Feasibility Study on Introducing a Voucher Scheme on Residential Care Services for the Elderly

Final Report

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GLOSSARY

Abbreviation code	Description
C&A	Care and Attention Homes
CCS	Community Care Services for the Elderly
CoC	Continuum of Care
CSSA	Comprehensive Social Security Allowance
CCSV	Pilot Scheme on Community Care Service Voucher for the Elderly
CWL	Central Waiting List
DA	Disability Allowance
EBPS	Enhanced Bought Place Scheme
EC	Elderly Commission
HDA	Higher Disability Allowance
IFSC	Integrated Family Service Centre
LORCHE	Licensing Office of Residential Care Homes for the Elderly
LTC	Long-term Care
LWB	Labour and Welfare Bureau
MMDHI	Median Monthly Domestic Household Income
NGO	Non-government Organisation
NHPPS	Nursing Home Place Purchase Scheme
OAA	Old Age Allowance
OALA	Old Age Living Allowance
OECD	Organisation for Economic Co-operation and Development
OT	Occupational Therapist
PT	Physiotherapist
RCHE	Residential Care Home for the Elderly
RCHE Ordinance	Residential Care Homes (Elderly Persons) Ordinance (Cap 459)
RCS	Residential Care Services for the Elderly
RCSV	Residential Care Service Voucher for the Elderly
RSP	Recognised Service Provider
RW	Responsible worker/referring worker
SCNAMES	Standardised Care Need Assessment Mechanism for Elderly Services
SWD	Social Welfare Department
The Study	Feasibility Study on Introducing a Voucher Scheme on Residential Care Services for the Elderly

EXECUTIVE SUMMARY

Background of study

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

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

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

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

Aims and objectives

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

   a) to assess the feasibility and desirability of introducing a voucher scheme on RCS, having regard to the potential benefits of such a scheme, whether such a scheme would bring about unintended and undesirable consequences, the market capacity, the practicability of such a scheme, the expected response from elderly persons with LTC needs and other stakeholders, as well as other issues identified in EC's 2009 study report on RCS; and

b) to draw up the details of a pilot scheme on RCSV if the feasibility and desirability of introducing RCSV can be established; including eligibility criteria, types of service providers and scope of services to be covered by the pilot scheme, voucher value, co-payment mechanism and means-testing mechanism, quality assurance requirements, and how the pilot scheme should be implemented and assessed.

Methodology

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

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

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

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

proportion of the type of homes in the population and the corresponding response rate of each type of home to ensure representativeness.

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

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

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

Current and planned provision

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

13. As at 31 July, 2015, there were 156 subvented/contract homes and 143 private RCHEs providing 26 384 subsidised places; and 74 subvented/self-financing/ contract homes and 546 private homes providing 47 022 non-subsidised RCS places in Hong Kong. A majority (64%) of RCS places was non-subsidised, including 57% offered in the private sector; and subsidised places occupied 36% of the total supply.

14. A multi-pronged approach was used by the Government to provide additional subsidised RCS places. According to information available at the end of 2015,

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

Issues pertinent to the provision of RCS

Ageing population and rising RCS needs

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

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

Financing

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

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

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

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

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

21. A significant percentage (estimated to be around 80%) of elderly persons residing in non-subsidised places in the private RCHEs are CSSA recipients, receiving an average of around $7,600 per month[2]. They have very limited resources and there is little incentive for the family to top up for better RCS. As a result, many private RCHEs could only peg their services to CSSA rates, and thus have low incentive to upgrade their services.

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

Overview on the use of voucher as a form of subsidy

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

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

25. Voucher, as a kind of 'consumer-directed care', is often used to encourage elderly to age in place or for their family caregivers to take care of the elderly in their own homes. A number of economies with similar social and economic development with Hong Kong are reviewed and benefits in cash for LTC are

[2] Figure as at 30 September 2015.

found to be available in United Kingdom, United States, Germany, the Mainland and Taiwan. Experiences outside Hong Kong show both potential benefits and undesirable effects.

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

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

Willingness to consider RCSV and views on means test

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

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

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

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

RCSV when needs arise were also taken into account.

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

Views on fixed amount/sliding scale of voucher subsidy

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

Willingness to top up for enhanced or additional service

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

CSSA status and willingness to give up CSSA for RCSV

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

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

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

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

staffing and space standards to meet the suggested EA1 standard, 63% of EA2 homes and 33.6% of non-EBPS private homes indicated their interest as an RSP.

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

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

Views expressed in public engagement

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

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

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

Feasibility and desirability of introducing RCSV

40. As stated in paragraph 29, 11.8% of all respondents showed relatively strong inclination to consider opting for the RCSV with means-test. This would increase to 15.2% if those who alleged themselves having no immediate need

but would consider RCSV when needs arise were also taken into account. The interest of another 35.3% of the respondents would depend on the actual design, in particular the means test, of the scheme. Overall, the interest on the RCSV was moderate among all respondents.

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

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

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

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

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

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

<u>Avoiding premature or unnecessary institutionalisation</u>

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

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

Impact on pricing and service quality

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

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

A proposed pilot scheme on RCSV

Objectives of the pilot RCSV scheme:

51. The main objective of the pilot RCSV scheme is to test the "money-following-the-user" approach in subsidised RCS. Having regard to the analysis on the potential benefits of RCSV, this means that the pilot scheme should be designed in order to test whether RCSV can:
    (a) provide elderly in need with a viable alternative for financial support other than CSSA so that they may receive RCS from eligible private or NGO-run RCHEs;
    (b) allow those financially more capable elderly and their families to share part of the service costs in accordance with their financial ability;
    (c) offer eligible elderly a wider choice of RCS, thereby better utilising the capacity of private RCHEs and enhancing their service quality; and
    (d) encourage the overall participation of private and self-financing RCHEs in the provision of elderly services, with a view to making available more quality care places in the medium to long term.

Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommended levels of co-payment

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

* MMDHI - Median Monthly Domestic Household Income

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

[6] The co-payment arrangement recommended is applicable to the voucher value only.

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

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

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

<u>Recommendation 17</u>: CSSA recipients opting for the RCSV should withdraw from CSSA.

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

<u>Recommendation 19</u>: A monitoring mechanism should be introduced to ensure service quality of RSPs. Visits, random checks, audit on files and records and complaint investigation, etc. should be conducted. Warnings may be issued and sanctions (e.g. suspension or termination of RSP status) may be imposed if an RSP has breached the service agreement. The RSP should be required to join a Service Quality Group (SQG) and be monitored by community stakeholders.

[7] $45,500 at the time of the preparation of the report.
[8] $484,000 at the time of the preparation of the report.

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

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

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

Other issues

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

Evaluation of pilot scheme

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

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

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

CHAPTER I: INTRODUCTION

Background of the study

54. In view of the increasing demand for subsidised RCS, in 2008, EC commissioned a Consultancy Study on Residential Care Services for the Elderly to explore how to: (i) target subsidised RCS at elderly persons most in need; (ii) promote further development of quality RCS in the non-subsidised sector; and (iii) encourage shared responsibilities among individuals, their families and the society in meeting the LTC needs of the elderly. Report on the study was released in 2009. One of the issues studied was whether a means-tested voucher scheme on RCS could be introduced to meet the LTC needs of our ageing society in a sustainable manner.

55. While the study suggested that RCSV would bring about a number of merits, it was also noted that if RCSV was implemented without viable CCS, it might bring about undesirable consequences such as pre-mature or unnecessary institutionalisation due to induced demand. The consultant team therefore recommended the Government to consider strengthening CCS first.

56. To follow-up on these recommendations, in 2010, the EC commissioned another study – the Consultancy Study on Community Care Services of the Elderly, to explore, among others, measures to strengthen CCS and to support the Government policy of 'ageing in place as the core, institutional care as back-up'. The consultancy report was released in 2011 and one of the recommendations was the introduction of a voucher scheme on CCS. This recommendation has been taken on board by SWD and a 4-year CCSV was implemented in September 2013. The Second Phase of CCSV, with a number of improved features including increased number of vouchers, wider choice of service package and providers, etc., will be implemented in 2016.

57. With CCSV underway, it is considered opportune to explore the feasibility of introducing a similar scheme for subsidised RCS. In the 2014 Policy Address, the Chief Executive has tasked EC to study the feasibility of introducing RCSV.

58. In July 2014, the LWB, on recommendation of EC, appointed a consultant team from the Department of Social Work and Social Administration, The University of Hong Kong, to assist EC in conducting the Study.

Aims and objectives

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

Methodology

60. Multiple methods were adopted in achieving the above objectives, including pre-survey focus groups and interviews, questionnaire surveys, secondary data analysis and public engagement. Details are as follows:

<u>Pre-survey focus groups and interviews with stakeholders</u>

61. The purpose of the pre-survey focus groups and interviews was to explore stakeholders' reactions to the general framework, issues, and wordings of items to be covered in the survey, which were then used to develop and fine-tune the questionnaires, ensuring that the questions are relevant and precisely posed, and the information collected could accurately reflect the views of the respondents.

62. Four focus groups and two individual interviews were conducted with elderly persons on CWL and carers of such elderly persons in September 2014 and a total of 20 individuals participated. The focus groups and interviews were organised with reference to the parameters below:
    a) Community-dwelling/living in institution
    b) Recipients/non-recipients of CCS
    c) CSSA recipients/non-CSSA recipients
    d) Elderly persons/carers

63. Questions asked included the conditions under which an application was made for LTC, factors affecting their decision to remain in the community or be admitted to an RCHE, factors considered when choosing the type of RCHE to be admitted to, as well as preliminary view on issues including the concept of 'money-following-the-user', means testing, co-payment and support needed for ageing in place.

