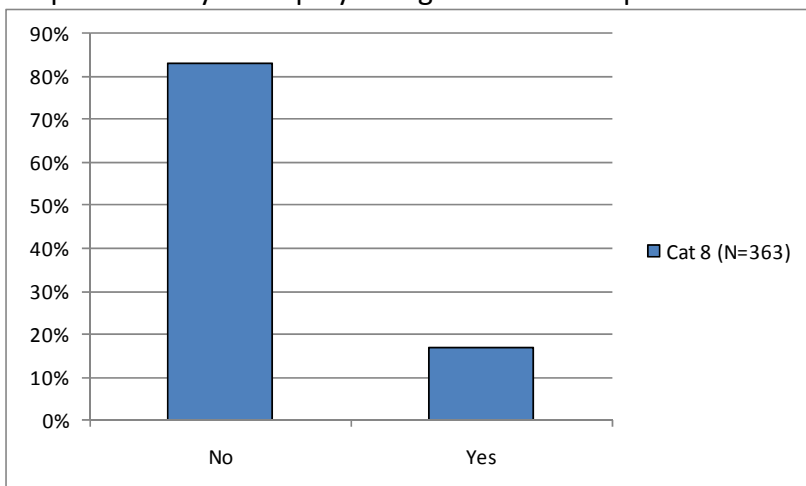


Graph 4.9c What kind of services can assist you to take care of your elders at home? (option 16-22)

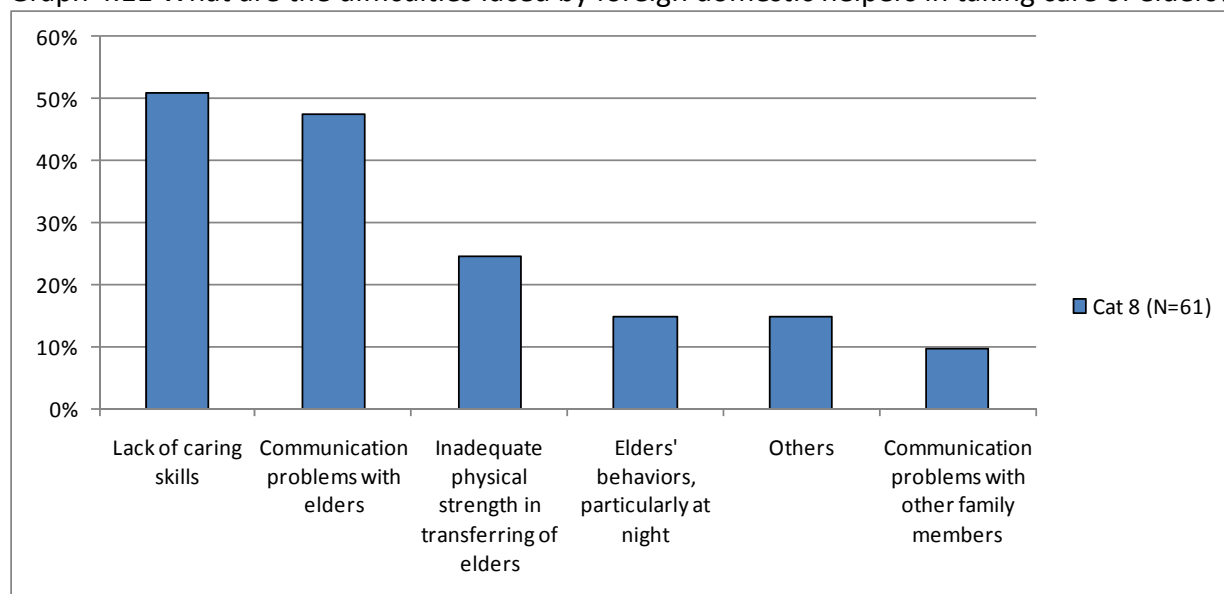


174. For those 16.8% of the 363 family carer respondents who had employed foreign domestic helpers (FDH) for taking care of elder at home, 50.8% complained their FDH was lacking caring skills, 47.5% had communication problem with the elder. Through in-depth interview with some of the family carers, it was revealed that some carers were hesitant to hire FDH due to the older person's resistance; however, if and when the time comes when they could not further endure the stress and burden of caregiving, these family carers might have to resort to hiring a FDH even against the wish of the frail older person. One carer, who is a medical doctor himself taking care of his spouse, opined that there is now inadequate training course for the FDH that are conducted in English, and he would really hope that there could be such courses so that his FDH could learn the caring skills.

Graph 4.10 Do you employ foreign domestic helpers to take care the elders?



Graph 4.11 What are the difficulties faced by foreign domestic helpers in taking care of elders?

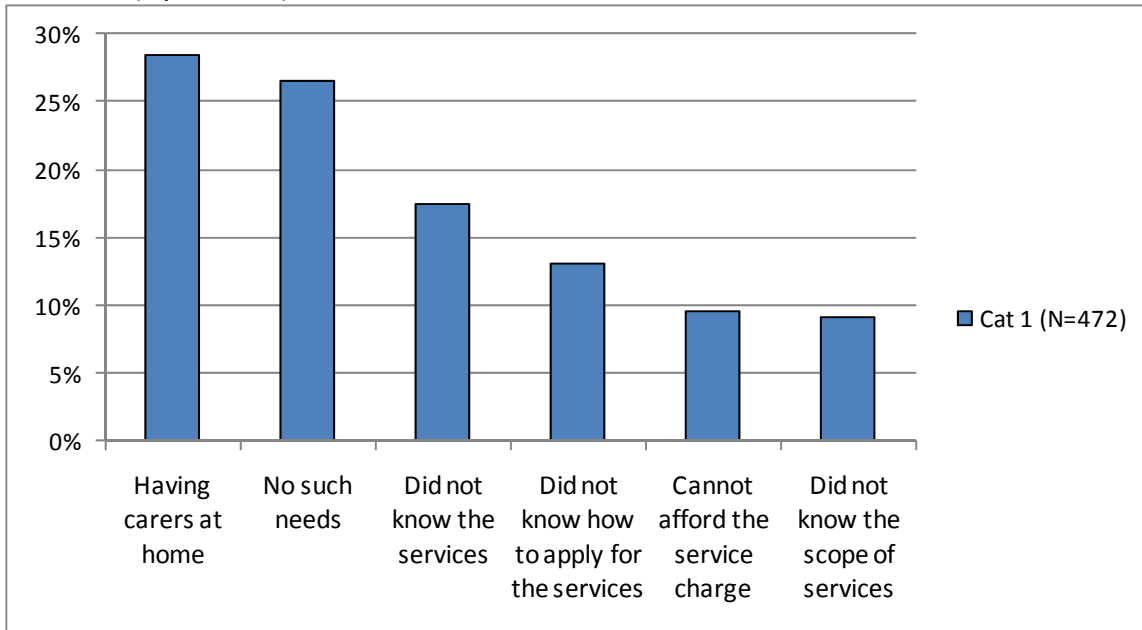


175. Some family carers revealed that due to the heavy weight of the older person being taken care of, it is really tiring for them to carry the immobile older person around the home, for say, toileting, bathing and the like. Frail older people need people's attention and would be very attached (攬身) to their family carers at all times, which exerts great pressure on the carers. In this regard, day care centres could provide a relief for the carers especially as the older person could have activities to "occupy them" and "consume their energy" so that they would feel tired at night, thus giving the family carer a good sleep.

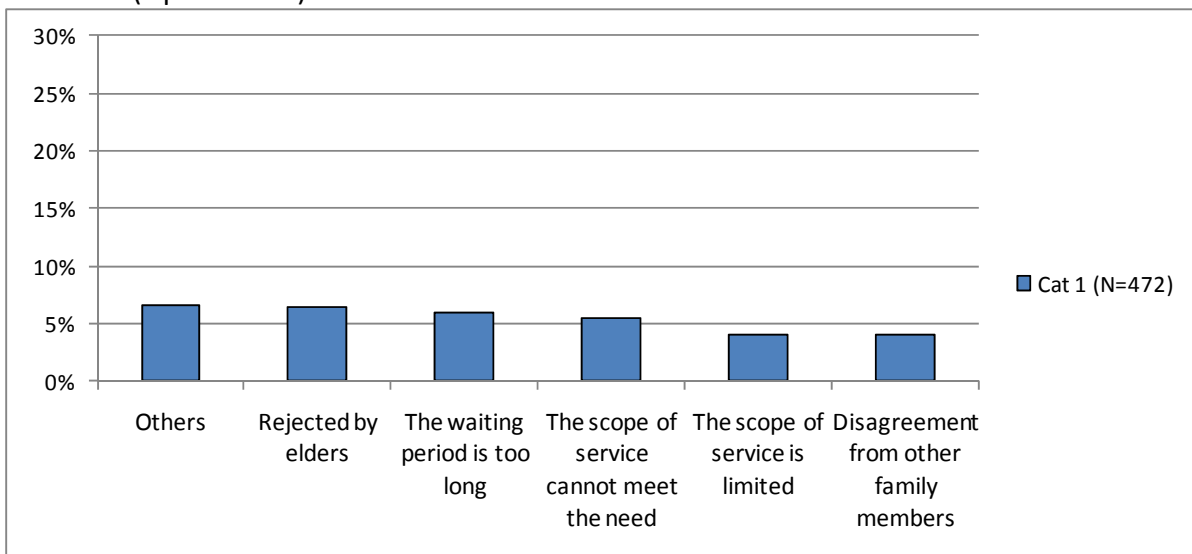
Reasons of not using CCS

176. Amongst the 506 elderly respondents who were non-users of subsidised CCS living in domestic household but waiting for subsidised RCS [Cat 1], 472 (93.3%) of them didn't use any CCS. 26.5% of those didn't use any CCS alleged that they had no need for CCS, and another 28.4% were having carer at home, and so were not keen to use CCS. On the other hand, there were also 17.4% who did not know about the service, 13.1% did not know how to apply for the service, and another 9.1% did not know the scope of service. Some 5.5% opined that "the scope of service cannot meet the need" and 4.0% had the view that "the scope of service is limited". Finally 9.5% revealed that they could not afford the service charge.

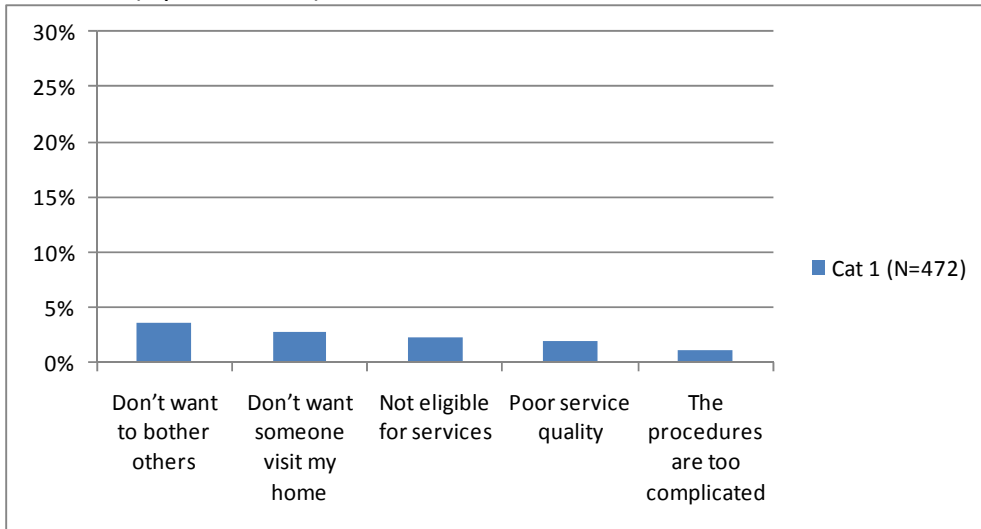
Graph 4.12a What are the reasons that hinder you from using the subsidized Community Care Services? (Option 1-6)



Graph 4.12b What are the reasons that hinder you from using the subsidized Community Care Services? (Option 7-12)

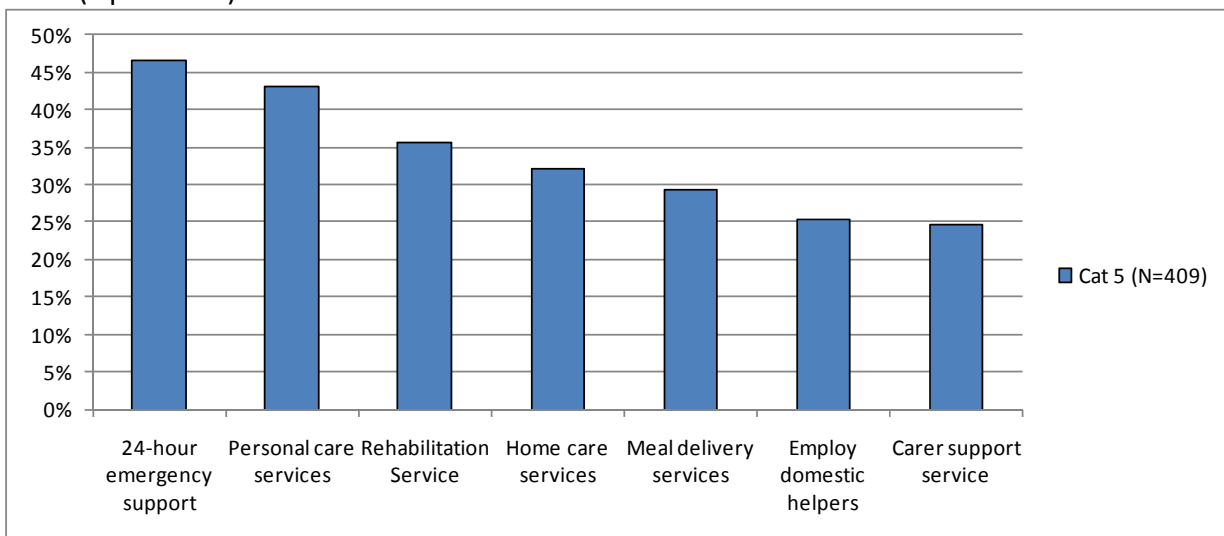


Graph 4.12c What are the reasons that hinder you from using the subsidized Community Care Services? (Option 13-17)

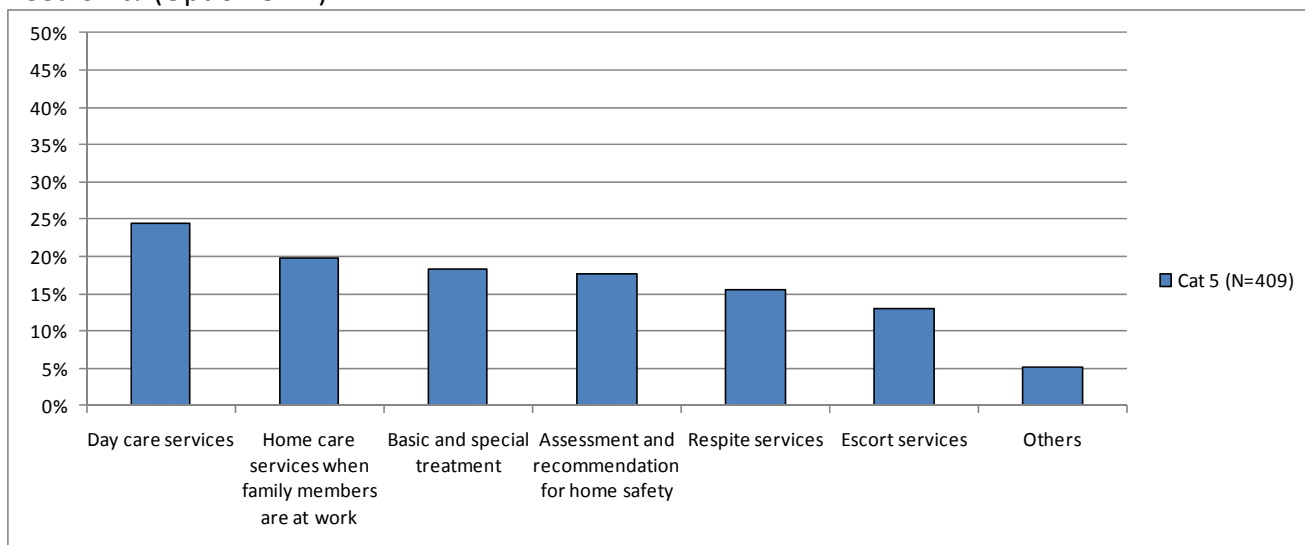


177. The study also collected views from non-users of CCS with no expressed need for such services [Cat 5], so as to solicit their expectations of the CCS that they anticipate would have to use if and when in need. The respondents expressed that they would expect to have “24-hour emergency support” (46.5%), “personal care service” (43.0%) and “rehabilitation exercise” (35.7%) that would facilitate their ageing in place when they get older.

Graph 4.13a What are the expectations towards Community Care Services when elders are in need of it? (Option 1-7)



Graph 4.13b What are the expectations towards Community Care Services when elders are in need of it? (Option 8-14)



Service delivery mode, service bidding and resources

178. Currently, the three types of CCS, i.e. DE, IHCS(FC)/ EHCCS are operated separately by different agencies or units under separate FSA and contracts. Under this system, there might be problems of services gaps; for instance, some DE users may need escort services that are only provided in the IHC service; however, since the two types of services are operated separately and even by different agencies, there are barriers to enabling such DE clients having access to escort services. Thus there is also the suggestion from CCS operators to allow more flexible deployment of resources amongst the three types so as to enhance the interface between different services.

179. In order to meet the service need of eligible elders on the waiting list and to support more elders living in the community, the DE’s are required to satisfy enrolment rate. Due to escalating community demand, the DE operators have to admit cases frequently, thus resulting in high work pressure that might compromise service quality for the elderly users.

180. Some operators opined that previously since the SWD had requirements on minimum number of hours for individual users, there might be times when some less frail users had to be given excessive services without such a need. If the concerned resources (in terms of service hours) could be redeployed to some more needy users or even the waitlisted applicants, it would better serve the clients and achieve better efficiency. It is reckoned that the SWD has released this measure in the new extension of contract of EHCCS 2011-2014, which would certainly contribute to facilitating the improvement of service quality.

181. There are suggestions by CCS operators to better utilize or interface with other community support services, specifically the DECC and NECs. For instance, it was suggested that the NECs may improve their canteen or meal service, so as to release the older people’s need for going to the market and cooking at home, which may also relieve some of the demand for meal delivery services provided by the IHC teams.

182. There are also concerns about the bidding system and the short duration of service contracts for CCS operators (the EHCCS and some DE). Though competitive bidding is one of the means

to ensure service quality and cost efficiency, the downside of this mechanism is the uncertainty of service duration, which thus hampers work morale amongst staff, and consequentially leads to high staff turnover in the operating teams.

183. With increased intake of older people suffering from dementia, the DCU and DE find it increasingly difficult for them to provide quality care as they are not having extra resources. It is reckoned that the Government has recently recognized the need to support to demented elderly attending Day Care Centre, in the Budget 2011/12, by extending the applicability of “dementia supplement” to this group of users, in addition to the original beneficiary of RCS users.

Space provision for elderly care units

184. Operators interviewed had revealed that there is the problem of insufficient space in the various types of services. For instance, home care workers often find no office space for them to do the documentation and records. The Day Care Centres (DE) are having insufficient space to cater to the needs of older clients, especially in view of the increasing frailty of the cases referred from the SCNAMES. Furthermore, the DE's are increasing admitting more users with dementia (some units may even admit up to 40% of their users being demented older people). Crowdedness in the DE or DCU may ignite emotional arousals and even conflict amongst elderly users; insufficient air conditioning due to congestion might lead to poor air quality and high temperature during summer. There is also insufficient space for holding groups for older people and for office work. There are even not enough lavatories for the elderly users in the DE, and no space for them to take a nap after meal, or for the demented elders to wander around.

185. The official guideline of Net Operational Floor Area (NOFA) for a standard DE (Capacity: 40) was 218 m², but if the non-activity area is excluded, a standard centre is only left with about 132 m². However, as a standard DE is now serving around 50 elderly users with moderate level of impairment, space is actually insufficient. It is reckoned that the SWD has since October 2010 upgraded the NOFA required for a DE (Capacity:40) to 267 m², which would hopefully relieve a bit of such space problem. Nonetheless there would still be room for further improvement as to enhance the service quality. In fact, there has been demand from the operators and users of EHCCS for some space in the DE for some recurrent social activities, so that the home-care users are not confined to their domestic home but can enjoy social life in the community. This certainly would touch upon the issue of linkage between home-care and community-care services, which would require some re-structuring of the entire CCS delivery system.

186. Furthermore, there are also very vocal demands from IHC operators for a larger space provision for kitchen, so as to meet the escalating demand for meal services from the community.

Manpower - shortage of formal care workers

187. Similar to the situation of most developed countries, Hong Kong is having the problem of shortage of formal long-term care staff, which adversely affects both the quantity and the quality of long-term care services. The present study also reveals that many of the informants

(including academics, government officials, NGO service managers and frontline practitioners at various levels) are concerned about the shortage of health care personnel which was considered as a major hindrance to the expansion or development of CCS. The shortage occurs in all the relevant fields including professional staff like nurses, occupational therapists (OT), physiotherapists (PT), as well as non-professional staff including health workers (HW), personal care workers (PCW), home care assistants (HCA) and home care workers (HCW).

188. Since the implementation of the Lump Sum Grant subvention system in 2001, NGOs operating the IHCCS and DE can have flexibility in their staff establishment for delivering their services. Such flexibility may enable the CCS operators to deploy their resources to hire relevant professional practitioners to deliver services commensurate with the care needs of the service users. However, there might also be the possible problem of not having a guaranteed staff establishment to ensure the provision of quality services.
189. It is appreciated that based upon the recommendations of the Review Report on the Lump Sum Grant Subvention System in December 2008, SWD secured funding from the Lotteries Fund in May 2009 to provide additional resources to NGOs (in three yearly instalments starting from 2009-10) for paying the salaries and employers' Mandatory Provident Fund contributions of paramedical staff or relief staff, and for hiring paramedical services to provide services subvented by SWD. This could contribute to relieve, to a certain extent, the tight financial constraint of NGO operators. It would be even more desirable if such practice could be sustained or additional funding be provided recurrently in the long run.
190. Nonetheless, as revealed from informant interviews with NGO CCS operators, usually the NGOs cannot offer comparable packages of salary and working condition as the Hospital Authority or other private hospitals. Specifically, while the hospitals could usually offer a longer term or even permanent contract, the NGOs may not be able to make such offer as some of the services are subject to competitive bidding and thus there is no guarantee of the continuation of service. This thus makes the career prospect of the professional practitioners working in NGOs less favourable. In addition, with the introduction of the Lump Sum Grants system (that provides subvention to NGOs at mid-point salary), the NGOs might have constraints in offering higher salaries to employ senior practitioners, making those experienced practitioners reluctant to work in NGO. Furthermore, as contrasted to those working in the public hospital, those professional practitioners working in the NGOs have no training and supervision provided, so that the fresh graduates may not be capable to work independently.
191. With specific reference to the OT/PT, the NGOs could usually employ only one OT/PT per team or even have to share an OT/PT (i.e. or often time, a "fractional" post) amongst several teams; but some of the tasks and services provided for frail elders require more than one worker, which thus makes the OT/PT unable to perform their duties optimally. With only one OT/PT in the team, they have to work entirely independently on their own, without sufficient collegial and administrative support. All these explain the relatively high turnover rate and thus shortage of OT/PT manpower in the NGO sector.
192. There may be other barriers to promoting home care provided by OT/PT. For instance, there is considerable difficulty for OT/PT to travel to a lot of different places when carrying a lot of equipment. Thus, more support is needed to assist the OT/PT for providing home care

services. For instance, transportation could be provided so as to reduce the time that OT/PTs spend on travelling on public transport.

193. The prevailing practice of stipulating referral for OT/PT services by medical doctors may further pose difficulties in the provision of professional services to the patients. This is different from other overseas countries like Australia where direct access to OT/PT is allowed. There may be the need for Hong Kong to review this mechanism especially for geriatric care or maintenance care, and the desirability and feasibility for OT/PT to have private practice, as in many overseas countries.

194. The shortage of OT/PT may also be attributable to the overall limited supply by local training institutes that only produce 60-70 graduates per year. With increased demand for the therapists from the private clinics the manpower supply of therapists in the public and NGO sectors may be adversely affected further.

195. Apart from the shortage of nurses and OT/PT, the problem of manpower shortage has already been extended to health workers in day care centres for the elderly and home care workers. It was revealed from informant interviews that many of the home care workers have turned to become "private practitioners" i.e. working as "self-employed" or "freelancers" for individual households / families, instead of working for NGOs. Such a work pattern allows them more flexibility in work time, less workload and stress, as compared to working in welfare service agencies. This has further exacerbated the already acutely short supply of health care workers in providing CCS for the NGOs and agencies.

196. As alleged by the representative of the union for the community care and RCHE workers, many of the personal care workers are always under-paid and the terms are not stable, leading to demoralization and thus dropout of serving workers. Worse still, though there are young people taking the training (e.g. the Vocational Training Council's courses), due to the unattractiveness of the working condition and career prospect, the dropout rate is very high. Even for those who entered the workforce, there is also high wastage rate, leading to shortage of manpower.

Ancillary services– transportation for users and operators

197. Both users and family carers expressed the view that there are difficulties of having accessible transportation to enable them attending day care centre services, going to clinics and hospitals for medical consultation and check-up, and engaging in social participation like social gatherings and shopping. This is particularly relevant to frail elders who are using walking aids or even on wheelchair. Thus, there are suggestions of providing other ancillary or supportive services, for instance, the provision of more Rehabus and non-emergency ambulance service to assist elders in going to clinics/ hospital, and inexpensive transportation means for wheelchair users.

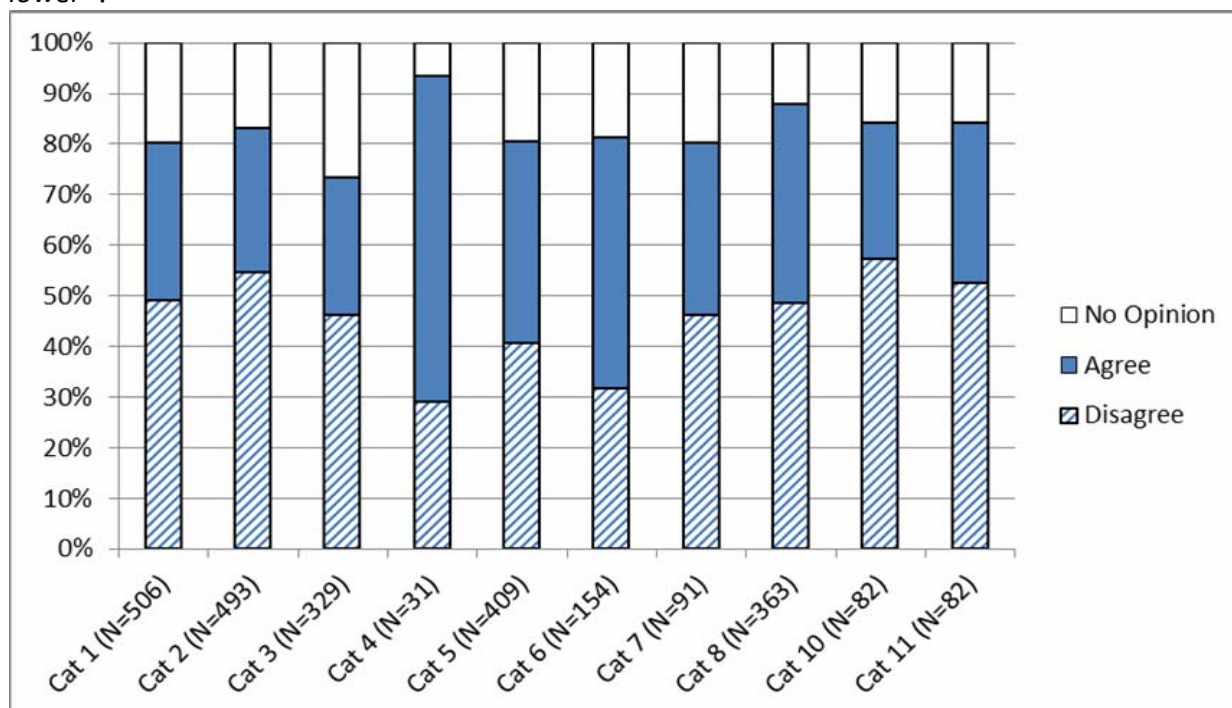
198. As for the CCS operators, it was revealed that though all the IHC and EHCC units are provided by the SWD with a van for meal delivery and staff transportation, but due to the voluminous of caseload (in such services as meals and escort to hospital follow-up), there are situations where the staff have to travel by public transportation. The problem is accentuated with the

large service boundaries in which the users are dispersed in a large catchment area of the operating unit. In addition, since the old 7-seater vans are no longer imported into Hong Kong, the operators have to purchase 16-seater minibus, which also increases all the operating costs in such aspects as fuel, maintenance and parking. It is reckoned that currently the SWD reimburses car-park rentals to DE and IHCS teams and for EHCCS, such expenses are absorbed by the contract payment.

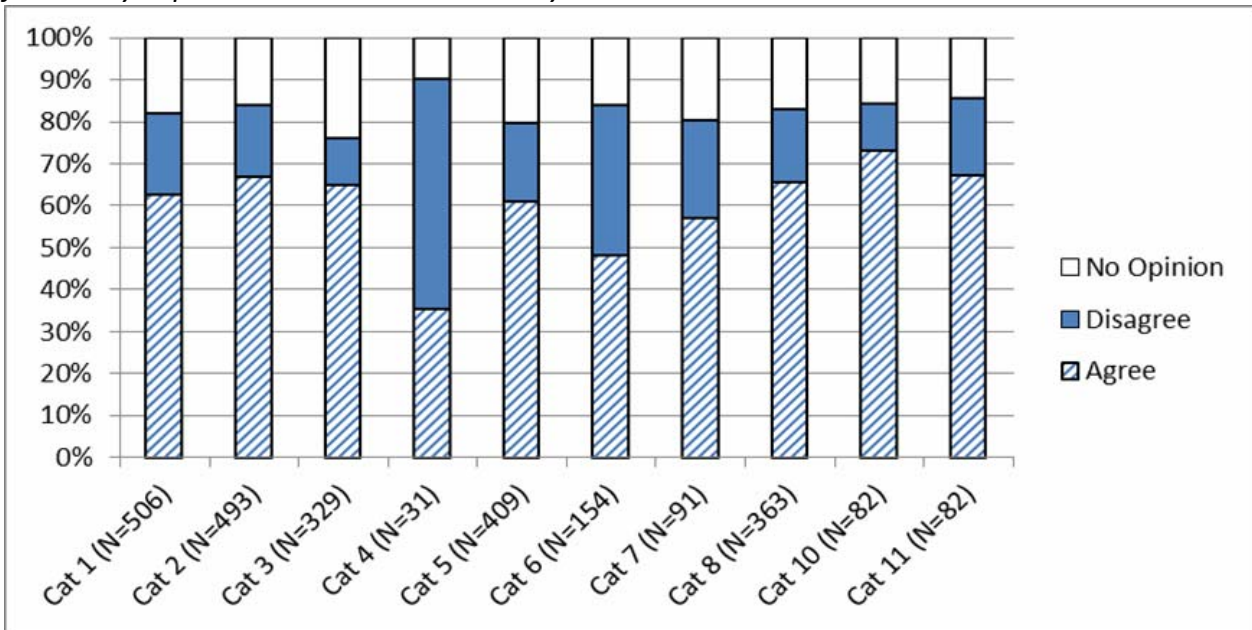
Part II. Means-test and CCS voucher

199. Nearly half (40.6-57.3%) of respondents of different categories (except for those users of non-subsidised CCS [Cat 4] and middle class elders [Cat 6]) disagreed to the statement *“Allocate the resources equally to all elders (regardless of their financial ability), but the subsidy for everyone is relatively lower”*; but less than 40% agreed. When this result is read in connection with that of the following, some 57.1% to 73.2% of respondents of different categories agreed to this statement *“Allocate the resources to those financially in need and the subsidy for everyone is relatively higher, while the elders who are financially capable have to bear the cost by themselves”*, this apparently reveals that respondents of this study mostly accept a somewhat “selective” provision of government subsidized services to those who are in genuine need.