64. Semi-structured interviews were also arranged with key informants, including:
    a) Operators of private homes, including those under EBPS;
    b) NGO operators providing non-subsidised services;
    c) Licensing Office of Residential Care Homes for the Elderly (LORCHE);
    d) Accreditation bodies; and
    e) Frontline workers

    (A list of parties interviewed can be found in Appendix I).

    The purpose of the interviews was to get an overview of the stakeholders' perception on the current provision of RCS (e.g. demand and supply of different types of services, service quality and room for improvement, etc.) and the possible implications that a 'money-following-the-user' approach could have on service providers, service recipients, and quality of services provided.

65. Views collected from the pre-survey focus groups and semi-structured interviews were used to fine tune the content and design of the questionnaires. These views were also taken into consideration when developing the recommendations on the pilot scheme.

<u>Questionnaire surveys</u>

66. To address objectives a) and b), two questionnaire surveys were conducted with potential users and service providers of RCSV respectively; namely, elderly persons on CWL and RCHEs providing non-subsidised places.

Survey on elderly persons on CWL

67. The purpose of the questionnaire survey was to collect data on elderly persons on CWL in the following aspects:
    a) socio-demographic profile and health status;
    b) existing care arrangement and expectations on RCS;
    c) interest in RCSV;

d) attitudes to means-testing for RCSV and willingness for/affordability in co-payment and top-up; and
e) for those living in an RCHE, the current costs and source(s) of payment, and the possibility of switching to a better service provider if RCSV were in place.

68. *Sampling:* Sample population of the survey was older people on CWL waitlisted for subsidised C&A or NH. A stratified systematic sampling methodology was used and 12 strata were formed based on the following parameters:
    a) Care arrangement (domestic/institutional; receiving/not receiving CCS)
    b) CSSA status
    c) C&A or NH waitlist status

69. In addition to the three parameters above, it was noted that some elderly persons who were assessed to be eligible for RCS (either 'RCS only' cases or 'dual option' cases) had chosen to receive CCS and agreed to temporarily put their application on hold (this type of cases are commonly known as be 'inactive' cases[11]). Since it was assumed that older people who were 'inactive' would have different considerations from "active cases", an additional stratum for "inactive cases" was included in the sample and thus a total of 13 strata were used.

70. Carers of the elderly persons are also key stakeholders in RCS. In EC's study on RCS in 2009[12], a substantial number of carers were interviewed as proxy because the elderly persons selected had limited cognitive ability to answer the questions. The questionnaire survey for elderly persons therefore included questions for carers so that information from carers could be gathered when the respondent was a proxy.

71. The target sample size was 1 500. Taking into account the estimated consent rate of the sampled cases to participate in the survey, to meet the target of the expected successful cases in each stratum, a total of 3 951 samples, in two

[11] 'Inactive cases' will not be called for admission to subsidised RCS places until they reactivate their applications. Going 'inactive' would not affect an elderly person's priority on the CWL.

[12] Chui, W.T.E. et al (2009*). Elderly Commission's study on residential care services for the elderly.* Elderly Commission, HKSAR. In this study, the percentage of proxy (family carers) for the samples for 'only waiting for RCHE' (including community living and living in private RCHE) is 64.5% and those waiting for RCHE and using CCS is 54.2%.

batches[13], were drawn from the 13 strata, and the expected number of cases successfully interviewed was 1 545[14]. Table 1.1 illustrated the sampling frame and the expected number of successful cases in each of the strata. Appendix II provides a detailed description of the sampling frame.

72. Verbal consent to participate in the study was first sought via the RWs of the respective cases. Cases that had given verbal consent either by him/herself or by the carer/proxy were then contacted to arrange a face-to-face interview. The location of the interview was either at the elderly person's home or at a place proposed by the interviewee. For cases which gave consent to be interviewed but the interviewee preferred not to do it face-to-face due to personal reasons and/or difficulties in arranging a suitable time, telephone interviews were conducted instead.

Table 1.1: Sampling frame and expected number of successful cases for questionnaire survey with elderly persons on CWL

Parameters			**Type of RCHE waitlisted for**	
			C&A	**NH**
			Expected number of successful cases	
Non-CSSA	Domestic	Not receiving CCS	108	129
		Receiving CCS	113	145
	Institutional		116	116
CSSA	Domestic	Not receiving CCS	115	77
		Receiving CCS	145	59
	Institutional		118	104
Inactive cases			200	
Total			**1 545**	

73. <u>*Survey design*</u>: Three sets of structured questionnaires were constructed for the following targets:

a) Type A: Elderly persons living in the community and using CCS
b) Type B: Elderly persons living in the community and not using CCS
c) Type C: Elderly persons living in institutions

[13] Due to the lower than expected success rate in arranging face-to-face interviews with consented cases, a second sample had to be drawn to make up for the targeted success case of 1 500. The number of 3 951 is the total number of cases selected from 2 sampling exercises.
[14] This is the nearest total number of cases to the target of 1 500 from the 13 strata.

Table 1.2: Sampling frame and questionnaire type

Parameters			Type of RCHE waitlisted for	
			C&A	NH
			Type of questionnaire	
Non-CSSA	Domestic	Not receiving CCS	B	B
		Receiving CCS	A	A
	Institutional		C	C
CSSA	Domestic	Not receiving CCS	B	B
		Receiving CCS	A	A
	Institutional		C	C
Inactive cases			A, B, or C	

74. The questionnaires were designed to collect information of the respondents on the following areas:
    a) Existing care arrangement and factors affecting care decisions;
    b) Usage of CCS and preferences;
    c) Attitudes toward proposed RCSV, means test, co-payment, top-up; and
    d) Socio-economic background.

75. The questionnaires were constructed in parallel with the pre-survey focus group interviews. Information obtained from the focus groups was used to fine tune the draft questionnaires to ensure that the questions constructed would be able to capture all possible scenarios and the spectrum of possible responses from the cases. A pilot test was conducted on 10 elderly persons, the results of which supported that there was no need for major adjustment to the questionnaire and the survey procedure.

Survey on RCHEs

76. The purpose of the survey was to collect information on the capacity and the attitude and readiness of RCHEs providing non-subsidised places towards the proposed RCSV. Information collected included capacity and vacancy status of the home, interest and readiness in accepting users of the proposed RCSV, intention to upgrade service standard and joining accreditation scheme(s).

77. *Sampling:* All RCHEs providing non-subsidised places as at the end of September 2014 were included in the sample. The total number of cases was 622.

78. *Survey design:* Assuming that the extent of the interest of operators providing non-subsidised places in RCSV varied with the type of RCHEs; five sets of questionnaires were constructed for:
    a) Private homes not under EBPS
    b) EA2 EBPS homes
    c) EA1 EPBS homes
    d) Self-financing homes
    e) Subvented and contract homes

79. The questionnaires were sent out by mail with a postage-paid return envelope. RCHEs that had not returned the questionnaire after a set time indicated in the covering letter were contacted by telephone to encourage their response. Some RCHEs eventually agreed to complete the questionnaire by phone interview.

Secondary analysis of existing data

80. Secondary data relevant to service demand and utilisation were collected from various government departments either through the corresponding departmental website or by request. Such information was analysed for estimating the service demand, availability of suitable vacancies, and the financial implications.

Public engagement and stakeholders' views on preliminary recommendations

81. After preliminary data analysis on the questionnaire surveys, tentative recommendations on the pilot scheme on RCSV were proposed. Views on the tentative recommendations were collected from various stakeholders through a multitude of means, including:
    a) two public engagement events with a total of 246 representatives from 153 organisations/units (11th and 14th February, 2015);
    b) presentation at the Panel on Welfare Services, Legislative Council (9th February, 2015);
    c) two deputation sessions at the Panel on Welfare Services, Legislative Council (23rd and 28th March 2015);
    d) further meetings with representatives from interest groups (26th March 2015 and 20th April 2016); and
    e) 13 written submissions[15].

[15] 1.爭取資助院舍聯席, 2.中小企國際聯盟安老及殘疾服務聯會李伯英主席, 3.立法會張國柱議員辦事處, 4. 一群關注長者福利及「長者院舍住宿照顧服務券試驗計劃」的長者服務同工 (two separate submissions were received at different time points), 5. 退休社會工作者劉光傑., 6. 鄧國俊, 7. 羅日光, 8. 香港安老服務協會(via LWB), 9. 救世軍華富長者中心 (via LWB), 10. 老人權

82. Views related to the RCSV from the following forums / channel were also noted and taken into account in the proposed recommendations presented in this final report, including:

a) views pertinent to the proposed RCSV received at the 2015 Welfare Agenda and Priorities Setting Exercise (3rd June, 2015),

b) views pertinent to the proposed RCSV submitted to LWB[16] (15th July, 2015), and

c) deputation sessions at the Panel on Welfare Services, Legislative Council on the quality of private RCHEs (23rd July, 2015).

益中心, 11. 關注家居照顧服務大聯盟, 12. 一封由多個團體聯署提供的意見書, 13. 葵涌邨居民權益關注組. Of the thirteen submissions, four were received after the draft final report was endorsed by the WGLTCM. The points raised in these four submissions have been considered and it is noted that they have already been addressed in the draft final report submitted to WGLTCM.