Graph 4.14 Do you agree with the statement *“the government should allocate the resources equally to all elders (regardless of their financial ability), but the subsidy for everyone is relatively lower”*?

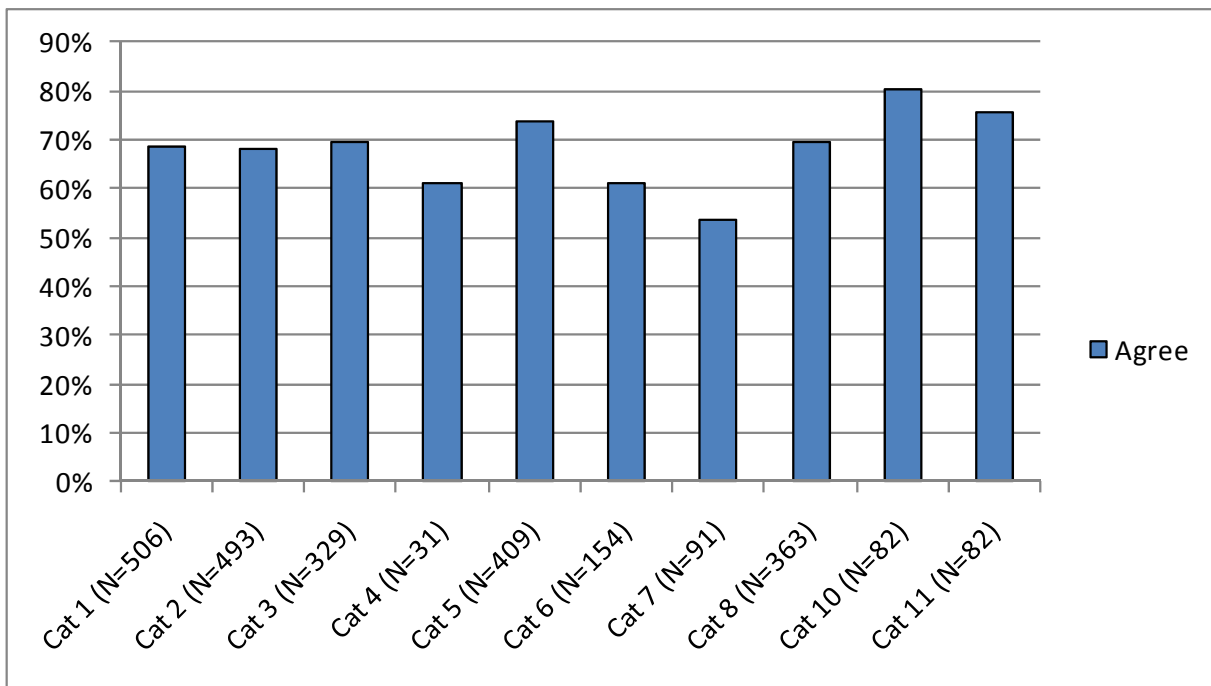


Graph 4.15 Do you agree with the statement “the government should allocate the resources to those financially in need and the subsidy for everyone is relatively higher, while the elders who are financially capable have to bear the cost by themselves”?

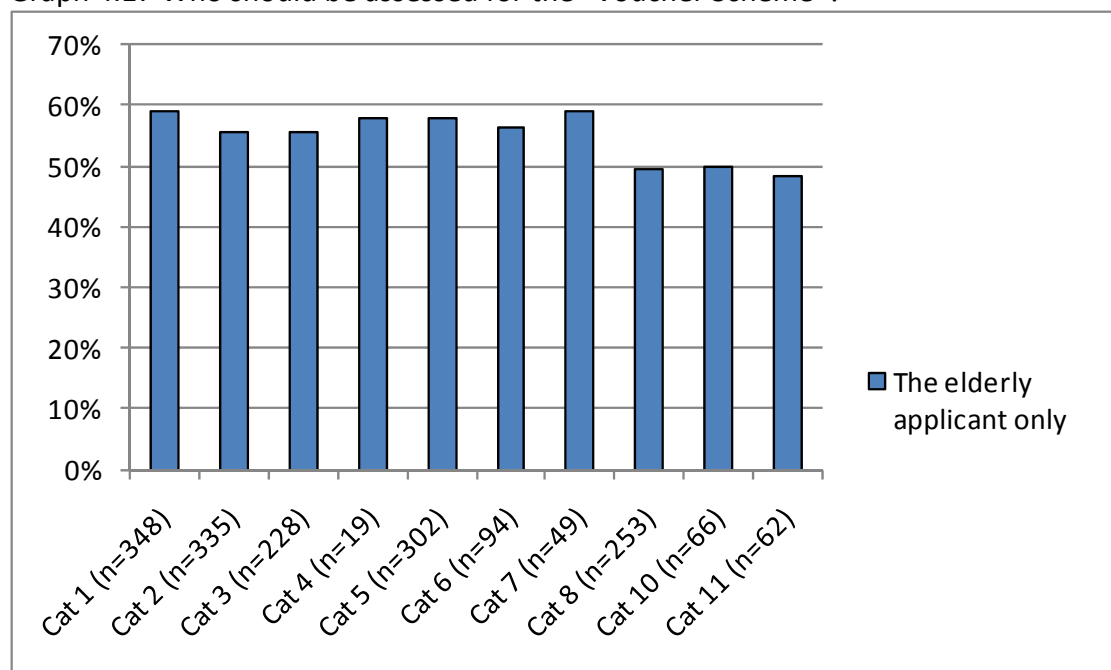


200. There is also a majority of respondents across different categories (ranging from 53.8% to 75.6%) agreed to administering means test for the proposed “Voucher Scheme”. A great majority (from 48.4% to 59.2%) of those in support of administering means test opined that only the elderly applicant / user should be assessed, but not their spouse nor their children, irrespective of their being co-resident or not. Nevertheless, the survey respondents did not suggest ways to avoid abuse of the system if only the elderly applicant/user’s asset would be assessed.

Graph 4.16 Do you agree that the government should administer mean test for the proposed “Voucher Scheme”?



Graph 4.17 Who should be assessed for the “Voucher Scheme”?



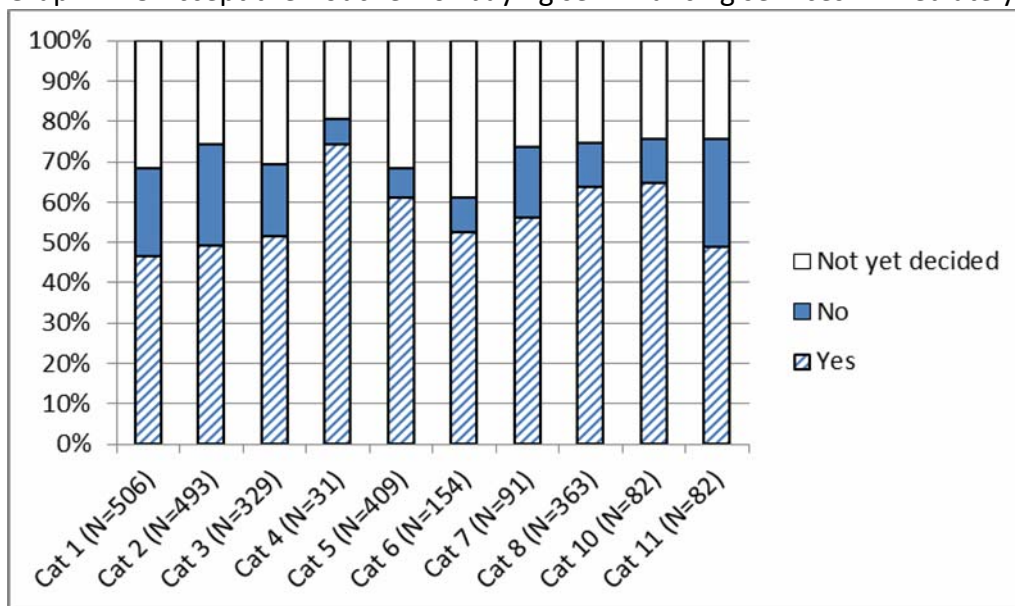
201.As revealed from the in-depth interviews with elderly users and family carers, there were divergent views on the issue of fairness in the allocation of resources, and the related issue of means-test. Some would say that it is fair to allocate equally to all people; especially in view of the undesirable impact on older people if they were asked to disclose their own financial conditions, or that of their children, or even to disconnect with their children in order to be exempted from the means-test. On the other hand, others would suggest it is unfair if all people, irrespective of their affordability, could get government subsidy.

202.There was also a view that universal coverage would lead to a lower rate of subsidy; while selective provision by administering a means-test would raise the level of subsidy to only those targeted beneficiaries. Some respondents in the in-depth interviews opined that an older person should have some assets that should not be subjected to be assessed or means-tested. Some suggested that those who are protected by some pension schemes should not be provided with subsidized services, as they could cover their daily expenses by their pension. Yet, there are others who thought that since there would be some “greedy” people who would apply for subsidized services if there were no means-test, and selective provision could serve those who are having genuine need. However, those disfavoured means-test would worry about the huge cost incurred in administering a means-test, which might defeat the original intent of achieving efficiency in utilization of public resources, or “placing the cart before the horse” (本末倒置).

203.Besides, some respondents alleged that as they are usually regarded as the so-called “middle class” and so should not receive any government welfare, it is difficult for them to access subsidized services. If there were means-test, it would be embarrassing for them to disclose their financial conditions, as such “help seeking” (放下身段) would incur “loss of face” (無面) to them.

204.As revealed in the survey, more respondents in various categories supported a CCS “Voucher Scheme”. Among all respondents, a considerable proportion from various categories (ranging from 46.4% to 74.2%) would readily accept the voucher if such a scheme is to be launched.

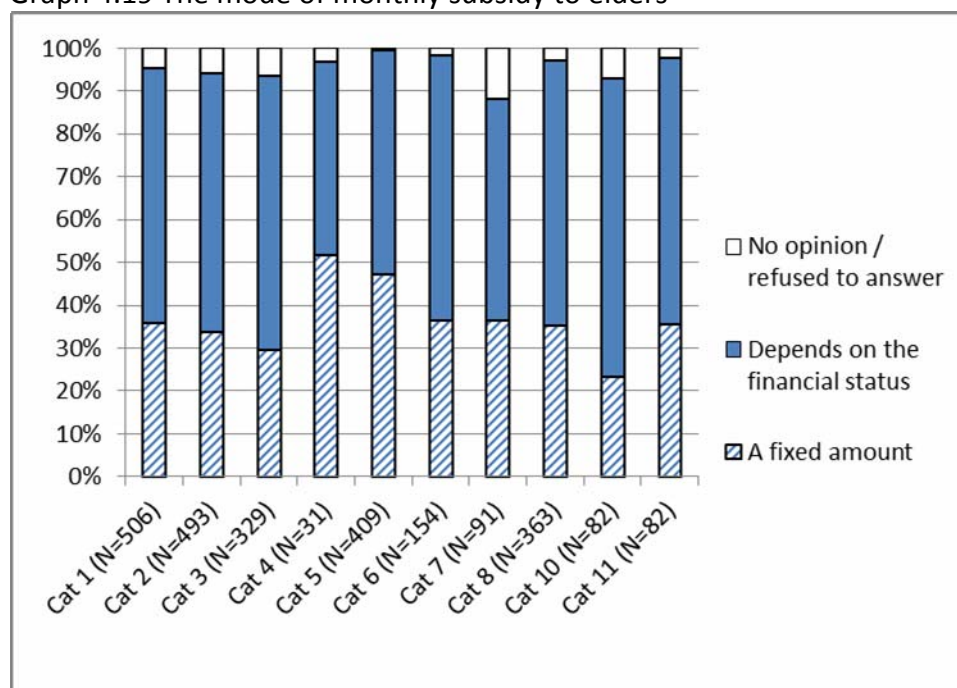
Graph 4.18 Accept the Voucher for buying self-financing services immediately.



205. The reasons supporting the respondents' acceptance of the implementation of a voucher scheme include *"the elders can have freedom to choose suitable"*, and *"there can be shared responsibility between the government and the elders"*. For those who were non-supportive of this new initiative, the most frequently given reasons are *"the subsidized CCS is cheaper"*, *"the subsidized CCS are having better facilities"*, and *"the staff of subsidized CCS are having better caring skills"*. That said, the reasons why the respondents came to such opinion/impression were unknown.

206. With regards the monthly subsidy to the elders (in the form of a voucher), more respondents (ranging from 51.6% to 69.5%) (except those users of self-financed CCS [Cat 4]) opined that the amount should vary according to the financial status, or affordability, of the elderly; or alternatively conceived as a "sliding scale".

Graph 4.19 The mode of monthly subsidy to elders

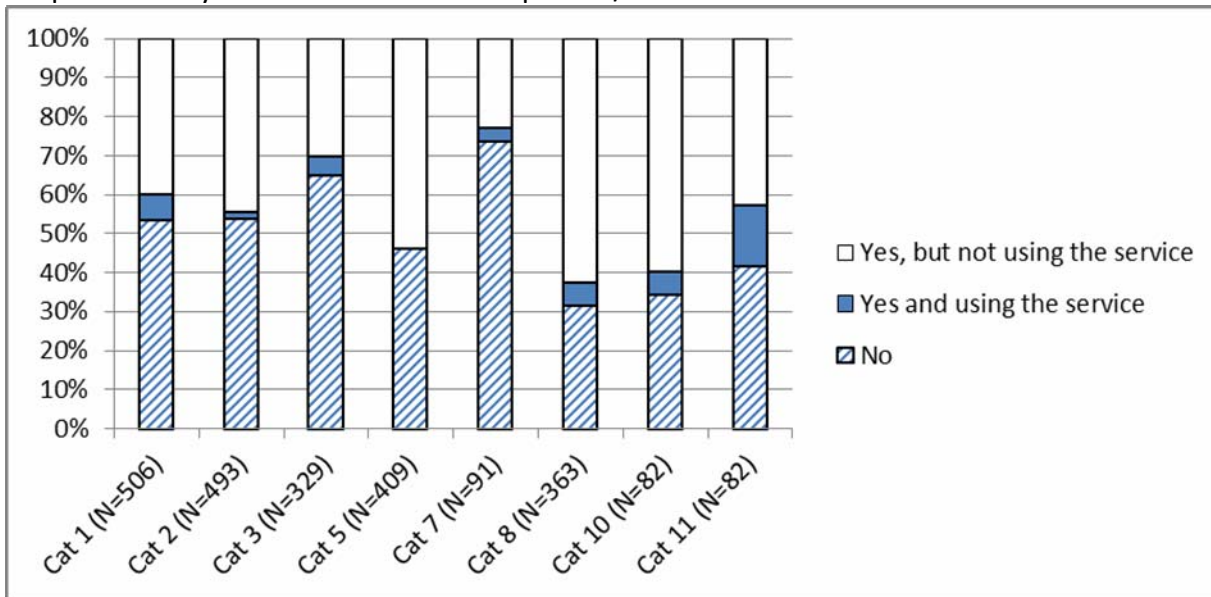


207.Regarding the usage of voucher, the views from Categories 1, 2, 3 and 5 respondents⁴ are analysed. More than half of respondents commented that the voucher should be used for purchasing assistive products, such as wheelchair, crutch, commode, diapers, milk powder etc.; rehabilitation services, including physiotherapy and occupational therapy, and home care services, such as meal delivery, bathing, shopping etc. On the other hand, more than 40% of respondents opined that the voucher should be used to cover such expenses as house cleaning and paying for personal emergency link, special nursing care and elder sitter.