[16] Letter to Secretary for Labour and Welfare from The Elderly Services Association of Hong Kong

CHAPTER II: RESIDENTIAL CARE SERVICES IN HONG KONG

Current and planned provision

83. In Hong Kong, RCS for the elderly are provided through a mix of public and private modes. Subsidised RCS places are provided by subvented/contract RCHEs, as well as bought places from the EBPS and NHPPS that purchase non-subsidised C&A places from private RCHEs and NH places from self-financing RCHEs respectively. Non-subsidised RCS places are mainly provided by private operators, though self-financing homes, contract homes and subvented homes also provide a small portion of non-subsidised places (around 7%).

84. As at July, 2015, there were 156 subvented/contract homes and 143 private RCHEs providing 26 384 subsidised places; and 74 subvented/self-financing/ contract homes and 546 private homes providing 47 022 non-subsidised RCS places in Hong Kong. That is to say, a majority (64%) of RCS places was non-subsidised, of which most (57% of all RCS places, and around 90% of the non-subsidised places) were offered in the private sector; and subsidised places only occupied 36% of the total supply (Table 2.1).

85. In terms of level of care, there are two major types of RCHEs, namely C&A homes and NHs that cater for older people with different levels of frailty. In line with the Government's policy of promoting continuum of care (CoC) in RCHEs, the SWD launched a conversion programme in June 2005 and most of the subvented C&A homes have now been converted to enable the provision of CoC. This could allow the older residents to stay in their original RHCEs without the need to move to NHs when their health conditions deteriorate. The current provision of subsidised and non-subsidised places by service types are tabulated in Table 2.1.

86. Elderly persons who wish to apply for subsidised LTC services can approach an RW at a Medical Social Service Unit, an Integrated Family Service Centre (IFSC) or an elderly service unit and arrange for an assessment on their care needs. After initial screening, eligible applicants will be assessed through the SCNAMES to ascertain their care needs (RCS and/or CCS) and be put on the CWL for matching with appropriate subsidised services. Applicants for RCS may indicate their preferences for a specific home or for homes fulfilling certain requirements, such as the district/region the home is located in, religious

background of the operator or provision of special diet. These preferences will be matched in allocation of service.

Table 2.1: Distribution of RCS places by type of RCHEs (as at 31 July 2015)[17]

Type of RCHE	**Subsidised places[18]**		**Non- subsidised places[4]**		**Total**
	Subvented and contract homes	EBPS (private homes)	Non-profit making self-financing homes/contract homes	Private homes	
C&A	15 062[19]	7 928	3 677	41 970	68 637
NH	3 394[20]	---	1 375[21]	---	4 769
Total (%)	18 456 (25%)	7 928 (11%)	5 052 (7%)	41 970 (57%)	73 406 (100%)

87. The Government has been taking a multi-pronged approach to identify suitable sites and premises for provision of additional subsidised RCS places. SWD has been working with relevant departments/organisations to reserve suitable locations in new public rental housing developments, private housing developments, urban renewal projects, as well as vacant school premises to provide new contract RCHEs. According to information available at the end of 2015, there will be an additional 1 700 subsidised places planned for the period 2014-15 to 2017-18, while locations have been reserved in another 16 projects that are expected to provide another 1 000 subsidised places. Furthermore, the Government has launched the Special Scheme on Privately Owned Sites for Welfare Uses which is expected to provide around 7 000 additional RCS places. That is to say, a total of over 9 000 RCHE places is expected to come into operation in recent years or are already in the pipeline.

[17] Information provided by SWD.

[18] Self-care Hostels for the Elderly and Homes for the Aged are being phased out and no new application is accepted, the existing 67 subsidised places in these homes are not shown in this table and are not discussed in this study.

[19] Including C&A places providing CoC.

[20] Including nursing home places under the Nursing Home Place Purchase Scheme.

[21] Including places provided by self-financing nursing homes purely under the registration regime administered by the Department of Health.

Issues pertinent to the provision of RCS

Ageing population and rising LTC needs

88. Hong Kong is facing the challenge of a rapidly ageing population. According to the 2015-2064 population projection, as compared with 2014, the number of elderly persons aged 65 or above will be more than doubled by 2041, amounting to 2.49 million by 2041 and representing 30.3% of the total population[22]. The life expectancy of people in Hong Kong is also increasing, that is to say, among those aged 65 and above, the proportion of those who are older; and thus, likely to be more frail and needing RCS, would be increased (Table 2.2).

Table 2.2: Projected mid-year population of people aged 65 and above[23]

	2014		**2018**		**2022**		**2035**		**2041**	
	'000	***%***	***'000***	***%***	***'000***	***%***	***'000***	***%***	***'000***	***%***
65-69	326.5	4.5	433.3	5.8	514.4	6.7	510.7	6.3	488.5	5.9
70-74	211.8	2.9	281.8	3.8	401.7	5.2	580.4	7.1	491.5	6.0
75-79	209.5	2.9	192.2	2.6	230.1	3.0	520.9	6.4	533.9	6.5
80-84	165.1	2.3	173.9	2.3	165.3	2.2	365.4	4.5	465.8	5.7
85+	153.0	2.1	194.3	2.6	224.2	2.9	346.0	4.3	509.6	6.2
Total	*1065.9*	*14.7*	*1275.5*	*17.1*	*1535.7*	*20*	*2323.4*	*28.6*	*2489.3*	*30.3*

89. Although for a large majority of the elderly persons, ageing at home or in the community with the continuous support of their family members, friends and neighbours is more preferable than being cared for in RCHEs, and it is the Government's policy to promote 'ageing in place', there are still elderly persons who are so frail that their care needs cannot be met by CCS (e.g. those with more severe cognitive/functional impairment). For these elderly persons, RCS would still be a necessary option[24,25].

[22] Census and Statistics Department (2015). Hong Kong population projections 2015-2064. Retrieved from: http://www.statistics.gov.hk/pub/B1120015062015XXXXB0100.pdf

[23] The projected figures exclude foreign domestic helpers.

[24] Lou, W.Q.V. et al (2009). Characteristics of elderly people who prefer to stay in the community. Asian Journal of Gerontology & Geriatrics, Vol.4 (1).

[25] Chi, I. et al (2011). Factors affecting long-term care use in Hong Kong. Hong Kong Medical Journal, v.17 n.3, suppl.3, p.8-12.

Financing

90. The Government has been allocating substantial resources every year for the provision of elderly services. In 2014-15, the SWD spent $3.92 billion in the provision of subsidised RCS, an increase of 95.5% since 2004-05[26]. For NGOs, the Government provides direct and/or indirect subsidies for the provision of subsidised RCS, including a) provision of premises charged at a highly subsidised rate; b) provision of capital costs (such as construction, fitting-out, furniture and equipment); and c) operating cost (such as staff remuneration and programme expenses). In the cases of subsidised places provided in private homes, government subsidies are provided through EBPS to up to 50% of the places in a private RCHE. Among all RCS places in private homes, around 16% are subsidised.

91. In addition, substantial portions of older person living in non-profit making or private RCHEs are receiving CSSA. This also constitutes an indirect subsidy by the Government on RCS. The average percentage of CSSA recipients residing in subsidised places is 60.5% and that for non-subsidised places (mostly in private homes) is 80.0% (Table 2.3).

Table 2.3: CSSA recipients in various types of RCHEs (as at 31 July 2015)

	Subvented, self-financing and contract homes	EBPS places	Private homes[27] (excluding EBPS places)
No. of CSSA recipients[28]	11 160	4 250	24 936
Capacity[29]	19 018	7 928	41 970
Occupancy rate	94.4[30]	94.7[31]	74.2[32]
No. of residents	17 953[33]	7 509[34]	31 162[35]
Percentage receiving CSSA	62.2[36]	56.6	80.0

[26] Information provided by SWD.
[27] This also includes those living in non-subsidised places in some self-financing homes and contract homes.
[28] Information as at 31 July 2015 provided by SWD.
[29] Information as at 31 July 2015 provided by SWD.
[30] Provision of long-term care services for the elderly (2014). Audit Commission, HKSAR
[31] Information provided by SWD as at July 2015
[32] Ibid.
[33] Estimated number of enrolment of self-financing home based on occupancy rate as at 31 Mar 2014.
[34] Actual enrolment
[35] Actual enrolment
[36] Estimated number.

92. At the moment, age and care needs are the only criteria in determining the eligibility for subsidised RCS. With the combined effect of an ageing population and increasing longevity, the demand for LTC services would continue to increase in the coming three decades[37]. If the current mode of financing RCS, i.e. needs based service that is largely funded by the Government through a tax-based regime, is to be maintained, it definitely will pose a tremendous fiscal burden on public finance.

93. In the final report of the EC's study on RCS[38], it was recommended that to meet the challenges of the growing expenditure in LTC in light of the ageing population, there is a need to devise a viable and sustainable LTC financing model. The current publicly–funded mode of provision by universal coverage regardless of the recipients' financial means may not be sustainable in the long run. On the other hand, there should be measures to ensure that the financial risk associated with LTC should be protected for people with limited means. It was recommended that public resources should be targeted at those with the highest care and financial needs.