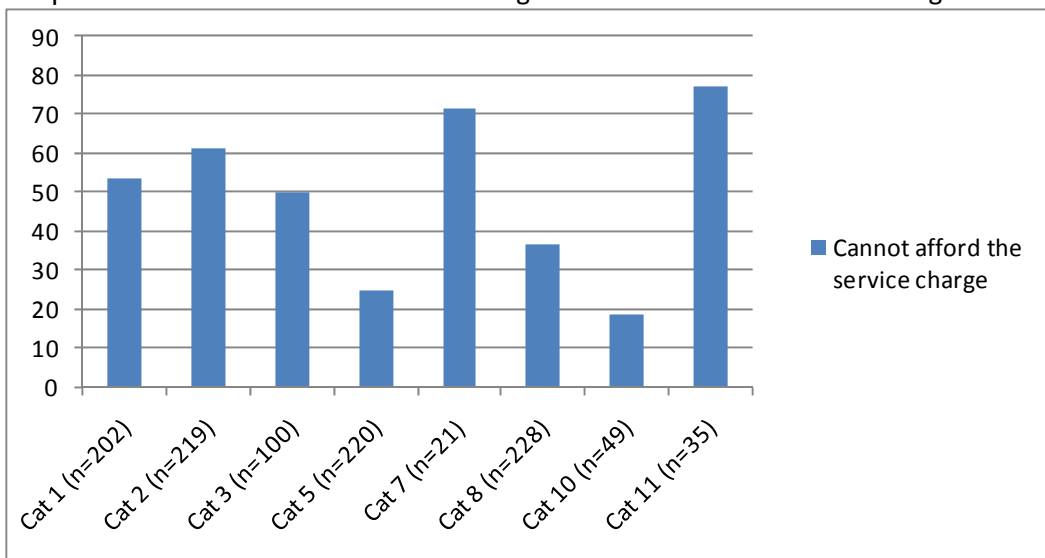
208.Across the different categories of respondents (ranging from 46.4% to 74.2%), a slight majority of them would accept the voucher and use it to pay for self-financing services provided by NGOs and/or private sector. However, survey finding also reveals that there is divergent degree of knowledge of the availability of such self-financing services: some 31.4% (family carers [Cat 8]) to 73.6% (IDSP users [Cat 7]) of different categories of respondents alleged that they did not know any of such services. For those who knew about such services, some 24.5% (non-users with no LTC need [Cat 5]) to 77.1% (recent applicants for LTC service [Cat 11]) alleged that they could not afford the service charge.

⁴ Categories 1, 2, 3 and 5 refer to respectively (1) Non-users of community care services (CCS) living in domestic household but waiting for subsidised residential care services (RCS); (2) Existing frail users of subsidised CCS; (3) Existing non-frail users of subsidised CCS and (5) Non-users of CCS with no long-term care (LTC) needs.

Graph 4.20 Do you know that there are private/self financed CCS?



Graph 4.21 Cannot afford the service charge as one of the reason of not using self financed CCS

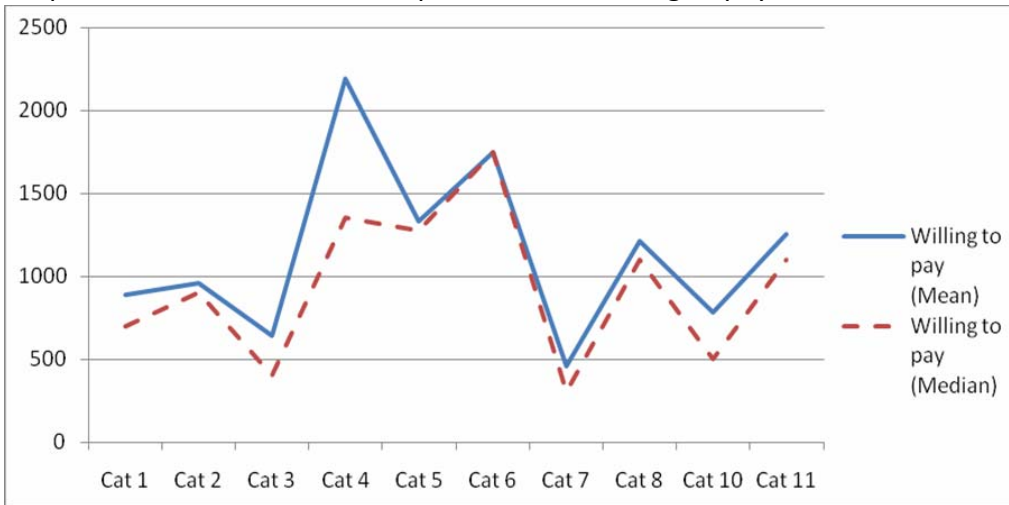


209. The survey of the study also explored the respondents' acceptance of the value of the CCS voucher and their readiness to top up for the voucher. In the survey interview, respondents were briefed about the existing subsidy level of the subsidized CCS, so as to enable them to have a realistic appraisal of the current situation and cost of the services. With this background, respondents were asked about the amount of money for the voucher they were willing to accept and the amount they were willing to pay to top up (i.e. "co-payment") the voucher provided by the government.

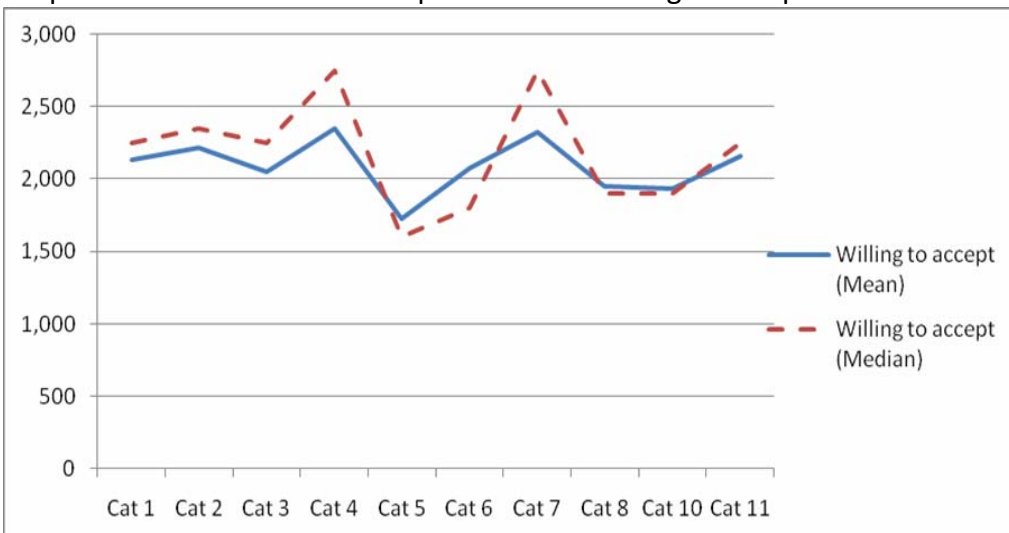
210. Across the different categories of respondents, there are varying amounts of the value of the CCS voucher, ranging from the lowest median value of \$1,600 to the highest \$2,750; and the lowest mean of \$1,727 to highest \$2,347. The amount the respondents were ready to top up ranged from \$300 (median) to \$1,750; and the mean ranged from \$458 to \$2,191. The users of the IDSP [Cat 7] were the same group of respondents who gave the highest amount for the voucher and the lowest amount of top-up or co-payment. Those respondents who were

non-users of subsidized CCS and currently in good health were the ones who were willing to accept the lowest amount for the voucher and to co-pay the highest amount.

Graph 4.22 Amount that the respondents are willing to pay for the service under voucher system



Graph 4.23 Amount that the respondents are willing to accept the voucher



CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Values and principles

211. The provision of sufficient and appropriate services for our senior citizens is an indispensable task for Hong Kong to prepare for an increasingly ageing population. The Government has the responsibility to ensure that the elders have access to services that can ensure their quality of life. On the other hand, families also have the responsibility to take care of elders' needs, and the Government's role is not to replace the function of families.
212. Though the majority of our senior citizens are basically healthy, there is inevitably the prevalence of increasing morbidity rendered by chronic illnesses and physiological deterioration amongst a particular group of the older population. This would result in the escalating demand for long term care (LTC) services for the elderly people in view of the increasing number of older people and the increased longevity within the ageing population. The development of a viable LTC service system is thus of paramount importance in enabling our senior citizens to be catered of their need.
213. In developing the vision of future development of LTC in Hong Kong there should be the adoption of some overarching values and principles. Firstly, the services should be "People-centred"; and in the context of CCS, it should be "elderly-centred" or alternatively conceived as "**elderly-friendly**". Secondly, "**Ageing in place**" should be upheld as far as practically feasible. This is congruent with both the local Chinese normative context, and also the Hong Kong Government's long-held policy direction, as well as consistent with the international trend of promoting elderly people's living in their preferred and familiar physical and social environment. Thirdly, there should be the recognition of "**Shared responsibility of care**" and thus concerted effort amongst a multitude of stakeholders, including the individual, the family, the community, the market, and the Government. Fourthly, there should be the realization of "**equitable allocation of resources**" in which the allocation of public subsidized services should be prioritized to those with most genuine need.
214. In the current LTC in Hong Kong, there is an imbalance between Residential Care Service (RCS) and Community Care Service (CCS) in terms of volume and government expenditure on the two types of services (24 746 subsidized RCS vs. 7 089 CCS places; HK\$2 549 million vs. HK\$381 million in 2009-2011 financial year (as estimated based on the figures from Head 170, the Budget of year 2011-12)). The relatively high institutionalization rate (of about 7% of the elderly population aged 65 and above) is quite high in international standard. Though such a situation is a result of a multitude of factors, it is nonetheless incongruent with the principle of promoting "ageing in place", nor the general aspiration of older people; which ultimately is thus also not "elderly-friendly". Thus, there is need to review the situation by continuing to increase the service volume of CCS, so as to meet the increasing community need and to encourage the general public to switch to home and community care instead of residential care.
215. Apart from problems of not achieving ageing-in-place and elderly-friendliness, there is also grave concern on problems related to equity and shared responsibility of care in the current LTC services. The Hong Kong Government has taken up a significant role in the provision of

health care and LTC services for the elderly population. To a great extent, the current health and LTC provision is largely a publicly-funded model in which the Government has been the main provider of funding either directly (through direct provision of services) or indirectly (through subvention to NGOs and through social security payments). However, there is concern as to whether public resources deployed in providing subsidized LTC services are utilized most efficiently and equitably, and whether such a financing model is sustainable in the long run in view of an ageing population. Given that Hong Kong may not be introducing a sea-change to its established tax and fiscal system and policies, it therefore calls for the attention and exploration into the possible development of alternative financing models for providing LTC services for our older population.

216. In a caring society, no older person should be deprived of elderly care services due to lack of financial means. However, due to considerations of equity and efficient allocation of public resources, there should also be the consideration of affordability or ability to pay, so that those with financial means should make their contributions proportional to their affordability, which would thus achieve shared responsibility and equity.
217. LTC policy and services, CCS being a significant constituent part, should be viewed as an integral part of the entire “elderly policy” of Hong Kong. This would require a holistic review of all the relevant policies related to financial security, health care, family, housing, and even town planning. However, due to the scope of the present study, this report only focuses on the review of subsidized CCS. Yet, review and modifications to the existing CCS policy and service provision would inevitably have implications on those other policy areas that require the concomitant actions from relevant government departments and other stakeholders in the community.
218. Apart from considerations about policies, services and resources, there may also be the need to review critically the prevalent culture or norms in society that are related to elderly care. For instance, the prevalence of family norms, including but not restricted to that of filial piety, co-residence, family structure and functioning, responsibilities of families and individuals, and the like; may also have implications on the possible configuration in the distribution of care responsibility for the older persons. Furthermore, community sentiment about neighbourhood and volunteerism may also have impacts on the viability of community care for our senior citizens, as well as fostering an “age-friendly” community and social environment for older people. Thus, there might also be the need for reviewing public education directions and strategies by relevant governmental and non-governmental bodies, for instance, the Family Council, the Commission on Youth, Women’s Commission, the NGOs, and the like. These might have implications in both formal and informal education aspects.
219. The present study serves not only to review the past and current situation of CCS policy and provision, but to provide a forward looking scenario to better prepare our Hong Kong society for facing the challenges of an ageing population. The study reviews some of the best practices in CCS provision in the international scene, thus provides reference for Hong Kong. The study also provides findings based on interviews with relevant stakeholders, through individual interviews and surveys, on the strengths and weaknesses of the present CCS delivery system. Survey of the present study provides findings on people’s perception of introducing means-test and voucher in the subsidized CCS provision, which also echoes the previous study on RCS carried out in 2009. All these are the foundations upon which the recommendations of the present study are made.

5.2 RECOMMENDATIONS

220. The following recommendations fall into three major areas: firstly, improving the existing mode of service delivery and increasing the service volume; secondly, modifying the financing mode; and thirdly, fostering supportive and facilitating environment in realizing the above two aspects; which in itself involves promoting the development of non-subsidized CCS, strengthening human resources, and promoting public awareness of CCS.

5.2.1 Area 1: Improving the existing mode of service provision of subsidized CCS and increasing the service volume

1a) Improving service hours, scope of services, and space for operators

221. In addition to increasing in quantitative terms the service volume, there should be equally important emphasis on improving the service quality. In light of realizing the principle of being “people-centred” or “elderly friendly”, there can be some modifications and improvements in the existing mode of service delivery.

222. Specifically, as revealed from the findings of the survey and informant interviews, there may be extension of the service hours of various types of CCS so as to accommodate the needs of the service recipients and their family caregivers. For instance, the service hours of day care centres for the elderly may be extended to 8pm so as to allow the family caregivers to escort their elderly family members back home after the office hours. In addition, services may be provided on weekend and public holidays.

223. Survey findings of the present study reveal that respondents from the family caregivers and service recipients and applicants converge to suggest that some community services are able to facilitate the older people to remain living at home, thus achieving “ageing in place”. While a significant portion suggested to increase the conventional Day Care Centre for Elderly (DE) and Day Respite services, others also suggested to further improve and/or add such other services as ad hoc escort service for medical appointment, massage at the users’ home, home visit with rehabilitation service, cognitive training service, traditional Chinese medicine treatment, regular home visit by nurse in order to keep track of the elders’ health status, and 24-hour hotline for consultation and emergency assistance.

224. As revealed from interviews with CCS operators, limited space has been a serious problem hindering their service delivery. It would be desirable if there could be improvement in the availability of more space for the operators, including the provision of kitchen for preparing meals for users, office space for the home care workers to receive training, supervision and perform required administrative duties like record keeping and reporting.