Long Waiting List for Subsidised Services and Underutilisation of Non-subsidised Places

94. As at 31 July 2015, there were 31 737 applicants (inactive cases[39] not included) waitlisted for subsidised RCS on the CWL. The average waiting time for the three months immediately before (May 2015 to July 2015) for C&A places provided by subvented homes and contract homes was 35 months, whilst that for places provided by EBPS homes was 8 months[40]; for nursing home places, the average waiting time stood at 30 months[41] (Table 2.4).

[37] Based on the changing demographic structure of the population in Hong Kong in the coming 25 years or so, it is expected that the age cohort of those 80+ years, i.e. age cohort most likely to require LTC, would be increasing continuously until 2050 where the number would drop slightly.

[38] Chui, EWT (2009) Elderly Commission's study on residential care services for the elderly: final report. China: Elderly Commission.

[39] These cases are mainly 'RCS only' or 'dual option' cases where the older person is receiving community care services.

[40] The average waiting time include normal and priority placement applications but exclude those with inactive history.

[41] Including subsidised nursing home places provided by subvented nursing homes, self-financing nursing homes and contract homes.

Table 2.4: Number of applicants and average waiting time by type of RCHE (as at 31 July 2015)

Subsidised service		No. of applicants	Average waiting time (months)[42]
C&A homes	Subvented/contract homes	25 525	35
	Private homes participating in EBPS		8
Nursing homes		6 212	30
Total		31 737	

95. Since eligibility for subsidised services is solely based on age and care needs, and there is no mechanism in place to differentiate those with better means and thus, have more choices in meeting their care needs (e.g. purchasing alternative services in non-subsidised services, employing a domestic helper); given the existing mode of financing, it is likely that the waiting list will continue to grow and the waiting time will correspondingly increase.

96. On the other hand, non-subsidised RCS places were underutilised. There was a considerable number of vacancies in all types of RCHEs, including 865 (18.3%)[43] in self-financing, subvented and contract homes, and 1 339 (16.5%)[44] in EA1 & EA2 homes. Among non-EBPS private homes, the number of vacancies was 9 469[45] (28.0%).

97. These figures indicated a general preference for subsidised services by the elderly persons (and probably their family members) who opted to continue to be waitlisted on CWL instead of making use of the non-subsidised places available to meet, at least temporarily, their RCS needs. In particular, self-financing homes and private non-EBPS RCHEs have the highest vacancy rates for their non-subsidised places (23.7% and 28.0% respectively) (Table 2.5).

[42] It is the average number of months taken between the waitlist date and the admission date for admitted cases in the past three months including normal and priority placement applications but excluding those with inactive history.
[43] Actual number of vacancies as reported by operators.
[44] Figure estimated based on the actual number of beds in the EBPS homes.
[45] Figure estimated based on licensing capacities of the private homes concerned as kept by SWD.

Table 2.5: Capacity and vacancies of non-subsidised places

Non-subsidised places as at 31.7.2015[46]	Capacity	Vacancies	%
Self-financing homes	3 097	733[47]	23.7
Subvented homes	358	37[48]	10.3
Contract homes	1 262	95	7.5
Sub-total	***4 717***	***865***	***18.3***
EA1 homes	4 148	738	17.8
EA2 homes	3 944	601	15.2
Sub-total	***8 092***	***1 339***	***16.5***
Non-EBPS private homes	33 878	9 469	28.0
All private homes (i.e. EBPS and non-EBPS homes)	41 970	10 808	25.8

98. Preference for subsidised places and the under-utilisation of non-subsidised places may be attributed to applicants having more confidence in the service quality of subsidised places. In fact, the quality of service of RCHEs in the private sector has been a constant concern over the years, and there has been doubt about the measures in quality assurance of private RCHEs.

99. At the moment, all RCHEs in Hong Kong have to comply with the RCHE Ordinance which was enacted in October 1994. It aims to regulate the infrastructure (such as premises design, building safety and fire precaution), management and staffing, of RCHEs to ensure the provision of RCS at a reasonable standard and that the physical, emotional and social well-being of the residents is safeguarded[49]. All RCHEs must be licensed to be able to operate in Hong Kong. Private RCHEs under the EBPS have to meet a higher floor space and staffing standard. For subvented and contract RCHEs, additional professional input are also required. The difference in space and staffing requirements could be one of the reasons affecting the attractiveness of subsidised RCHE places.

[46] Information provided by SWD.
[47] This figure is estimated from the latest available data in 2015 provided by SWD.
[48] ibid.
[49] How to apply for a license under the Residential Care Homes (Elderly Persons) Ordinance and policy statement on Residential Care Homes (Elderly Persons) Ordinance. SWD website: http://www.swd.gov.hk/en/index/site_pubsvc/page_elderly/sub_2552/id_2555/

100. Furthermore, for private RCHEs, the operating costs are supported by home fees which, on average, charged around $5,445-$8,792 for private RCHEs not participated in EBPS and $5,822-$9,559 for those participated in EBPS. It is noted that a significant percentage (estimated to be around 80%, Table 2.3) of elderly persons residing in non-subsidised places in the private RCHEs are CSSA recipients, receiving an average of around $7,600 per month[50]. They have very limited resources, and under the CSSA, there is little incentive for the family to top up the CSSA payment granted to the older person concerned for better RCS service. One of the reasons being financial support received from the family would be treated as income and the amount of CSSA payment will be deducted correspondingly. Due to the financial situation of this group of target residents, many private RCHEs could only peg their services to CSSA rates. As a result, there is often little room and incentive for private RCHEs to upgrade their services. Many private RCHEs not participating in EBPS could only meet the minimum statutory requirement in staffing level and had the lowest net floor area per capita[51].

101. The monthly user fee of subsidised RCS places is substantially lower than non-subsidised places. Depending on the level of care needed, the monthly fee of subsidised C&A places is $1,603-$2,000. Furthermore, there is no means test for subsidised RCS, all elderly persons are eligible to apply regardless of their financial status. As long as they are assessed by SCNAMES as in need of RCS, they will be put on the CWL.

102. Another factor that might contribute to the underutilisation of places in the private sector is that many private RCHEs are located in commercial or residential buildings which are relatively less spacious and more expensive in rental cost. While for subvented or contract homes, with support from the Government, most of them are located in public housing estates or purpose-built complex provided by the Government. Therefore, it is not surprising that many elderly persons would prefer staying on the CWL for a subsidised RCS place.

Conclusion

103. While the Government has committed to providing more subsidised RCS through traditional means (i.e. subvented homes, contract homes and EBPS

[50] Figure as at 30 September 2015.
[51] Provision of long-term care services for the elderly (October 2014). Audit Commission, HKSAR

places), in view of the increasing demand for RCS and the long waiting time for subsidised places, it would be worthwhile to explore additional measures to increase the supply of subsidised places, such as optimising the existing, underutilised resources in the private non-subsidised RCS sector (including self-financing homes, non-subsidised places in subvented/contract homes and private RCHEs) to better meet the service demand of the elderly.

104. In addition, exploration into possible alternatives in quality subsidised service provision can serve to offer additional choices to the older people on CWL, on top of the existing ones like remaining on the CWL and wait for subsidised places provided by NGOs, contract homes or through EBPS; or turning to non-subsidised private RCHE places with their own means.

CHAPTER III: VOUCHER SYSTEM – EXPERIENCE OUTSIDE HONG KONG

Overview on the use of voucher as a form of subsidy

105. Voucher system is defined as 'the use of a state-funded demand-side subsidy to purchase social goods in a competitive market as an alternative to pure public provision of such goods'[52]. As explored in the two studies on RCS and CCS completed by EC in 2009 and 2011[53], the use of voucher as a form of subsidy for LTC services is based on the idea that by entitling care recipients to choose among competing providers, it has the potential to change providers' and users' behaviour by strengthening incentives for quality improvement. The basic principle is to provide freedom of choice to users, to ensure fees paid are commensurate with service quality, and to incentivise providers to compete on quality and responsiveness[54].

106. In other words, a voucher scheme may, through the increased consumer choice enabled by a more flexible use of Government subsidies (i.e. 'money-following-the-user') as well as top-up arrangements, induce service improvement in the non-subsidised sector. This may help build up confidence in and preference for such services by the elderly (and their family members), allowing a more efficient use of non-subsidised places in meeting the needs of our ageing population. Furthermore, as the improvement in facilities, staffing and general management of the RCHE will affect all RCS places offered, the quality improvements brought about by a voucher scheme should be able to benefit other end-users of RCS; for instance, elderly persons that are not receiving vouchers and are living in non-subsidised places,. If properly designed (e.g. inclusion of means testing arrangements coupled by a co-payment arrangement which matches with the affordability of individual elderly persons), a voucher scheme should also be able to address the considerations concerning fee levels and means testing.

107. In view of the ageing population and the anticipated increasing demand for RCS, as well as the low tax regime of Hong Kong, a publicly funded, non-contributory system of provision of LTC might not be financially sustainable in the long run.

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[52] Daniels, R.J. & Trebilcock, M.J. (2005). Rethinking the welfare state: the prospects for government by voucher. London and New York, Routledge.

[53] The two studies are: 'Residential Care Services for the Elderly (2009)' and 'Community Care Services for the Elderly (2011)'.

[54] Murakami, Y. & Colombo, F. (2013), Incentives for providers and choice for consumers. In *A good life in old age? Monitoring and improving quality in long-term care (chapter 6*). Retrieved from ec.europa.eu/social/BlobServlet?docId=10292&langId=en

Resources should be utilised in the most efficient way and service provision should be given to those most in need. It would be desirable for the society to start exploring other possible modes of financing and provision of RCS whereby elderly people who are in a better financial position can take up a larger share in the cost of LTC, e.g. via co-payment and/or a contributory system. In this connection, a voucher scheme, through providing more quality choices for elderly persons, may also help develop a 'market segmentation' mechanism where people who can afford higher service fees could be diverted to higher-end non-subsidised services.