1b) Increasing the support service for family carers

225. In order that older people could be taken care of adequately at home, it is critically important to ensure that the family serves as a viable caring system for their elderly family members. In this regard, support to family caregivers, especially those who are working, is urgently needed. This is especially crucial to enable them to balance their work and carer responsibilities.

226. Currently, the District Elderly Community Centre (DECC) and CCS operators are vested with the responsibility of providing carer support services to family caregivers. However, the present study reveals that only a very small portion (7%) of the interviewed family caregivers had participated in any of these services. It might be due to the fact that such services are either provided during office hours or at the centre, which is not user-friendly to the family carers who are working or unable to leave their frail elderly family members at home to attend to the centre-based support services. It is therefore desirable if such support services could be provided in both office hours and off-office hours to cater for the need of different groups of family caregivers, as well as provided to the caregivers at the domestic home. In this connection, the frontline home-based staff have to be equipped with the relevant skills, and the whole care plan has to be adjusted to include this domain and time and resources be deployed accordingly. It is commendable that currently some elderly centres would offer “elder-sitter” service for those carers who attend services at their centres. However, it requires sufficient manpower and venue in the centres in the provision of such supportive services.
227. In addition, the study’s survey results also show that family caregivers would like to be provided with more knowledge on community resources, on elderly caring skills and techniques, and on the common elderly diseases and symptoms. These show that CCS could be further enhanced in the provision of relevant information to family caregivers, to enable them to take up their caregiver’s role more effectively. There could be various ways that such information or knowledge be disseminated or conveyed to the family carers, for instance, through talks and training courses (offered at convenient time for working family carers and supplemented with elder-sitter service), mass media, internet (e.g. via the eElderly website), and the like.
228. Furthermore, learning from the experience of the Government of Western Australia, the Hong Kong Government may encourage employers to adopt flexible working hours, flexible leave arrangements, and temporary part-time work or home-based work arrangements. Reference could also be made to some of the Swedish municipal governments in appointing a special public officer to provide consultancy and support for informal care givers and established contact points (Lundsgaard, 2005).

1c) Providing more transitional care and respite

229. The availability of transitional care and respite for short-term may help promote ageing-in-place and reduce unnecessary institutionalization. When older people enter into a residential care homes for the elderly (RCHE), there might be chance that they could return to live in domestic setting, provided that there is the provision of appropriate training and exercise for the older people. Such training could avoid the problem of deteriorating self-care ability due to their reliance on personal care provided by the staff in a routine pattern. The shortage of staff in RCHE may further accentuate the problem of lack of such training and exercises.
230. In fact, if provided with adequate, appropriate and timely services, some of the older persons who enter into RCHE may have the chance to return to community living. For instance, in the case of older patients discharged from hospitals, if transitional care is provided, some may

regain their self-care ability. Such transitional care should include pre-discharge care planning, post-discharge follow-up by medical / health care professionals by means of tele-health and home-based services. The success of the three pilot projects of ***Integrated Discharge Support Program for Elderly Patients (IDSP)*** best illustrates the merit of such transitional care.

231. Currently, there are 11 designated care-and-attention places in subvented RCHEs designated for respite service. All subvented RCHEs (including nursing home (NH) and care-and-attention (C&A) homes) are required to provide residential respite places by casual vacancies. However, due to the fact that there is great demand, and thus for the subvented places at C&A and NH, the availability of such casual or designated vacancies is extremely in short supply. The utilization rate of designated place is rather high as the public, especially the referral workers, can check the information of availability from SWD website. Contrarily, casual vacancies are not properly or fully utilized. The present study reveals that this situation might be resulted from the inaccessibility of information on the availability of casual vacancies as well as the procedures of referral by responsible workers. It would be desirable to examine how to improve the current mechanism to enable a more efficient access to such casual vacancies.
232. Some local NGOs have developed self-financing services to supplement the service gap. For instance, the Hong Kong Sheng Kung Hui has two self-financing RCHEs at Cheerful Court (capacity: 57) and Shatin (capacity: 54) that provide long stay or short stay beds for respite and transitional care. There is also a “Stroke Rehabilitation Plan” for elderly people discharged from hospital that provides a 3-month one-stop professional treatment service for their rehabilitation. The Centre provides active rehabilitation therapy and activities for the clients to improve their mobility level and self-care management. The Haven of Hope Christian Services also operates self-financed elderly home that provides short-term transitional care service with a capacity of 50 beds. These transitional care services are so designed as to adopt a “revolving door” concept in which older persons may choose to change from CCS to RCS and vice versa; or utilizing “step-up” or “step-down” services; according to the changing health condition and self-care ability.
233. In the Housing Society’s Senior Citizen Housing projects – the Cheerful Court and Jolly Place – there is the provision of respite service so that residents in the domestic units at the upper floors can occasionally move to live in the nursing home units in the lower floors. Upon recovery, they can then return to their original domestic flats and resume normal living. This aptly illustrates the viability of continuum of care and ageing in place.
234. These initiatives from the NGOs have shown that effective transitional and/or respite services could help to alleviate the pressure of premature or unnecessary or prolonged institutionalization. Thus, there may be the need to increase the provision of subsidized respite and transitional care services.

1d) Fine-tuning the existing funding mode and service performance monitoring system

235. Previously, the SWD requires the EHCCS operators to meet the contract requirements in terms of the minimum number of hours that individual service user receives. There is also a requirement of maintaining no less than 2% discharge rate per annum of service users for informal care or other community support services so as to encourage discharge of elders who have improvement in physical and social conditions and no longer require EHCCS. It is

also noted that the SWD has since 2009 waived the turnover rate of subvented DEs and there is no turnover rate requirement in IHCS.

236. Though these are reasonable measures for quality assurance and equitable resource allocation, such requirements may incur some inflexibility in the service provision as the operators may not be able to deploy their resources from some less frail users to serve some more needy users. As the operators would assess the frailty of their service users to determine their care plan, it would be desirable if the SWD could entrust the operators to decide on the overall case-mix of the whole group of users served by individual operators. Furthermore, there might be merit in exploring the possibility of allowing a portion of cases as short term cases which involve less statistical reporting so as to reduce the administrative workload on the case turnover for the social workers. Such a "Short Term Case" system may serve those acute frail elder discharged from the Hospital or those who only need household cleaning once every few months for a 3-month period. In the SWD's recent review with EHCCS service operators in late March 2011, the provision of an operating environment flexible enough for service delivery corresponding to the levels of frailty of the elders has been taken into account. It has been agreed that, among others, each service user would be provided with no less than 15 hours of direct care and counselling services in each quarter. In this manner, the service mix for each user would be dynamically designed under the wide spectrum of "direct care" and "counselling services" so long as he/she is given at least 15 service hours. The Pilot Scheme on Home Care Services for Frail Elders would shed light on the possible areas for further enhancement of the operational mode that would facilitate the service delivery better meeting the individual needs of the elderly with different health and social profiles.
237. Furthermore, as revealed from the interviews with CCS operators, the mechanism of bidding for service has caused considerable problem of service continuation and staff retention due to the uncertainty of renewal of contract. Understandably, the bidding mechanism has served to secure best value services through the allocation of welfare services, and by ensuring the monitoring of contract compliance, as well as benchmarking performance standards to ensure continuous improvement of service quality. Nonetheless, there may be the need to strike a good balance in ensuring service continuity and stability with rational allocation of resources.
238. The "Pilot Scheme on Home Care Services for Frail Elders" newly introduced in 2011 would adopt a new monitoring system that is different from the existing CCS contracts. One of the distinctive features is the designation of a "Case Manager" who is charged with the duty and authority to provide tailor-made Individual Service Plan (ISP) for service users. This would serve as a good reference for future CCS delivery and monitoring. The issue of "case manager" is to be dealt with in more detail in a later section.

1e) Realigning the service boundaries

239. Currently, the original 18 EHCCS are district-based while the 6 new teams (introduced in 2009) are cluster-based. The 60 IHCS teams are distributed on a district basis.⁵ The large service boundary would incur excessively long traveling time for the service operators and the

⁵The service boundaries of the IHCS (Frail Cases) are equivalent to Constituency Areas as listed out in the "2004 Legislative Council Elections --- Lists of Geographical Constituency Areas". (source: SWD website)

frontline staff, which in effect has reduced their work efficiency and the overall capacity of service provision. It is therefore desirable if CCS operators could be allocated according to a more “community-based” mechanism, to the extent that smaller teams could be deployed at the estate or street-block or Tertiary Planning Unit level. The provision of CCS services within the elderly people’s vicinity would firstly reduce their need to travel, thus reducing the demand for such specially designed transportation services as the Rehabus, and secondly reduce the traveling time of service operators. Understandably, the availability of office space or venue is a crucial factor in making this service provision feasible. Furthermore there should also be prudent planning with regard to the scale of operation, especially in view of the staff establishment for each team that could serve a “critical mass” of service users.

1f) RCHE serving as CCS base

240. There is merit in promoting better interface between RCS and CCS. Currently, there are 777 RCHEs in the community, in which 192 are NGO-run or contract homes or self-financing homes and 585 are privately operated. The wide geographical spread of these RCHEs can be a very penetrative network of base that CCS operators could utilize to provide in-home and/or day-care services since the RCHEs are already equipped with kitchen, dining hall and space for the necessary equipment. Currently, the Enhanced Bought Place Scheme (EBPS) is implemented by SWD to enhance service quality for private RCHEs. One possible way to increase the supply of self-financing CCS is to launch some pilot projects with those private RCHE that have participated in the EBPS. However, this may require the necessary review of the existing licensing and monitoring mechanisms on RCHE in order that such changes in the operation and schedule of accommodation could be appropriate. For instance, the license conditions may be relaxed or modified to allow those RCHE that are of larger scale to provide services to non-residents who use such services as meals canteen and day-care within the premise of the RCHE, or the home-care services (e.g. meal delivery) provided by the RCHE.

1g) Promoting synergy between centre-based (DE) and home-based (EHCCS/IHCCS) services

241. The current CCS delivery system is premised upon the principle of avoidance of “double benefit” i.e. to avoid the same service user to enjoy the provision of more than one type of services. This might serve to ensure equitable allocation of public resources; yet would also incur the possible problem of service fragmentation and the inability to serve the users the best possible.

242. As the success of day care service reveals, older people may benefit from having social contacts with other people in the community; or at least other users in the day care centre for the elderly. If older people are confined to their domestic home without being able to go out to the community to have social engagement, this would adversely affect their psychosocial health. Thus, it would be desirable if there is better synchronization and interface between EHCCS / IHCS(FC) and DE, so as to enable the elderly service users to benefit from both home-based and centre-based services. The effect of synchronization could be best achieved with the seamless coordination between the different service providers along the EHCCS / IHCS(FC)-DE continuum, so that case sharing could be allowed. Better still, there could be the reallocation and thus reshuffling of service providers, or realignment of service boundaries, amongst the various service providers along such a continuum, so that the various services

could be provided by the same agency, so as to avoid the complication of inter-agency referral. Currently, there are seven districts (Eastern, Wan Chai, Southern, Kwun Tong, Wong Tai Sin, Kowloon City and Sham Shui Po), in which one agency provides all the three types of CCS (EHCCS, IHCCS, DE); and five districts (Kwun Tong, Sai Kung, Sha Tin, Tsuen Wan and Kwai Tsing) in which one agency provides two of the three types of CCS. Such reshuffling of operators across different service boundaries may start with these districts to promote better synergy.

243. In fact, there might be merit in exploring the possibility of expanding the scope of service and function of day care centres to become a base for multi-services provision for older people living in the vicinity of a community. Such a multi-service centre may offer a continuum of care services to older people, ranging from day care to home care, and even respite residential care. Nonetheless this would incur re-provision of the current standard of accommodation, manpower and other resources as well as the concomitant service realignment that would require a holistic review of the current CCS service delivery mode.

1h) Promoting interface between LTC and non-LTC services - review of IHCS(OC) service

244. Currently, the IHCS(OC) cases are not included into the LTC system as the service users are not assessed by the SCNAMES as the service beneficiaries include the elderly people, people with disabilities and individuals and families with social need. However, the majority (about 90%) of the existing IHCS(OC) users are older people.

245. A local study (Chui et al., 2009), by means of administering the MDS-HC assessment to IHCS(OC) elderly users or waitlisted applicants, revealed that a considerable portion of the subjects (specifically some 19.9% of the 498 interviewed current users and 16.4% of the 92 waitlisted applicants) had actual needs for more intensive level of LTC services [i.e. EHCCS or IHCS(FC)]; but were only using or wait-listing for a lower level of services (i.e. the IHCS(OC) service). This helps to reveal that there might be either the problem of ignorance on the part of the elderly (and their family members) about other alternatives of LTC services; or the inadequacies of the current service delivery system, which in effect had denied these frail elderly people their deserved access to higher level of LTC services.

246. It may be desirable to review if it is feasible to re-integrate the IHCS(OC) elderly cases into the LTC system by, say, merging the part of the IHCS(OC) team serving the older people into the existing EHCCS (with increased manpower and financial support) while setting up a new service (which resembles the former “home-help” service) specifically for the other non-elderly users. One possible strategy is to target to those applicants assessed by the SCNAMES as having “mild” level of frailty. As these “home-help” services, such as household cleaning, escort, meals delivery; may not require professional or allied professional input, they could perhaps be operated by private operators or social enterprises, so that the NGOs could concentrate on providing professional services. The provision of the necessary supportive services via the IHC(OC) services could help to reduce the rate of physical deterioration amongst older people, and this could in the long run postpone their demand for higher level of LTC services, such as the EHCCS.

247. On the other hand, the various elderly centres i.e. DECC, Neighbourhood Elderly Centre (NEC) and Social Centre for Elderly (SE), which amount to 211 in number (as at February 2011) and

themselves being another type of “community support service”, are actually the first contact point for older people in the community. To capitalize on the wisdom of “prevention is better than cure”, it would be desirable if the DECC / NEC / SE can be taken as the “front-desk” to identify and refer relevant and needy older people who are on the verge of needing CCS. In this regard, either the social workers at the DECC / NEC / SE have to be trained and empowered to be able to serve as initial SCNAMES assessors, or nurses could be deployed to provide such clinical assessment to centre members. This might involve devolution of responsibility from the centralized SCNAMES, which requires the necessary training and appropriate deployment of assessors at the local /district level.

1i) Promoting interface between hospital and health care and CCS

248. The HA’s evaluation of the project shows that the IDSP has achieved its goals of providing seamless follow-up service for patients discharged from hospitals. The HA and the Government’s decision to expand the IDSP to all the seven HA clusters is a timely and most desirable move in promoting such interface between hospital care and CCS.

249. Nonetheless, survey findings of the present study also show that there could be further improvements in the operation of the IDSP; for instance, increasing the service scope and/or flexibility of the IDSP in terms of providing domestic cleaning, ad hoc vehicular and/or personal escort service for medical appointment at clinic, hospital or Day Care Centre/ Day Hospital, massage and home repair.

250. The Department of Health (D of H) also contributes in promoting elderly health. The D of H has launched the Elderly Health Services since 1998 and has set up 18 Elderly Health Centres (EHC) with a annual membership of some 38 500 elders (i.e. covering about 4% of all community-living elders) and 18 Visiting Health Teams (VHT), one in each district, to enhance primary health care for the elderly, improve their self-care ability, encourage healthy living and strengthen family support so as to minimize illness and disability. The EHCs in particular, provide clinic service of health assessment, physical check-up, counselling, curative treatment and health education to elderly people aged 65 and above who enrol as members. The annual enrolment fee is \$110 but such fees will be waived for Comprehensive Social Security Allowance (CSSA) recipients and those with financial difficulties (Department of Health website).