108. With reference to the experiences in other places in using voucher as a means of government provision of subsidy to social services, there can be both potential benefits and undesirable effects.

Potential benefits

Enhances consumer choice

109. The essence of a voucher system is respect for users' choice. It can provide consumers with a choice that can be both prescriptive and proscriptive, that is, beneficiary of a voucher may have a choice on a range of service providers and at the same time, requirements may also be set on the scope and/or standard of goods and services that can be purchased in order to achieve specific policy goals. In this regard, a voucher system is a good policy tool in providing an 'intermediate' level of choice[55]. The scope of prescription and proscription allowed should be designed with due consideration and reference to goals and principles of a specific program.

Increases consumers' purchasing power

110. Another potential benefit of a voucher system is that it may increase consumers' purchasing power. In theory, voucher as a form of subsidy would release the household resources originally devoted to the service or goods subsidised by the voucher. This is regarded as a 'substitutability' effect brought about by vouchers that may improve household budgets. For elderly persons or households that previously have to pay for RCS in the private market or expenses incurred from caring the elderly at home while waiting for subsidised service, vouchers can help them release such household resources.

[55] Steuerle, C.E. (Ed.) (2000). *Vouchers and the provision of public services.* Washington, DC, USA: Brookings Institution Press.

Incentivises provision of higher quality of services

111. By providing users with choice over the care provider they prefer, it has the potential to stimulate competition and to incentivise providers to improve the quality of their service. Furthermore, as mentioned in paragraph 109 above, a voucher scheme may include requirements on the standard of goods and services that can be purchased. In addition to enhanced competition, a voucher scheme may also encourage service quality improvement through setting higher service standards.

Channels public fund to those most in need

112. The current provision of RCS in Hong Kong is primarily based on care needs and is heavily subsidised by the government. The voucher system can introduce a mechanism by which resources are allocated with due consideration to the level of affordability of the voucher users (e.g. a co-payment arrangement with a sliding scale). Those who have lesser means can be provided with a higher level of subsidy and vice versa.

Encourages sharing of responsibility by users

113. A voucher scheme with co-payment arrangements would also have the advantage of ensuring the sharing of responsibility by service users instead of merely relying upon public subsidy. Furthermore, as the purchasing power of voucher users increases, they may choose to purchase additional services or services of higher quality by means of top-up payments, which is another form of responsibility sharing by service users.

Shortens waiting time for service

114. The provision of a voucher as an alternative to waitlisting for allocation of a subsidised place can shorten the waiting time for both the voucher users and those who remain on the waiting list.

Potential undesirable effects

Prices may increase

115. There are concerns that the voucher system might provide an opportunity for the service provider to increase the prices of their service, knowing that the voucher user will be subsidised. In addition, similar to other forms of subsidy, vouchers may increase the demand for services; and if the supply fails to catch up after the existing vacancies are fully utilised, prices may also increase.

Cream-skimming problem

116. Another related concern is the possibility of service providers taking preference for users with lower-care needs relative to costs. If the demand is high and there is little incentive for the service providers to adjust their supply, the problem of 'cream-skimming' and 'shunting' may occur[56].

Premature or unnecessary institutionalisation

117. There is an apparent tendency for elderly who are assessed to have LTC needs to opt for RCS on the CWL. Given that a voucher scheme is another form of government subsidy, it was pointed out in the 2009 study that the introduction of RCSV might induce premature or unnecessary institutionalisation. That said, judging from the relatively high percentage of offer declines (22.3% in 2014)[57] by applicants, it is possible that some of the applications for RCS were submitted to make sure that the elderly person could 'get in the queue first' in view of the long CWL. In other words, the extent of premature and unnecessary institutionalisation resulting from the provision of additional subsidised service (either through traditional means or through the introduction of a voucher scheme) might be limited.

Experiences outside Hong Kong

118. In the international scene, the use of voucher-based subsidy instead of provision of service in kind is usually adopted as a kind of 'consumer-directed care'. A number of economies with similar social and economic development with Hong Kong are reviewed. They include Australia, Canada, United States, United Kingdom, Japan and Germany; as well as Chinese communities such as Taiwan, Singapore and the Mainland. Cash benefits for LTC are available in United Kingdom[58], United States[59], Germany[60], the Mainland[61] and Taiwan[62]. From the literature reviewed, these subsidises are often used to provide more choice and flexibility for service users, so that they may select services that can

[56] Valkama, P. & Bailey, S.J. (2001) Vouchers as an Alternative Public Sector Funding System. Public Policy and Administration. 16(1): 32-58. doi: 10.1177/095207670101600103

[57] Figure provided by LWB.

[58] United Kingdom long-term care (2011). Retrieved from http://www.oecd.org/unitedkingdom/47908664.pdf

[59] United States long-term care (2011). Retrieved from http://www.oecd.org/unitedstates/47902135.pdf

[60] Germany long-term care (2011). Retrieved from http://www.oecd.org/germany/47891361.pdf

[61] 北京市民政局 (2008)《北京市财政局關於深入開展居家養老服務試點工作的通知》, 上海市民政局(2004)《關於進一步深化居家養老服務工作的通知》

[62] The Preliminary Plan of Long-term care insurance (PowerPoint). www.mohw.gov.tw/MOHW_Upload/doc/The_Preliminary_Plan_of_Long-Term_Care_Insurance_0001765000.ppt

best meet their needs and preferences and, hopefully, lead to higher user satisfaction. In many economies, the voucher-based subsidy is also used as a tool to encourage "ageing-in-place" by allowing the voucher to be used for purchasing home-based care services or as a form of allowance for family caregivers. A third objective often associated with this funding mode is promoting competition among providers. Customer surveys performed in Denmark and Finland found general satisfaction among users of LTC service voucher. What is interesting is that this sense of satisfaction is related to freedom of choice rather than the service itself[63].

119. From the reports on Organisation for Economic Co-operation and Development (OECD) countries, Austria is the only one that provides cash allowance (known as 'Pflegegeld') to buy institutional services. However, the Austrian experience still had some differences when compared to the Hong Kong situation. In particular, the Austrian system allows for greater freedom to users in the selection of service types. For instance, in Austria, cash benefits/allowance can also be used for community and/or home-based care services. Furthermore, for those requiring 24-hour care at home ('Care around the clock'), additional subsidises are available as an alternative to choosing institutional care. It was reported that in 2008, 24% of the population over the age of 65 received long-term care at home and only 0.9% of the population received care in an institution.[64]

Overcoming the undesirable effects

120. The potential undesirable effects could be avoided or minimised if due considerations are taken in formulating the implementation mechanism of the voucher. For example, the concern of possible increase in service fees without corresponding service enhancement could be overcome by ensuring that a wide network of accessible service providers is available, and an effective regulatory system is in place, so that there will be an environment for competition and can incentivise providers to deliver better quality service. Furthermore, setting a standard package of service to be provided RSP under a voucher should protect voucher users from impact of price increases. The cream-skimming problem can be minimised by requiring service providers to provide service to voucher users in accordance with the terms in a service agreement. On the issue of premature or

[63] Cited in Colombo, Francesca, et al. (2011), 'Can We Get Better Value for Money in Long-term Care?', in Help Wanted?: Providing and Paying for Long-Term Care, OECD Publishing. http://dx.doi.org/10.1787/9789264097759-15-en

[64] Austria long-term care (2011). Retrieved from http://www.oecd.org/austria/47877397.pdf

unnecessary institutionalisation, strengthening CCS; ensuring that a care need assessment mechanism accurate in assessing RCS needs is in place; and including a co-payment arrangement with means-testing, could encourage ageing in place and ensure that the voucher subsidy would be given to applicants with genuine needs.

121. As revealed from the practices outside Hong Kong, there is no single type or model of voucher that can be applicable to different countries, societies and contexts. The design and implementation of voucher system must be congruent with the prevalent social conditions of a specific society. In general, the following are the main features that any voucher system may need to address:[65]

Finance dimension

- The value of the voucher
- Top-up – whether the user and/or the service provider can charge on top of the value of the voucher

Service content and service quality monitoring dimension

- The target beneficiary(ies)
- The type(s) of services covered by the voucher
- The type(s) of service providers from whom the voucher can be redeemed
- The conditions and criteria of the service providers' operation, including requirements on service quality and service input

Information dimension

- Dissemination of information to users, including the parameters of the scheme, services and service operators available
- Support to voucher users in decision making
- Complaints mechanism

122. In designing and implementing a voucher system as a means of government subsidy to targeted beneficiaries, there should be some overarching principles and evaluation criteria[66] that have to be adopted. These principles include the four elements of "**A**dequacy", "**A**ffordability", "**E**quity" and "**E**fficiency" (i.e. , "A-A-E-E"). They are described in the paragraphs below.

[65] Valkama, P. and Bailey, S.J. (2001) Vouchers as an Alternative Public Sector Funding System. *Public Policy and Administration*. 16(1): 32-58**.** doi: 10.1177/095207670101600103

[66] Hurst, J., & Jee-Hughes, M. (2000). Performance Measurement and Performance Management in OECD Health Systems (p29). DEELSA/ELSA/WD(2000)8. OECD working paper.