251. It would be desirable if there could also be synergy and coordination between the D of H and the SWD in the provision of CCS for community-living older people, in which the EHC may serve as the mechanism of early identification of LTC needs and thus make referrals to the SWD for the allocation of CCS. This would avoid and prevent unnecessary and immature institutionalization of older people, especially in view of the D of H’s finding that EHC members were more health-alert and better informed about health knowledge and practice (Department of Health, 2010).

252. The HA’s 74 General Out-patient Clinics (GOPCs) actually constitute a wide network for identifying elderly patients with LTC needs. There are also some health centres operated by NGOs that can also serve as a channel of early identification of elderly with LTC needs. There is thus the merit in further synthesizing the service referral between the GOPC, EHC and

these NGO health centres, to promote the knowledge, receptivity and utilization of CCS by elderly people.

1j) Introducing case management in CCS delivery and better utilization of clinical assessment tool data

253. As revealed from overseas experiences, effective CCS delivery is usually coupled with the implementation of “case management” or “care management”. The nature and merits of case / care management as practiced in the overseas context was introduced in Chapter 3. It should however be pointed out that other countries which have an elaborate “case manager” system have a different financing system in LTC services, mainly a “private insurance” system (as in USA) or “self-contribution” model. Hence, the case manager system adopted in other countries may not be entirely applicable in Hong Kong.
254. With specific reference to the local context, there are a couple of issues that need to be tackled so as to provide facilitating condition for the successful implementation of case management. Firstly, the successful implementation of case management requires the existence of a large number of competent case managers in the frontline, each allocated a reasonable caseload and provided with the requisite mandate of coordination or command of resources. However, currently with the prevalent manpower establishment of the existing EHCCS / IHCS(FC) and DE, coupled with the considerably high caseload of such teams, it might be uncertain if the case management model could be implemented in the near future. Furthermore, the eminent shortage of caring professionals in elderly care sector in the fields of social work and nurses further accentuates the problem of inadequate supply of case managers. Efforts and resources have to be committed to increase the supply of these professional practitioners through pre-service and in-service training, and enhance their career paths. In due course, there might also be the need to implement accreditation for such case managers, similar to the MDS assessors in the current SCNAMES.
255. Secondly, the three types of CCS, namely EHCCS, IHC(FC) and DE, are operated by different agencies, and each team/operator has to meet their respective FSA’s in terms of service volume. Currently, there are only seven agencies that operate all the three types of services within the same district /cluster. Such division of labour between different services and different operators might incur considerable effort of negotiation between the case manager and the various operators.
256. Most recently, the Government has launched the ***Pilot Scheme on Home Care Services for Frail Elders*** in which the concept of “case management” is officially adopted. This indicates the recognition of the pivotal role played by case managers in the planning and implementation of services for the elderly service recipients. The experience gathered from this pilot scheme (to be completed in early 2014) will shed light on the development of the case management approach in the provision of LTC services in future.
257. Effective case management also hinges upon the availability of effective and accurate clinical assessment of care needs. This relates to the better utilization of the existing SCNAMES data. As revealed from overseas experience in developing LTC in general and CCS in particular, one of the formidable challenges is to address the issue of collection, retrieval and analysis of relevant data to inform current and future decisions about service planning, implementation and evaluation. Currently, the SCNAMES has already served the crucial function in providing

clinical assessment of the eligibility of LTC service applicants. In fact, since its implementation in 2001, it has accumulated a sizeable volume of some 170,000 cases, and the huge dataset can thus serve as a viable pool of data about clinical and demographic information of LTC users. Thus, there would be merit in reviewing the SCNAMES to identify its potential strengths in contributing to long-term service planning.

258. Actually, the MDS-HC that is used in the existing SCNAMES is an assessment tool that can be used to develop patient classification system – resource utilization groups (RUG). According to a study in the USA, home care case-mix system would categorize users into seven groups: special rehabilitation group, extensive service group, special care group, clinically complex group, impaired cognition group, behavioural problem group and reduced physical functions (Bjorkgren, Fries & Shugarman, 2000). Case-mix can be used to estimate cost, make decision on funding, and adjust quality indicators for home care services (Arling et al., 1997). Thus, there is merit in exploring better utilization of the existing SCNAMES data for various functions.

Area 2: Introducing CCS voucher based on affordability and shared responsibility and equitable allocation of resources

2a) means test and sliding scale of subsidy

259. In the spirit of promoting equity in the allocation of public resources, there may be the need to review the current situation of universal provision of subsidized CCS and consider the adoption of a selective provision, which boils down to the issue of introducing means-test.

260. The need and desirability of introducing means-test in the allocation of subsidized LTC services have been examined in the Elderly Commission's 2009 study on Residential Care Services (hereafter "the 2009 RCS study"; para. 134-141 in the Final Report). To re-cap the major tenets that are relevant to the present concern on CCS, it is observed that the current CCS provision is basically publicly-funded with a very tiny private market or non-profit sector. The increasing ageing population, together with the preference of the older people, further coupled by the Government's promotion of ageing-in-place policy direction, would jointly pose an escalating demand for CCS. The continuation of a publicly-funded model may not be sustainable in the long run and the nearly universal provision to older people only based on health condition may not be the best possible equitable allocation of limited public resources.

261. Survey findings of the present study also reveal that across different categories of respondents, ranging from current users and applicants on the waiting list of subsidized CCS and users of non-subsidized CCS, family carers and community people, there is considerable support to the principle of equitable allocation of public resources and thus a more targeted provision of subsidized CCS services. A majority (from 57% to 73% across different categories of survey respondents) was in support of administering means test.

262. Nevertheless, even with the introduction of a mean-test mechanism, it may not necessarily be an "all-or-nothing" mode in which those who cannot pass the means-test would be denied access to subsidized services. Rather, it could be the case in which there is a "sliding scale" of varying degrees of provision or fee charged to the subsidized services, so that those assessed

to be of better financial condition would be required to pay a higher fee. This is also another manifestation of equitable allocation of public resources.

263. The proposition of a “sliding scale” of subsidy is also premised upon the understanding that the older population is not a homogeneous community and there is considerable diversity in the socio-economic status, and thus varying degrees of affordability, amongst the elderly people in Hong Kong. To achieve better equity in resource allocation, there might be the need to introduce such concepts as “co-payment” and “affordability” in the provision of subsidized public services. The introduction of the principles of co-payment and affordability may help to address to the varying needs of different sectors of the older population, in which those who can afford can either top-up some payment in view of getting higher quality subsidized services; or shift to the private sector altogether, while those who cannot afford should remain being subsidized. This might help to retain some resources that are originally deployed to subsidize this specific sector of the older persons who have better financial means and divert to those who are in greater need for subsidized services. This may draw reference to the concept of “market segmentation” in which different products or services are to cater to the various needs of different “market sectors”, as inspired by literature on “mixed economy of welfare”. On the other hand, the introduction of co-payment by users would help to avoid or reduce abuse of public resources, as it would encourage people to seriously consider their actual need in accessing and applying for subsidized public services.

264. The need and merit of introducing the principles of “user-pay” and “co-payment” and the concomitant implementation of a “sliding scale of subsidy” have also been discussed in the 2009 Study Report (para. 100, 105-107, in the Final Report). Those principles and considerations on the RCS are also applicable to the present concern on the CCS domain. That is, with consideration of a more equitable allocation of public resources, and to promote user’s sharing of responsibility in paying the cost of service consumption, with specific consideration of affordability based on different financial conditions, a variable amount of subsidy to CCS services should be introduced. In this regard, the recipients (and/or their family members) could pay up the difference to purchase the required level and types of CCS that they would deem appropriate.

265. Such a principle of varying amount of subsidy to users is supported by survey respondents in both the 2009 RCS study and the present CCS study. In the current study, it shows that different categories of survey respondents, including current users and waitlisted applicants of subsidized CCS and users of non-subsidized CCS, family carers and community people, showed support (ranging from 52% to 70% in different categories) to adopt a “sliding scale” of varying amount of subsidy according to the financial status of the elderly. Actually, in the fee charging system in the current IHCS(FC), EHCCS and the Pilot Scheme on Home Care for Frail Elders, there is already the introduction of the principles of user-pay, co-payment and sliding scale.

2b) voucher of variable amount

266. International experiences have revealed that the provision of subsidies, in the form of cash or voucher can effectively empower elders to exercise choice in using LTC services, encourage them to age in place, and enable their family caregivers to take care of elderly in their own homes.

267. In Hong Kong, there has been increasing application and accumulated experience in the use of subsidy or voucher. The Hong Kong SAR Government has introduced a variety of voucher or subsidies in various policy domains, including the Pre-primary Education Voucher Scheme (PEVS) and the Elderly Health Care Voucher Pilot Scheme. The Government, in collaboration with the Hospital Authority (HA), has also introduced a scheme in which Cataract patients waitlisted for the operation in public hospitals can get subsidy to undertake operation in private clinics/hospitals, in order to promote private sector involvement and diversification of the public service users to relieve pressure on the public service system.
268. In the domain of LTC, though there is not yet the implementation of a voucher system in Hong Kong, the nature, merits and limitations of a LTC voucher system were detailed in the 2009 RCS study (para. 93-114 in the Final Report). Making reference to the overseas experience, as well as the successful experiences in the administration of various other voucher schemes in Hong Kong, further supported by findings of the present study, there could be merit in exploring the introduction of a CCS voucher scheme in Hong Kong. Coupling the above discussion on achieving equity and shared responsibility, such a proposed CCS voucher scheme could be administered with a means-test with varying amounts of value for various groups of applicants for subsidized CCS in accordance with their frailty and financial conditions, so that those who are in genuine need could be provided with subsidized public services while those who have better financial means could make use of the voucher of varying values to purchase non-subsidized CCS by co-payment. The introduction of such a CCS voucher would enhance “user choice” and flexibility in their service utilization. For instance, the users may make use of the voucher to purchase additional services that are not included in the original care plan, and that are provided by the operators on a self-financing mode; or other services provided by private operators in the future.
269. In determining the value of the proposed CCS voucher, there could be some basic parameters to be considered. In view of the varying need of personal and nursing care service with reference to the different degrees of impairment of the elderly people, the voucher should differentiate between a “higher” from a “lower” level of care need. On the other hand, in view of the varying financial conditions of the older people and thus their affordability in co-payment of “topping up” to the Government’s subsidy, there could also be variable amount of the voucher.
270. Based upon the methodology adopted and proven appropriate in the previous RCS study commissioned by the Elderly Commission, the present study also makes some projections on the impact of the proposed CCS voucher based on the survey data collected specifically in this study, and the secondary data provided by the Census and Statistics Department. If the government continues with the present approach in the provision of CCS (including a constant increase in the service places), the number of applicants in Central Waiting List (CWL) of day care and EHCS/IHCS(FC) will increase steadily and the waiting time will prolong.
271. If a voucher system were to be introduced, the number of applicants in CWL of day care and EHCS/IHCS(FC) will decrease. The magnitude of decrease depends on the value of voucher: the higher the value, the greater the decrease and the shorter the waiting time. If the voucher system is to be implemented with a mean-tested mechanism, it will further help in shortening the waiting time. On the other hand, it is also estimated that the introduction of voucher system may create certain induced demand for CCS, the magnitude of which will depend on the amount of voucher and the availability of the private market.

2c) CCS Voucher as incentive to choose CCS for “dual option” applicants

272. The provision of a CCS voucher, coupled with the anticipated expanded volume of provision by the NGOs with a self-financing mode and the private operators, may serve as an incentive to encourage elderly applicants for subsidized LTC services to opt for CCS under the dual option system. The provision of an incentive, rather than a compulsory arrangement for dual option applicants to use CCS instead of RCS, as suggested in the 2009 RCS study, could be a better strategy that could solicit higher public receptivity as revealed from the feedback to the RCS study. Furthermore, if the service quality and the service delivery mode could be enhanced, it is anticipated that applicants offered with dual option could be induced to use CCS instead of RCS. Nonetheless, there might still be the merit to allow the applicant to maintain their waitlisted status for RCS while they are using CCS, to provide them with a sense of security.

2d) Implementing monitoring mechanisms on voucher users

273. The success of a voucher system requires an effective mechanism of monitoring and scrutiny to be put in place. Furthermore, with specific consideration of the prevalence of poverty amongst the older population in Hong Kong, there might be chance that cash subsidies given to the older persons and/or their family members might be not appropriately used on CCS, but instead used to subsidize / supplement other daily household expenses. Thus, there is need to ensure that such subsidy in the form of a voucher, if introduced, is used specifically on CCS and that measures have to be stipulated accordingly.

274. Actually it would be better to avoid disbursing cash so as to ensure proper usage of the subsidy on targeted consumption. Making reference to the case of Shanghai, the community care voucher is implemented by means of a “bank book” in which the utilization is recorded as entries in the book. Alternatively, the voucher could be implemented by means of a stored value card from which value could be deducted upon the users’ usage of the CCS. In fact, the experience of the Elderly Health Care Voucher scheme can provide reference for the proposed CCS voucher if it were to be implemented.

275. As the introduction of voucher has significant implications on public resources, there is need to ensure equitable, efficient and effective implementation. Reference could be made to overseas experiences in the implementation of a monitoring mechanism in the process of providing cash subsidies in LTC system as discussed in Chapter 3. To recap the major ones here, in Germany, the health condition and wellbeing of the *Cash Allowance for Care* recipients are reviewed every three or six months, and if the older people concerned are found to be receiving insufficient care, the cash allowance will be withdrawn (OCED, 2005). In the Netherlands, the user has to report to the care administration office which will also carry out random checks. In the USA, recipients of cash support are required to sign undertakings to ensure the money is to be spent on home care services, and violation of such would result in prosecution by the government. These measures may be able to avoid the misuse of such subsidy.

276. Apart from the provision of subsidy to the end-users of CCS, there have also been suggestions in the community for providing cash subsidy to family caregivers so to compensate for their employment income forgone due to caring. Such propositions may be based on making

reference to the experience of some overseas countries, including Australia, Canada, Ireland, Sweden and the UK. However, such a proposition should be examined with due consideration on firstly social and moralistic grounds; secondly on the macro-economic implications i.e. in the labour market; and thirdly on administrative and financial implications.

277. Firstly, with respect to social and moralistic grounds, it should be reckoned that in Hong Kong there are still the traditional Chinese cultural norms that emphasize the family's responsibility of taking care of older family members. There might be the concern that the provision of cash subsidy to family members for taking care of their frail older family members might be construed as monetizing and thus tarnishing such traditional virtue. Secondly, as discussed in Chapter 3, the experience of USA reveals that the provision of cash subsidy to family caregivers may turn out to be a disincentive for people to join the workforce and thus would affect the labour market. Thirdly, the institution of monitoring mechanisms would inevitably incur financial and manpower costs, which ultimately would increase the financial burden of public services.
278. It is also to be reckoned that there are considerable differences in the socio-cultural contexts between the western countries and Hong Kong, including the cultural norms of filial piety, caring for family members, and living arrangement. Thus, given that there are still controversies as to the desirability and appropriateness of introducing carer subsidy to family carers, there is need to have prudent consideration on the various issues pertaining to such a suggestion.
279. All in all, the implementation of a CCS voucher system administered on a sliding scale based on differential affordability of co-payment would contribute to promoting more effective, equitable and efficient allocation of public resources. However, its success should be coupled with a host of prerequisite conditions. Firstly it is imperative to have appropriate supply-side infrastructure which includes the availability of a sufficiently large number of service providers and the attendant ample supply of staff of various levels who are equipped with relevant skills. Reference could be made to Austria and Germany when they implemented their Cash Allowances for Care in the 1990s, which reveals the need for establishing a support system of professional home-care services that can help reduce the workload on family caregivers (OECD 2005:30). Secondly, there should be the institution of a clinical assessment system that operates independently from the CCS providers to ensure impartiality. In this connection, there is need to review the existing SCNAMES as to how best it can serve such a function. Thirdly, there must be the stipulation of quality assurance mechanisms. The issues of promoting the development of non-subsidized CCS providers and the concomitant quality control mechanism would be dealt with in a later section in this Chapter. All these would inevitably incur substantial input of resources and manpower, and would require considerable time for gradual implementation.