123. Adequacy – the voucher value should be adequate to enable the voucher users to procure services that can meet their basic care needs. For additional/value-added services, consideration should be given to include a "top-up" arrangement in the design of the scheme. At the societal level, the provision of voucher should also be adequate to cover a sufficiently large number of beneficiaries so that the scheme would have sufficient impact to bring about the potential benefits mentioned above.

124. Affordability – the value of a voucher should cover a reasonable scope of services and the amount required of user's co-payment should be affordable to the least advantaged group, as to avoid possible incidences of exclusion.

125. Equity – as a voucher scheme is fundamentally a type of public subsidy, it should, similar to other public resources, be allocated equitably. The design of the voucher scheme should be able to appropriately exhibit both 'vertical' and 'horizontal' equity, i.e. those who have more resources and can afford more should receive less public subsidy (vertical equity), while those with equal amount of resources should receive the same level of support from the society (horizontal equity).

126. Efficiency – it relates with the requirement that the implementation of a policy should minimise administrative costs. The administration of a voucher should avoid incurring excessive administrative costs for the government, service providers, as well as voucher users.

CHAPTER IV: STUDY RESULTS

Pre-questionnaire focus groups and interviews with potential voucher users or their carers

127. Four focus groups and two individual interviews were conducted with a total of 20 participants who were potential vouchers users or their carers. The purpose is to get a more in-depth understanding of their circumstances within which an application was made for LTC, the existing care arrangement while on CWL, and their views on a proposed RCSV[67], means-testing, co-payment and implications on their CWL status and other financial subsidy such as CSSA. Findings were used to enrich and fine-tune the wordings of the questionnaire.

128. Key findings from the pre-survey focus groups and individual interviews were:

a) Health condition requiring immediate residential service was the major consideration in whether they would take up the proposed voucher. This was particularly important if using the voucher would require leaving the CWL;

b) Quality of service of private homes was another important factor affecting their decision of joining RCSV and selection of service provider. They were aware of the concerns on service quality of the private sector, and their perceptions were mostly formed based on reports from the media and hearsays from peers. Overall, they considered it difficult to obtain necessary information on the RCHEs to make fully informed decisions;

c) Incentive to take up the voucher would be increased if they have a choice to switch service provider;

d) Means-testing was not a major concern in the proposed voucher scheme as long as the assessment would be conducted on individual basis. A sliding scale whereby those with better means would be paid more was deemed acceptable up to a maximum of around $4,000-$5,000 per month; and

e) For CSSA recipients, albeit agreeing in principle that voucher users should leave CSSA, had concern over the potential expenditure on CSSA-related benefits such as the medical expenses.

[67] A hypothetical case was provided describing preliminary ideas of a RCSV, including a proposed service standard of at least EA1 level, the spectrum of potential service providers (private RCHEs, self-financing home, contract home, NGOs providing non-subsidised places), standard scope of service etc.

129. The questionnaires were then fine-tuned to ensure that the issues and concerns raised by the participants were covered in the questionnaires and the various factors and considerations were captured in the options, which enabled the generation of useful data for quantitative analysis.

Questionnaire survey with elderly persons on CWL

130. To ensure that respondents were able to grasp the idea of RCSV, a sample scenario depicting all the key features of an RCSV was read out by the interviewer before they were asked the corresponding survey questions. These included:
    a) standard in staffing and space requirements (EA1 or above) that service providers would have to meet;
    b) types of possible service providers (private or NGO operators providing non-subsidised places);
    c) standard service package to be provided similar to the service scope of subsidised EA1 places;
    d) variable co-payment amount to be determined based on financial situation of the applicant as an individual or the family;
    e) possibility of top-up for enhanced or additional services;
    f) withdrawal from CWL upon opting for RCSV; and
    g) flexibility in changing to other eligible service providers.

<u>Findings</u>

131. Three sets of questionnaires were used for different categories of samples, including:
    Type A: community dwelling and receiving CCS
    Type B: community dwelling and not receiving CCS
    Type C: institutionalised

132. Across the three types of questionnaires, the total number of cases successfully enumerated was 1 030. (Table 4.1).

133. A stratified systematic sampling method was used to select cases from the CWL who were waitlisting for C&A home or nursing home. A detailed explanation of the sampling method is attached in Appendix II. To obtain the targeted sample size of 1 545, 3 951 cases were drawn from the CWL. They were contacted by their respective responsible worker and a total of 1 522 cases gave their initial consent to be interviewed. This number was slightly lower than the expected

number of 1 545 due to a higher than expected rate of refusal. The number of interviews successfully conducted was 1 030. Breakdown of the consented cases by the responses was summarised in the following table (Table 4.1):

Table 4.1: Consented cases by responses

Type of responses	Number
Total number of consented cases	1 522
Invalid cases[68]	44
Unable to contact[69]	260
Not free for interview	86
Refusal	102
Successfully enumerated	1 030
Response rate	70%[70]

Response rate and weighting adjustment

134. The data were weighted with respect to the 13 strata used in the sampling so that it is more representative of the population. One case was excluded from the analysis due to missing information pertinent to identifying which stratum it belonged to, therefore, the total number of cases included in the analysis is 1 029. (Appendix III, Table I)

135. After weighting, the number/type of respondents by type of questionnaire was illustrated in Table 4.2. It was noted that 82.7% of the questionnaires were answered with the participation of a proxy/carer. In general, the higher level of care the elderly is receiving, the more likely that a proxy/carer would be involved in the answering the questionnaire (98% for Type C, 74.5% for Type A and 28.6% for Type B).

Table 4.2: Respondents by self/ proxy

	A		B		C		Total	
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*
with Proxy/Carer	257	74.5	81	28.6	386	98.0	845	82.7
Elderly persons only	88	25.5	202	71.4	8	2.0	177	17.3
Total	345	100.0	283	100.0	394	100.0	1 022*	100

*missing data = 7

[68] This included 32 cases of invalid contact and 12 cases of deceased at time of contact.
[69] The case was contacted at least five times at various times of the day.
[70] Excluding the invalid cases, the response rate = 1030/(1522-44)=70%

Demographic profile of the respondents

136. In this sample, the proportion of male was lower than their female counterpart, and the ratio was 1:1.7 (Appendix III, Table II). In terms of age, a large majority of them were over 80 years old (79.3%) and around half had reached 85 years old or above (Appendix II, Table III). The mean age was 83 and the median was 84. Over half of the respondents (53.2%) were widowed. Among those living in the community, 15.3% were living alone (Appendix III, Table IV). On highest education level attained, around 40% of them had no schooling, were illiterate or could only read a little (Appendix III, Table II).

Circumstances surrounding application for subsidised RCHE

137. Respondents were asked to rank the reason(s) why they had to apply for subsidised RCS. The most common reason ranked with the highest importance was 'deteriorating health and family members not able to provide care' (63.1%). This percentage was substantially higher than all the other reasons (the next highest percentage being 'living alone without care support' (10.7%). (Appendix III, Table V)

138. On whether the reason(s) leading to the application for subsidised RCS had changed over time, around 20% of the respondents reported that the reason(s) leading to the application had changed (Appendix III, Table VI). Among them, 76.4% stated that their health condition has deteriorated, and 13.2% said that their health condition had improved (Appendix III, Table VII).

139. Around one-third of the respondents (31.9%) had been on CWL for 1-2 years and 27.6% had waited for 2-3 years (Appendix III, Table VIII). When the data were further analysed by their active/inactive status on CWL, it was noted that the longer the duration on the CWL, the more likely the case was inactive (Appendix III, Table IX). This may mean that some of the respondents have been on CWL for some time because their care needs are met by the CCS they are using and are able to age in place and have no immediate need for RCS. As their status could be re-activated at a future point at the initiation of the applicants and their original position on CWL would not be affected, these respondents may choose to keep their inactive status.

140. The child(ren) of the respondents was(were) the most important decision maker in applying for subsidised RCHE for over half of the respondents (52.8%). Only 22.8% of the respondent stated that the older person him/herself was the key

decision maker. Professionals such as doctors and social workers were also important in deciding the need for RCS. They were ranked as the most important decision maker by 10.9% of the respondents. (Appendix III, Table X)

Factor(s) affecting choice of RCHE

141. A large majority of the respondents would have one or more preferences in choosing a suitable RCHE. 90.5% of the respondents stated that there were factor(s) affecting their choice (Appendix III, Table XI). Among them, the location of the RCHE was ranked with highest importance for 62% of the respondents, the second in rank was service quality, 20.3% of the respondents ranked it the first and 26.2% ranked it the second important factor; and the third important factor was health care support, where a total of 33.2% of the respondents ranked it of first or second importance (Appendix III, Table XII).

142. Respondents were also asked the reason(s) for preferring subsidised places to non-subsidised places. The most common reason chosen by respondents was that subsidised places charged a lower fee (81.4%). Another common reason given was the staffing resources and facilities (better equipped in caring skills: 67.3%; better facilities: 66.9%; higher staffing ratio: 61.6%; and better living environment: 59.6%). Reputation of the RCHE was considered a factor by around half of the respondents (51.5%). Around one third would also consider factors such as amount of activities (34.9%), location (31.1%), and dietary preference (30.1%). The role of family members and/or professionals was also important. 38.8% of the respondents stated that the choice was the decision of family members and 27.6% reported that the preference was suggested by professionals (such as doctors or social workers). (Appendix III, Table XIII)

143. Not all the respondents would immediately accept a subsidised place even if one was offered. 14% of the respondents had refused an offer before (Appendix III, Table XIV). Among them, 46% indicated that they did not accept the offer of a subsidised place because at the time of the offer, the applicant could still be cared at home. Another key factor was the location of the RCHE. 21.4% indicated that the offer was not accepted because the location was not suitable (Appendix III, Table XV).