Area 3: Creating an environment for further development of CCS

3a) Promoting the development of non-subsidized CCS with quality assurance mechanism

3ai) Providing support to operators

280. The success of administering a voucher system relies on the availability of a viable supply of CCS in the “market” so that beneficiaries can actualize their choice in “purchasing” the CCS. With the introduction of a CCS voucher, there could be an expansion in the demand for CCS, which would require concomitant expansion of CCS providers.
281. However, as revealed in the current situation, there is a relative underdevelopment of private providers for CCS; but rather, the predominance of a publicly funded model of LTC provision may have probably restrained the development of a viable private market of service provision. Though some of the NGOs have ventured to develop self-financed CCS, but they could only operate in a rather limited scale, given the constraints in the availability of venue, manpower and the like.
282. Currently, the great majority of CCS is provided by NGOs with government subsidy or subvention and their service capacity has basically been full, without being able to spare extra capacity absorbing the new demand derived from the implementation of a voucher scheme. The implementation of a CCS voucher scheme may probably serve as a stimulus for private operators to venture or expand CCS provision. As revealed from informant interviews of the present study, representatives from some private RCHE operators and social enterprises show interest and readiness in operating CCS, especially in view of the availability of the proposed CCS voucher.
283. In order to expand the volume of CCS provision in the community, the Government may need to devise strategies to promote the development of self-financing CCS, in addition to continuously increasing the volume of subsidized services. There can be such possible measures as the provision of premise, financial support, review of existing licensing requirements for RCHEs, and the like. Furthermore there should be the setting up of relevant monitoring and quality assurance mechanisms to ensure the service quality of such non-subsidized CCS services.
284. As land is the scarcest resource in Hong Kong, it would be of utmost importance to explore possible ways to increase the provision of land or venue for operators to establish CCS. The government may consider utilizing the vacant flats in the public rental housing estates, office spaces in the community centres managed by the Home Affairs Department and other vacant premises under government management for this purpose. Such premises or venues could be rented to NGOs which operate CCS with a “social enterprise” (SE) mode.
285. In view of the high concentration of older persons in public rental housing (PRH) estates, and also the availability of workforce in such housing estates, it would be desirable if CCS could be operated in these estates so that the home care workers can be easily recruited from within the neighbourhood. Currently, the Housing Department (HD) and LINK regularly provide SWD with an up-to-date list of vacant non-domestic premises in PRH estates which may be available for welfare lettings to NGOs, and the list is made available in the SWD website. The current practice of the HD in offering welfare rates or reduced rentals to operators should be further expanded, which would contribute in promoting CCS provision at the community level.
286. Alternatively, there could be better utilization of the existing venue of RCHEs – including the self-financing and private ones, in providing CCS; as mentioned above (para.30). For instance, RCHEs might have a little extra sitting out area that can serve as day-care units; and their

kitchens might also be able to provide meals to elderly living in the vicinity. There could be pilot projects that start with a few private RCHes in the Enhanced Bought Place Scheme (EBPS) and at the same time have the spare capacity or space. Nonetheless, there is need to review the licensing terms and schedule of accommodation of these RCHes to comply with safety and other related requirements , in particular the statutory requirement.

287. While it may not be appropriate for the Government to provide venue at subsidized rental rate to profit-making private operators, there may be merit in exploring the stipulation of lease terms in private development to include purpose-built premises for elderly services. However, it is reckoned that there might be resentment from within the community against the setting up of elderly service units in the neighbourhood. There is thus the need to have concerted effort in promoting public receptivity to having elderly service units in their vicinity, to foster a more “elderly friendly” community environment.

288. As CCS for the older people is a “high-touch”, labour intensive service, the expansion of non-subsidized CCS would hinge upon the availability of manpower, both professional and non-professional ones. The current shortage of manpower in the elderly care industry would be a hindrance to the expansion of non-subsidized CCS. This critical issue of human resources in LTC is to be dealt with in more detail in a later section in this Chapter.

289. In fact, the promotion of non-subsidized CCS may serve to increase the supply of CCS service, and to provide employment opportunities to some low-skilled middle-aged workers who might find difficulty in entering the main labour market. In this connection, the Government’s relevant labour policies may supplement on this. For instance, making reference to the “Employment Programme for the Middle-aged”, in which the Government, through the Labour Department, provides “on the job” training allowance (of \$2,000 per month per employee) to employers who employ job seekers aged 40 or above, having an unemployment period of not less than one month within one year prior to the commencement date of employment, the Government may consider providing training allowances to employees of private or self-financing CCS operators.

290. Nonetheless, the survival of private CCS operators or the viability of a private market of CCS hinges upon the existing of a “level playing field” between the non-profit NGOs that operate subsidized services and the private operators that charge market rate. Currently, subsidized CCS is charged at a rather low rate with the Government’s high level of subsidy. Such a low fee would make the private operators uncompetitive and thus jeopardize their survival. Thus, there might be the need to review the fees level of subsidized services; that is to be coupled with the introduction of CCS voucher, so that users could “top-up” by co-payment. This is also a switch from “producer subsidy” to “user subsidy”, so that the users can make good use of the voucher to “purchase” their needed services from either the subsidized or private sectors.

3a) Quality assurance of non-subsidized CCS operators

291. In the promotion of provision of non-subsidized CCS by the NGOs and private operators, a crucial precondition is the quality assurance of these operators. As revealed in the 2009 RCS Study, the launch of a voucher scheme that encourages private sector development would need the prerequisite establishment of a viable accreditation mechanism to ensure the quality of service providers. In the case of CCS, such a concern is equally paramount in

ensuring that the CCS voucher is used appropriately where quality services are provided to the older people.

292. Unlike residential care homes for the elderly, there is at present no statutory licensing requirement for CCS providers. Practically, it is difficult to define the licensing requirements for CCS providers because the range of services covered is too wide, from simple house cleaning and elder sitting, to nursing care and rehabilitation exercises. In fact, many domestic or part-time helpers taking care of elders are providing CCS to a certain extent. In other words, setting up a licensing or statutory regulation regime for CCS providers may not be practicable in the short run.
293. Currently, the NGOs that operate subsidized CCS provision are monitored by the SWD's Service Performance Monitoring System (SPMS) or Contract Management System (CMS). If a CCS voucher was to introduce, which allows both private and/or NGOs operators and even SEs to provide the service, there should be a separate monitoring mechanism, e.g. through contractual management, to ensure their service quality.
294. In order to promote a healthy market, legal and institutional measures should be taken so that quality of service and rights of service consumers can be protected. In this regard, establishment of service performance standard, independent party audit, and transparent complaint system are some of the prerequisites for developing a viable and healthy private sector of service provision (Go, 1998). Reference could be made to the Home Care Alliance (HCA) of Massachusetts in USA and the Canadian Council on Health Services Accreditation (CCHSA) in Canada mentioned in Chapter Three.

3b) Strengthening human resources in Long Term Care

295. A healthy development of LTC in general and CCS in particular in Hong Kong hinges upon the availability of human resources in terms of both formal and informal carers. It is therefore recommended that the Government and relevant stakeholders should collaborate in developing manpower supply in both formal and informal carers that fall into the following four areas: a) nurses, b) physiotherapists and occupational therapists (OT/PT), c) home/personal care workers (H/PCW), d) DHs. In addition to the above, neighbours could also be a viable source of "human resource" that supplements the work of formal care workers.

3bi) strengthening recruitment and retention of formal carers / paid staff

296. In the first instance, there should be strategies to promote the recruitment of more formal carers. In view of the possible incidence of ageism or stereotypical preconceptions about older people and the related caring duties, there can be the promotion of the positive aspects and advantages of working in the elderly personal care industry. For instance, the experience of the Greenhouse retirement communities in the USA shows that care staff may take multiple roles to avoid segmentation of roles and creating a fixated image of a "caretaker". This may help foster a positive image and thus attract young people to join and work in the care industry.

297. Furthermore the nature of CCS can allow considerable flexibility in working hours, so that it can accommodate a wide range of people, including both professionals and non-professionals, who might want to work at short intervals, especially those who might have to attend to other household chores or duties. Actually, Hong Kong may make reference to the campaign in the USA mentioned in Chapter Three which targeted to recruiting some “unconventional” pool of workforce to join the elderly care industry, i.e. the newly retired or recently widowed adults looking to fill empty hours; college students looking for part-time or other job options; retail or food-service workers looking for more “meaningful” jobs; and homemakers looking to be paid for their caregiving skills (Stone, 2000). In addition, given the wide coverage in the whole territory if non-subsidized CCS is to be flourished; and the potential high demand for in-home services, elder care personnel may easily find service clients or users within their vicinity. This would allow them to attend to both work and family as they could travel just within short distance between work and home.
298. On the other hand, the provision of “real advantage”, career paths, training and opportunities to learn new skills, opportunities for promotion are important measures conducive to higher job satisfaction, and contribute to attract and retain care workers. This is substantiated in the international human resource management practices in the LTC sector (Kane, 2003; Nakhnikian and Kahn, 2004).
299. Similar to the case of RCS, there is also a shortage of nursing professional in the CCS. The shortage of nurses in the RCS was acknowledged in the 2009 RCS study (para. 207 of the Final Report). To increase the supply of nurses serving in CCS, it is recommended that sustained efforts could be made to increase the intake of local training institutes. It is also commendable that the SWD had earlier organised eight classes of full time training programme to train 930 Enrolled Nurses (ENs) for the welfare sector in the period 2006-2011. Two classes of EN training programme for welfare sector will commence in October 2011 and February 2012 respectively. The total of ten classes offers a total of 1,150 training places. In such special training programme, graduates who have received full subsidy by the Government for their tuition fees have to undertake working in the welfare sector for at least two consecutive years after graduation. For the total of 300 graduates of the first three classes, nearly 90% of them have joined the workforce as EN in the welfare sector. Similar special programmes should therefore be launched to increase the overall supply of nurses, some of whom might be able to join the elder care sector.
300. Similarly, in order to increase the overall supply of OT/PT, there can also be increased annual intake of local training institutes (currently 60-70 per year). In fact, the Government had previously resorted to supporting local tertiary institutes in offering “blister programmes” for professional training programmes based on manpower needs. Such programmes may serve to provide extra graduates to meet the manpower demand in the CCS sector.
301. Apart from professional staff like nurses and OT/PT, it is also important to increase recruiting non-professional staff like the H/PCW. At present, 30 training bodies are providing regular training courses on “health care workers”. This could provide an additional avenue or route for people, either young school leavers or middle-aged workers, who intend to pursue a career in elderly / personal care to be trained and thus obtain recognized semi-professional qualifications. Making reference to the Elderly Commission’s earlier initiative, in collaboration with the HA, in implementing a pilot training programme, the Government included elderly care services into the Skills Upgrading Scheme (SUS) in 2003 with 496 classes under 15

modules offered for workers in the elderly care sector to enhance their skills and competence in caring for frail elders. It may also be desirable if similar training could be provided for H/PCW so as to increase the supply of relevant manpower.

302. The Employee Retraining Board (ERB) has also provided Certificate in Personal Care Worker (PCW) Training (起居照顧員證書課程) and Certificate in Elderly Home Care Worker (HCW) Training (家居長者照顧員證書課程). There are also courses on Diploma in Health Worker (HW) Training (保健員文憑課程) that are provided by some NGOs and labour unions free of charge. In the 2009 year, there were some 2,706 enrolled in the PCW/HCW courses with 2,498 completed (92.3%) and some 1,270 attended the HW Training courses with 941 (74.1%) completed. Over the period 2006-2010, there are a total of 13,682 people having attended such training courses by ERB and SUS⁶. It is understandable that not all these course participants would eventually enter the personal care workforce. Nonetheless they could still be a potential pool of manpower if the private and/or self-financed CCS service is to be expanded in the future.
303. At the same time, the Education Bureau launched in 2008 a Qualifications Framework (QF) in Hong Kong. The QF serves as a platform to promote lifelong learning, and provides a comprehensive network of learning pathways. The QF is also underpinned by a robust quality assurance mechanism so as to ensure that only the quality assured qualifications and the associated learning programmes will be recognised under QF. At present, 16 industries, covering over 40% of the total labour force in Hong Kong, have joined the QF. It would be desirable to extend QF to cover elderly care service industry, which would help facilitate further education and training of the in-service personnel and attract more people to join the sector, in return helping to relieve the manpower shortage problem.
304. In addition to increasing the supply of graduates of elder care staff at various levels, there is also the need to improve the salary and working condition of NGO, to make it more comparable to those offered in the hospitals. In addition, there should also be efforts in promoting “job enrichment”, “job rotation”, enhancing promotion prospects by developing prospective career ladder, and the like. Specifically, there can be the development of “Nurse Practitioner” (NP), especially that of a “Geriatric Nurse Practitioner” (GNP) who is an advanced practice nurse who specializes in elderly adult care; which could be a possible strategy to retain nurses. These would contribute both to attract and retain staff in the industry. Reference could be made to the SWD’s provision of special funding arising from the 2008 review on the Lump Sum Grant Subvention System, in which funding was secured from the Lotteries Fund to provide NGOs with additional resources for a limited period of time.
305. In fact, in tackling the problem of shortage of formal care staff in LTC services, there could be the possible consideration of introducing **“Protocol-based care”** in the service delivery process. The term actually can be used to refer to a wide variety of clinical care processes, including algorithms, care pathways, clinical guidelines, procedures and patient group directives. It can also be applied in two different ways. First, it can be used in generic health care contexts where protocols, pathways or guidelines are used as tools by the multidisciplinary team or individual professions, to standardize and co-ordinate care processes. Secondly, it can be used in situations where there is delegated authority and accountability for specific clinical processes; and such delegation might involve devolving authority from

⁶numbers in this paragraph expressed in “person-time”(人次), information provided by LWB.

doctors to nurses or from nurses to health care assistants (Ilott, Rick, Patterson, Turgoose & Lacey, 2006). If there could be clear job descriptions, further supported with ample training and monitored through competence assessments, there could be the possibility of devolving some of the tasks “downward” to less skilled care workers, e.g. H/PCW, which would, firstly, reduce the time and resources needed in training up skilled professional staff; and secondly, absorb recruits with relatively lower educational qualifications.

3bii) Enhancing the caring skills of DHs

306. With increased labour force participation by women, there is a gradual decrease of the caring capacity of the family in taking care of older family members. Many Hong Kong families have resorted to the “importation” of FDH or the engagement of local DH (LDH) to share or even substitute the family members’ caring responsibilities. While some of them might have undertaken some training on performing domestic household duties, they may not necessarily be well equipped with the specific caring knowledge and skills in taking care of frail older people.

307. As revealed in the survey of the present study, many family caregivers who had employed FDH for taking care of elder at home alleged that their FDH were lacking caring skills; and there was communication problem between the elder and the FDH. These indicate that there is also need to provide training to DHs (including FDHs and LDHs). Currently, some NGOs have provided training on elderly care, that could also benefit DHs. Efforts should be made to promote awareness amongst the employers of DH to encourage their DH to attend such training.

308. The Government may consider some collaborative projects between the relevant Government departments, like the Immigration Department, the Labour Department and SWD and the NGOs, in providing tailor-made training classes conducted in various languages suitable for different types of DHs. Furthermore, in order to ensure the DHs are well equipped with the necessary elderly care skills, perhaps Hong Kong may need to consider taking reference from the experience of Japan and Taiwan in which the DHs who serve as elderly caregivers are required to undertake training and obtain a license for their practice.

309. While encouraging DHs to receive training on elderly care, there should also be corresponding efforts in mobilizing neighbours to serve as elder sitters when the DHs attend such training classes.

3biii) Mobilizing neighbours in providing support

310. Informal caregivers such as neighbours could be a viable source of “human resource” that provide additional support supplementing the formal professional care providers. There could be a good mix of volunteers and informal caregivers whom are given some monetary reward for the provision of low-end personal support in such aspects as “elder-sitting”, escort to clinics, grocery service, and the like.

311. The Elderly Commission has since 2008 launched the “Pilot Neighbourhood Active Ageing Project” to promote neighbourliness and mutual help and support amongst neighbours, especially in view of the need to provide timely support and assistance to older persons living

alone in the community. The Project had successfully mobilized some 12,400 volunteers and served some 95,000⁷ elderly people through home visits, outings and interest classes (LWB, 2010). This proves the viability of neighbourhood support network in elderly care.

312. In developing neighbourhood support for older persons, reference could be also made to the SWD's 3-year pilot project "Neighbour Support Childcare Programme" commenced in 2008. In such a programme, neighbours are paid honorarium to provide care and attention to children below the age of six from 7 am to 11 pm during weekdays and occasionally on weekend / public holidays. In the case of "elder-sitting", either the neighbours go to the older persons' home or alternatively escort the older persons to their own home within the vicinity, say on the same floor or the same building; so as to avoid the travelling to and from the service centre. This would avoid the hassle of the older persons during travelling.
313. The mobilization of neighbours to serve as informal caregivers may also serve an economic function of promoting employability of some low-skill workers or homemakers who would like to have additional income. This would also contribute to promote local economy, especially in some old urban areas and old PRH estates with high concentration of older people and low-income households, by improving their financial condition. Reference could be made to the EasyHome service operated by the Senior Citizen Home Safety Association (SCHSA) in recruiting homemakers via the Employee Retraining Board (ERB) and Vocational Training Council (VTC).
314. In fact, the availability of homemakers and job-seekers in such old urban areas with high concentration of older people would be a considerable market opportunity for social enterprises (SE) to tap on and develop a business model on self-financing/private CCS with ample supply of clients and manpower. Perhaps the Government may provide further support to the sprouting SE as mentioned in part 3ai) above.
315. However, in the effort in mobilizing neighbours or community lay people as additional manpower in providing support to older people, there should be measures to address the problem of providing insurance coverage for these helpers in case of injury or other accidents. As revealed from informant interviews of the present study, some NGOs are reluctant to "employ" these "casual" workers as home care workers, and that family members who need some casual home helpers are also concerned about the trouble of "buying insurance" for these ad hoc helpers, even at a low price of \$50.
316. Furthermore, there should also be clear division of labour between formal care providers and volunteers, specific expectation, recruitment, training, service matching, evaluation, support and monitoring, that are all imperative in mobilizing and utilizing neighbours and volunteers in the provision of such informal help.

3c): Promoting public awareness of CCS

317. From interviews with service providers and applicants for subsidized LTC services and other contacts, there is considerable prevalence of public conception that applying for subsidized RCS is a kind of "insurance" or assurance that such service could be provided when need arises. As revealed from both the SWD and the RCS applicants, there are quite often cases

⁷both numbers expressed in "person-time"(人次), information provided by LWB.

that applicants rejected or postponed the offer of a subsidized RCS place based on the reason that they would still remain living in the community / domestic setting. This might reflect that there might be a certain degree of over-estimation of the current waiting list for subsidized RCS, but a genuine demand for more CCS.

318. In view of this, there could be room for improvement in promoting public education in changing people's (including both the elderly applicants and their family members) conception in the application of subsidized RCS. That is, if provided with sufficient and appropriate subsidized CCS (in kind or in voucher), there can be a viable alternative to refrain from waiting for subsidized RCS.
319. The present study reveals that a substantial portion of the older people's family caregivers claimed that they did not know about the community resources that can facilitate them to take care of their frail elderly family members at home. This is due primarily to the unavailability of private market provision of CCS on the one hand, and the inadequacy of publicity by subsidized CCS operators. The latter may also be attributable to the fact that existing CCS operators are already working at full capacity and some are even having a long waiting list of applicants and so they are not apt to further publicize or promote their services. Although there are some NGOs that provide self-financed CCS, their relatively small scale might render public accessibility inadequate. On the contrary, the availability of a substantial number of private operators in the RCS has made RCS more easily "accessible" to the general public and the older people and their family members in particular. It might account for the high institutionalization rate and the comparatively lower service volume or number of users in CCS in Hong Kong.
320. Thus, there is need to promote the provision of CCS by a number of possible strategies, including the further increase of subsidized CCS, the support to NGOs in operating self-financed CCS and the encouragement of private CCS operators. With the increased supply of CCS in the community, there is also the corresponding need for increasing publicity, public education and provision of readily available information to the public, the older people and their family members. This would provide alternative choice for people to choose CCS rather than RCS when need arises.
321. Learning from the overseas experience in the provision of readily accessible information to older people, there is merit in further promoting the setting up an "elderly portal" that provides comprehensive information related to the various aspects of elderly people, including CCS. The "eElderly" website operated by the SAGE, commissioned by the Government's Office of the Government Chief Information Officer (OGCIO), may be a good starting point for this. Alternatively the current government hotline (1823) may be further developed and enhanced as to provide a one-stop inquiry / access to information related to elderly services. This is to be reckoned that there is yet a relatively low utilization rate (about 10%) of the internet among older people (C&SD, 2009).

CHAPTER SIX OTHER PERTINENT ISSUES

322. In the development of a sustainable model of CCS provision in Hong Kong, there are a couple of pertinent issues that are related to the context of Long Term Care (LTC) services in Hong Kong that should be further explored and examined by the Government. These issues relate to the following areas: 1) fostering elderly-friendly infrastructure, and 2) improving services for older people suffering from dementia.

Issue 1: Fostering elderly-friendly infrastructure

323. The sustained development of a viable system of CCS in the community actually requires other policy measures in fostering an “elderly friendly” environment. This boils down to the availability of premises for the provision of CCS, barrier-free community environment, accessible transportation to enable elderly people’s accessibility and thus community engagement; and a sustainable LTC financing system.

324. The present study reveals that many CCS operators would hope to have larger premises in providing a spacious environment in operating their CCS. This would enable the staff to have a better working environment, and allow more space for the day-care service users to have activities and social interaction. As suggested in Chapter 5, it is recommended that the Government could provide more premises to NGOs, e.g. in the Housing Department’s public rental housing estates. On the other hand, if non-subsidized CCS is to be promoted, there is also need to have ample supply of venue in the community. However in the current Planning Standard and Guideline (PSG), although there are provisions for elderly centres and day care centres/ units, there are no designated provisions for other community care service facilities. It would be desirable if the PSG could be reviewed to add designated standards for the provision of CCS in the community.

325. Furthermore there is also need to further promote the barrier-free community facilities and environment to enable older people to have more convenient access within the community. Specifically, the Government may further promote the adoption of “Universal Design” and barrier-free access in public and private premises and community facilities to enhance the mobility of older people. Greater efforts in enforcing the provisions of the Building Ordinance in obligatory and recommended design requirements would be desirable. The Government may also consider stipulating requirements for public transportation operators in providing more elder-friendly access facilities and concessionary fares to older passengers.

326. As revealed from the interviews with both the elderly service users and their family caregivers, there is urgent need to expand the scope of transportation services to enable older people to attend medical appointments and day care services.

327. Currently, elderly people and people with physical challenge could hire Rehabus service provided by the Society of Rehabilitation which is a subvented service. However due to huge demand from such a diverse and large group of users, there is always a long waiting time for the users. There may thus be the need to review the current provision of subvention to this service, or to designate specific transportation service for elderly users.

328. On the other hand, there could be the promotion of similar accessible car services provided by the private sector or social enterprise. The recent launch of the “Diamondcab” service could be a good reference. The DiamondCab is introduced by a venture philanthropic organization in partnership with taxi owners and drivers by the end of 2010. Currently there are only five cabs in total but the company has planned to increase to 20 cabs in the near future. Similar to other taxis, such cabs can take a maximum of five passengers in a single trip, or it can accommodate two wheelchair users with their two carers.
329. In fact, making reference to overseas experience in which such accessible cars can also be used not only for attending medical appointments or therapeutic treatments there may be the merit in promoting the provision of such transportation services, operated either by NGOs or private operators on a self-financing basis, to provide such ancillary services. This could also be one of the possible channels on which the proposed CCS voucher be used, so as to promote the older persons’ accessibility and community participation.
330. On the other hand, due to escalating community demand for CCS service that has overwhelmed the capacity of the operators, there is a need to increase the provision of transportation so that the home care staff could deliver their services more efficiently. For instance, additional resources could be provided to CCS operators to purchase or rent vehicles in delivering their staff to reach to the service users, so as to reduce their traveling time on public transportation.
331. The issue of sustainability of LTC financing is also an important element in the development of an elderly-friendly infrastructure. In view of the increasing demand for LTC services, including CCS, there may be a need to explore the possible establishment of Long Term Care Insurance (LTCI).
332. The Government has in the past decades been exploring the possibility of developing health care insurance. Most recently, in 2008, the Government published the Healthcare Reform Consultation Document that provides six options for providing supplementary financing for healthcare (Food and Health Bureau, HKSARG March 2008), in which three of them are insurance. In the second stage of public consultation, the Government proposed the Health Protection Scheme (HPS) which aims to make available government-regulated health insurance to provide better choices to those who choose private healthcare services. The Government also acknowledges the possible difficulties faced by the older people in engaging in health insurance and thus has proposed to provide some financial support for older people to enter into health insurance policies.
333. It is to be reckoned that there is close relationship between the “cure” (health service) and “care” (long term care) aspects for the older people. A good interface between health and LTC insurances would help to provide a viable safety net for protecting the older people in their health issues in both acute and chronic aspects. Nonetheless, it is observed that there is yet a mature “market” for health insurance for older people as the coverage of health insurance amongst older people has been rather low: there were only 8.2% in 2008 and 10.2% in 2009/10 elderly (aged 65 and above) covered by medical insurance, in which more than half of the insurance were purchased by their employers; and that only 3.5% of elderly in 2008 and 4.9% in 2009/10 respectively purchased medical insurance individually (C&SD, 2009; 2010). The LTCI is an even more novel concept in Hong Kong and amongst the older people in particular. Thus, there may be a need to further explore the possible interface between the

two streams of insurance as they have different stages of development in the local context. There is also the need to launch more public education regarding the nature, merits and limitations of various types of insurance schemes, so as to gauge public receptivity in the long run.

Issue 2: Improving services for older people suffering from dementia

334. One of the potential challenges to the development of CCS is the increasing number of older people suffering from dementia. There is need to explore the possible implications in CCS service planning and delivery.
335. Cognitive impairment, including dementia, is one of the main factors predisposing older persons to be admitted to long term institutional care (Woo et al, 2000; cited in Yu, et al., 2010:80). A recent study estimated that the figures for older person living in institutional care homes suffering from dementia is estimated to increase from 19000 in 2010 to 48000 in 2036. On the other hand, the number of community-dwelling older people (aged 60 and above) with dementia will increase from 86000 in 2010 to 225000 in 2036 (Yu, et al., 2010). Another study on all the 59 government-subsidized day care centres also reveals a high proportion (44%) of the 1420 day care centre users were suffering from dementia (Jockey Club Centre for Positive Ageing and HKCSS, 2010).
336. A local study has shown that primary informal caregivers for older people suffering from dementia have worse health, more doctor visits, anxiety and depression, and weight loss compared with non-caregivers, and that all domains of health-related quality of life were adversely affected (Ho et al. 2009, cited in Yu, et al., 2010:80). The “burnout” suffered by family caregivers may be one of the possible reasons giving rise to the eventual placement of older people suffering from dementia into RCHE.
337. It was found that social interaction was one of the care needs of those people in the middle stages of dementia (Chung, 2006). Day care centre can provide a setting for people suffered from dementia to have social interaction. Also, day care programmes have been proved to maintain the level of the quality of life and cognitive and self care ability of elders with dementia and lower the burden of family carers (Kwok, Ho & Li, 2009). According to another study (Chan, Mok, Wong, Pang & Chiu, 2010), carers of those with milder dementia preferred day care facilities to other support services, say home care, respite services, etc. The programmes have further been shown to reduce behavioural and psychological symptoms of dementia (BPSD), the rate of functional decline, and caregiver stress. An overseas study also shows that day care centres can benefit elders with dementia, such as being more relaxed and more responsive. (Abramowitz, 2008). Furthermore, the use of telemedicine may enable a professional to provide group cognitive training programmes from a remote site (Poon et al, 2005; cited in Yu, et al., 2010:80) while the older person may remain living at home.
338. Thus, if provided with appropriate and adequate CCS, older people suffering from dementia may be able to slow down their deterioration rate, and thus prolong the period of their staying at home together with their family members. Currently, there are yet no subsidized services specifically tailored to the community-living older people suffering from dementia, while there are some self-financing day and community care services operated by NGOs. It is recognized that the Government, in the Budget 2011/12, has recognized the need to support

to demented elderly attending Day Care Centre by extending the applicability of “dementia supplement” to this group of users, in addition to the original beneficiary of RCS users. However, it might be desirable to explore the possible extension of provision of such supplements to other CCS services, including the home-based services like EHCCS and IHCs(FC), so that the service operators could have more resources to be deployed to serve the home-bound elderly people suffering from dementia.

339. In view of the merit of prevention and early intervention, it would be desirable to explore if the DECCs can serve as “front desk”, as mentioned in Chapter 5, to perform the function of early identification of older people suffering from dementia. The DECCs may also serve to provide the necessary information and training for family members in detecting the early symptoms of dementia and providing timely and necessary care for their family members suffering from dementia.

340. Making reference to overseas experience (e.g. in Australia) in setting up dementia day care centres, there might be merit in exploring the setting up of such centres in Hong Kong. As revealed from informant interviews with family carers and service operators, there could be problems of disturbing behaviours by demented elderly upon other Day Care Centre users, especially with the limited space in such centres. However, there should also be prudent considerations as to the relative merit of a specialized dementia centre vis-à-vis an integrated centre with a mixture of different user groups, with respect to concerns about segregation versus social inclusion.

*****End*****

List of Informant Interviews

	Organization
1.	Home of the Elderly Research Society for Elderly Services 長者家安老服務研究社
2.	Haven of Hope Christian Service
3.	Jockey Club Centre for Positive Ageing (Dementia service)
4.	Christian Family Service Centre
5.	Senior Citizen Home Safety Association
6.	Hong Kong Alzheimer's Disease Association
7.	Community nursing, HK West Cluster, HA
8.	HK Chinese Women's Club
9.	SKHWC - Cyril and Amy Cheung Aged Care Complex
10.	Hong Kong Social Workers' General Union
11.	Hong Kong Council of Social Service
12.	Hong Kong Housing Society
13.	St. James Settlement (Dementia service)
14.	St. James Settlement
15.	Bamboos Professional Nursing Services 百本專業護理服務
16.	The Elderly Services Association of Hong Kong 香港安老服務協會
17.	Yan Oi Tong
18.	The Evangelical Lutheran Church of Hong Kong
19.	Monitoring Alliance on Elderly Policies 長者政策監察聯席
20.	CADENZA Hub
21.	工聯會 - 商業機構及家居服務從業員協會
22.	Baptist Oi Kwan Social Service - integrated health service for the elderly
23.	Hong Kong Family Welfare Society
24.	Community Care and Nursing Home Workers General Union 職工盟 - 社區及院舍照顧員總工會

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