144. Even when a subsidised place was offered now or in the near future, over half of the respondents (54.5%) said that they would not/would probably not take up the offer (Appendix III, Table XVI). Among them, over half (52.0%) indicated that

since the applicant could still be taken care of at home, they would not/would probably not consider taking up a subsidised place in the near future. 30.2% had to consider the location of the offer and 22.9% would consider the quality of service of the RCHE offered. Similar to responses to other questions, the role of the family was still significant, 24.3% would leave it to be decided by the family (Appendix III, Table XVII).

CCS usage and preferences

145. To examine the usage pattern of CCS and respondents' preferences on CCS and RCS, respondents who were living in the community were asked about their views on CCS and factors affecting their preference for CCS or RCS.

146. For respondents who were using CCS at the time of the survey, in most of the cases, respondents had started using CCS nearly at the same time or soon after they were put on CWL (Appendix III, Table XVIII). A large majority of them were using subsidised service (84.1%) (Appendix III, Table XIX). When the respondents were asked whether they would continue to receive CCS or switch to RCS should a subsidised RCS place be offered in the near future, most would prefer the status quo (62.4%) (Appendix III, Table XX). When asked about the reason why they preferred CCS over RCS, apart from the consideration that some of them could still take care of themselves (35.5%), the availability of carer was also considered important. Having a member of the family or a domestic helper as carer was considered a contributing factor by 46.7% and 30.8% respectively in their preference for CCS. In addition, 21.5% of the respondents reported that the current CCS they were receiving were able to satisfy their caring needs in the community (Appendix III, Table XXI).

147. The views of the carers of elderly persons using CCS were also explored. A large majority of them (81.8%) found CCS useful (Appendix III, Table XXII). When they were asked what measures they would consider useful in further supporting them to encourage the older person to use CCS instead of RCS, about half of the carer respondents found training in caring skills useful (49.4%) and around 40% indicated the need to provide carer allowance and education on ageing process. Strengthening home care or day care services was considered useful by around one-third of the carer respondents. However, 26.5% of the carers of those using CCS still prefer RCS over CCS. (Appendix III, Table XXIII)

148. For respondents living in the community but were not using CCS at the time of the survey, they were asked about the reason(s) for not using CCS. Around half stated that CCS was not needed because their informal care network (family, domestic helpers) was able to support them in the community. Yet, there were around 15% of the respondents who either did not know what CCS could offer or they felt that the current CCS were not able to meet their caring needs. (Appendix III, Table XXIV)

Willingness to consider RCSV and views on means test

149. Three questions, in increasing specificity, were asked to explore the receptiveness of the respondents on RCSV and examine their views on means test, including (i) whether they are willing to consider RCSV, if yes (ii) whether they agree to means test; and if yes (iii) would it affect their initial inclination towards RCSV.

150. Over one-third of the respondents (36.5%) were willing to consider taking up the RCSV, with co-payment, to get a non-subsidised EA1 equivalent RCHE place provided by private operators and/or non-profit making organisations. Another 14% reported that they would consider it in the future when needs arose. Respondents who were currently living in an institution were more likely to consider taking up the RCSV (48.2% living in an institution; among them, only 7 out of the 192 cases were in private non-EBPS RCHEs as compared with 31.5% living in the community with CCS and 26.2% living in the community without CCS) (Table 4.3).

151. Among those who were willing to consider RCSV or willing when needs arose, 43.3% agreed to having means test, 45.4% disagree and 11.3% had no opinion (Appendix III, Table XXV). To further explore if having means test would affect respondents' receptiveness to RCSV, for those who said they agreed to means test, they were asked if it would affect their inclination towards RCSV. A total of 72.2% said that having means test would not affect their inclination to accept RCSV. (Appendix III, Table XXVI)

152. The willingness of respondents to consider RCSV at different levels of specificity was summarised in Table 4.3. If the most prudent figure, i.e. willing to consider RCSV and agree to means test and not affecting inclination, is used to estimate the take-up rate, 11.8% of all respondents will consider the RCSV. If those who alleged to have no immediate need but will consider RCSV when needs arise were also taken into account, the figure would be 15.2%.

Table 4.3: Respondents by willingness to consider RCSV and agreement to means test

Attitudes towards RCSV	A=346		B=286		C=398		Total=1 029	
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*
Willing	109	31.5	75	26.2	192	48.2	376	36.5
Willing + agree to means test	54	15.6	38	13.3	77	19.3	169	16.4
Willing + agree to means test + not affecting inclination	36	10.4	36	12.6	49	12.3	121	11.8
Willing when needs arise	71	20.5	44	15.4	29	7.3	144	14.0
Willing when needs arise + agree to means test	27	7.8	14	4.9	15	3.8	56	5.4
Willing when needs arise + agree to means test + not affecting inclination	18	5.2	8	2.8	9	2.3	35	3.4

153. Respondents who were interested in taking up RCSV (willing to consider RCSV/ willing to consider RCSV when needs arose) and agreed to means test were asked for their views on the unit for financial assessment. Over half (53.7%) suggested that only the older person him/herself should be assessed, while 45.5% of the respondents thought that financial situation of family members should be taken into account. (Appendix III, Table XXVII)

154. Duration on the CWL seemed to be a factor influencing the respondents' willingness to consider the RCSV and the critical timeline appeared to be in their third year and the fifth year. Percentage of respondents who indicated their willingness to consider RCSV had a relatively sharp drop after their third year on the CWL, from 61.5% for those waited between one year to less than three years to 17% for those waited between three years to less than five years. After the fifth year, respondents indicating interest dropped drastically to 3.4%. (Appendix III, Table XXVIII)

Reasons for taking up RCSV

155. On further examination on the reasons given by those who were interested, 75.3% said that RCSV was attractive because it might shorten their waiting time for services. Having a choice to select a suitable and satisfactory RCHE was also considered important by the majority of respondents who were interested in RCSV, with 69.1% saying that they were interested in the scheme because

they could choose a suitable service provider and 55.6% quoting a corollary of this reason, i.e. that the voucher would provide the option to switch operators if the user considered its service unsatisfactory. Finally, another 55.3% also indicated their appreciation of the flexibility under RCSV to pay for better services via top-up payments. (Appendix III, Table XXIX)

Reasons for not taking up RCSV

156. Among those who stated that they were not interested in RCSV, 71.1% felt that other forms of subsidised place were better for their lower price and higher quality (e.g. living environment, facilities, sufficiency and training of care workers, etc.). 68.2% of the respondents insisted that they preferred to stay on CWL and wait for a traditional subsidised place. Meanwhile, 61.6% of the respondents not interested in RCSV mentioned that they did not have confidence in the service quality of non-subsidised places currently available in the market. (Appendix III, Table XXX)

157. While the above are the three most frequently stated reasons for not taking up RCSV, it is also noted that a considerable percentage (27.0%) of elderly persons responded that they did not have an immediate need for RCS at the time of the interview and would therefore like to remain on CWL to wait for a traditional subsidised place. In addition, 16% stated that they did not know how to choose a suitable service provider with quality, 8.6% worried that procedures of applying for RCSV might be tedious and 5% was not interested because they preferred CCS over RCS. (Appendix III, Table XXX)

Views on fixed amount/sliding scale of voucher subsidy

158. Among those who were interested in taking up RCSV, 62.6% agreed to a sliding scale of voucher subsidy depending on the financial situation of the person; only 31.5% stated that the subsidy should be a fixed amount. (Appendix III, Table XXXI)

Co-payment ratio affordable

159. In line with the existing practice where full-subsidy would be provided for CSSA recipients for RCS, it was assumed that CSSA recipients would not be required to co-pay. For those who were interested in RCSV and not on CSSA, their ability to co-pay was analysed. A large majority (74.4%) of the respondents had a monthly individual income broadly equivalent to 50% of the Median Monthly Domestic Household Income (MMDHI) or less at the time of the survey

(Appendix III, Table XXXII). Based on the midpoint of their individual income and the amount they reported to be able to afford for the standard service package (i.e. the voucher value of $12,134), over half (55.4%) of the respondents, which spanned across all individual income groups, stated that they were able to afford co-paying less than 5% of the voucher value. The percentage of respondents decreased at the next two levels of affordability, with 10.2% and 10.3% stated respectively that they were able to afford co-payments at 5% to less than 10% and 10% to less than 15% of the voucher value. The number increased to 18.0% for the next level, i.e. co-payments of 15% to less than 25% level. Beyond this level, the percentage dropped to less than 5% for the remaining levels (Appendix III, Table XXXIII).

160. In terms of asset, excluding property, a large majority of the respondents had an asset level of less than $50,000 (85.9%). Among non-CSSA recipients, 78.7% had an asset level of less than $50,000, while another 14.1% had assets with value ranging from $50,000 to $500,000. (Appendix III, Table XXXIV)

Willingness to top up for enhanced or additional service

161. To examine the receptiveness on the possibility of paying top-up for enhanced or additional service (such as escorting service, consultation with Chinese medicine practitioners, acupuncture etc.), respondents who were interested in RCSV were asked their willingness to consider topping up in addition to the standard package covered by the basic voucher values. Among non-CSSA recipients who were interested to take up RCSV, 78.9% were willing to consider paying top-up for enhanced or additional service. Even among CSSA recipients, 53.2% stated they were willing to contribute more to obtain an enhanced or additional service. (Appendix III, Table XXXV)

CSSA status and willingness to give up CSSA for RCSV

162. Among all respondents, 35.2% were CSSA recipients. Also, CSSA status was most common (58.3%) amongst elderly persons who were living in an institution at the time of the survey, as compared to elderly persons living in the community with the help of CCS and elderly persons living in the community without the help of CCS. In terms of the basis of assessment in the means-test for CSSA, 75.3% applied as an individual, and the remaining one quarter or so applied as family cases. (Appendix III, Table XXXVI)

163. Respondents were asked about their willingness to choose RCSV and withdraw from CSSA if the RCSV subsidy is higher than that of CSSA. To ensure that respondents were aware of the implications, specific description on the possible loss of CSSA-associated subsidies such as supplements, special grants and waiver of medical charges at public hospitals or clinics; as well as the availability of other forms of allowances such as Old Age Allowance (OAA), Old Age Living Allowance (OALA) and Disability Allowance (DA) were read out before asking the question. Given the circumstances described, 46.2% of the respondents indicated that they would be willing to choose RCSV and withdraw from CSSA. (Appendix III, Table XXXVII)

Factors considered by elderly persons when choosing a service provider

164. Respondents who had indicated interest in RCSV either at the time of the survey or when needs arose were asked what factors they would consider if they were to choose a service provider for RCSV. Three factors were selected by around two-thirds of the respondents, namely service quality (68.5%), location (66.4%) and the environment of the home (66.4%). The flexibility of switching operators was once again stressed by around half (50.5%) of the respondents. (Appendix III, Table XXXVIII)

Summary on questionnaire survey on elderly persons on CWL

165. Findings from the questionnaire survey suggested that there was a moderate level of interest among the respondents towards the RCSV. Respondents who were willing to consider this alternative to traditional subsidised places found the possibility of having a 'fast track' to obtaining services and the freedom to choose and change service providers appealing. Around half of the respondents were willing to consider RCSV as an alternative choice now or in the future when needs arose.

166. It was found that the idea of RCSV was particularly attractive to those already living in private RCHEs while waiting for a subsidised place. We learnt that a majority of those living in private RCHEs were CSSA recipients, and that to match the affordability of these elderly persons, many private RCHEs would peg the fee (at least for some of their places) at a level comparable to CSSA level. With this limitation in resource input, there was little room for improvement of service quality. It was likely that for those who were living in private RCHEs, especially for those on CSSA, the RCSV could allow them to look for a better service in the market through the provision of a higher amount of subsidy. In

fact, among CSSA recipients currently residing in non-subsidised place in private RCHEs, over half were willing to opt for RCSV and withdraw from CSSA.

167. Although nearly half of those who were interested in the RCSV agreed to a sliding scale of government subsidy assessed through means test, most respondents probably did not like to reveal their financial situation. When a specific question regarding means test was asked, those indicated their willingness to join dropped. If acceptance towards means-tests was also taken into account, using a prudent approach, around 11.8% of the respondents showed clear intention in immediately taking up the voucher. When this figure was projected onto the population of elderly persons waiting for subsidised C&A places (N=25 525) as at end of July 2015[71], it could be assumed that roughly 3 012 cases would be willing to consider the RCSV when the scheme is launched.

168. For those who preferred to stay on the CWL, service quality and the low fee of subsidised services were two major considerations. Another interesting finding was that at the time of the survey, only less than half of the respondents felt that they were ready to take up a subsidised place even one were offered to them now or in the near future. In fact, 14% of the respondents have refused an offer of subsidised RCHE before. That is to say, a significant number of respondents might not have immediate need for RCS. Findings have repeatedly suggested that the preference would be CCS if family members were able to take care of them at home.

169. Admission into an institution is a significant transition for most elderly persons and their family and it is understandable that they are cautious in making related decisions. RCSV did have its attractiveness as respondents showing interest in it considered that it could shorten their waiting time and give them more choices and flexibility. To make the RCSV a viable alternative to waiting for a traditional subsidised place, quality assurance of RSPs, assurance of informed choices, allowances for flexibility in the use of voucher, and an appropriate level of financial support are important considerations in the voucher design. Moreover, for CSSA recipients, consideration should be given on whether and how the elderly's medical expenses would be met once they withdraw from CSSA to participate in the voucher scheme.

[71] On 31 December 2014, i.e. at the time when the samples were taken, there were 25 201 elderly persons waiting for subsidised C&A.

Questionnaire survey with RCHEs providing non-subsidised places

170. A questionnaire survey was conducted on all service providers of non-subsidised RCHE places. The main purpose was to collect data on their intention to be an RSP and the availability of suitable places. Five types of service providers were included; namely, RCHEs under the EBPS of both categories EA1 and EA2, private RCHEs not participating in the EBPS, self-financing RCHEs, and subvented and contract homes. All service providers in the population, i.e. a total of 622 homes[72], were invited to participate in the survey.

Findings

Response rate and weighting adjustment

171. 346 cases have been successfully completed and the response rate was 55.6%. The data were weighted by the proportion of the type of homes in the population and the corresponding response rate of each type of home is illustrated in Table 4.4:

Table 4.4: Type of RCHE by responses

	No. of homes	No. of responses	Response rate (%)	Weighted frequencies appeared in this report
Type 1: EA1 private homes	60	25	41.7	33
Type 2: EA2 private homes	82	38	46.3	46
Type 3: Non-EBPS private homes	411	225	54.7	229
Type 4: Self-financing homes	36	34	94.4	20
Type 5: Subvented/contract homes	33	24	72.7	18
Total	622	346	55.6	346

[72]Total number of RCHEs when the questionnaire survey was arranged in September 2014.

Interest to become a service provider for RCSV

172. Respondents were given a scenario in which EA1 was suggested as the standard required of an RSP. Expectedly, RCHEs under the EBPS at Category EA1 showed the most interest in becoming an RSP (90.9%). Among other types of RCHEs likely to be able to provide EA1 equivalent or higher level of places, 61.1% of responding subvented/contract homes and 30% of self-financing homes showed interest. Among private homes that probably need to upgrade their staffing and space requirements to meet the suggested EA1 standard, 63% of EA2 homes and 33.6% of non-EBPS private homes have indicated their interest as a service provider for RCSV (Table 4.5).

Table 4.5: Responding RCHEs by indication of interest as a service provider for RCSV

	Type of RCHE									
	EA1 n=33		**EA2 n=46**		**Non-EBPS private n=229**		**Self-financing n=20**		**Subvented/ contract n=18**	
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*
Interested	30	90.9	29	63.0	77	33.6	6	30.0	11	61.1
Not interested	0	0.0	10	21.7	120	52.4	11	55.0	2	11.1
Have not decided	3	9.1	7	15.2	32	14.0	3	15.0	5	27.8

173. RCHEs which indicated no interest as a service provider for RCSV were asked for the reasons behind. Many stated that they wanted to maintain the status quo. Another common reason was that the home did not feel that they would be able to meet the staffing and space requirements of EA1, including difficulties in recruiting professional staff such as PTs and nurses. A number of responding homes also said that they were unclear about the scheme, and therefore, not interested. (Appendix IV, Table II)

174. For RCHEs which had not decided, the most common reason provided was that they were unclear about the scheme. A number of non-EBPS private homes expressed concern about the financial desirability in becoming a service provider for RCSV. (Appendix IV, Table III)

Readiness to accept RCSV

175. RCHEs that indicated their interest in becoming a service provider for RCSV and those who said that they have not yet decided were asked about their readiness to accept RCSV residents[73]. EA1 homes were the most ready, 100% stated that they would be ready to take RCSV residents when the scheme commenced. A majority of EA2 homes also seemed to be very positive, 94.4% indicated that they were ready, and around 70% of the subvented/contract homes and self-financing homes felt that they were ready. However, when this data were compared with figures indicating their interest, the number of EA1 and EA2 homes who felt they were ready was more than the number showing interest. This may mean that some EA1 and EA2 homes felt that they should be capable of becoming a service provider though they might not join the scheme due to other reasons (Appendix IV, Table IV). This echoed the feedback from EA2 homes during various interviews and engagement events.

Capacity and vacancy

176. Data regarding the capacity and vacancy situation of various types of RCHEs were collected and were analysed by their indication on inclination to be a service provider for RCSV. In general, responding RCHEs showing clear interest to become a service provider tend to have a higher vacancy rate; except for subvented and contract homes where the vacancy rate was relatively even across different homes and for those indicate interest, the vacancy rate was even a bit lower. This could indicate that for these types of RCHE (i.e. subvented and contract homes), their inclination would be less affected by the number of vacancies in their home (Appendix IV, Table V). The turnover rate of non-subsidised places across different types of RCHE was 15.6% per year (Table VI).

Intention to upgrade to EA1 or higher

177. To explore the likelihood of potential service providers who might not have reached the EA1 level now but wished to upgrade, RCHEs that indicated their interest to become a service provider for RCSV and those who said that they had not yet decided were asked about their intention to do so.

178. Among private RCHEs that were not yet at EA1 level (EA2 and non-EBPS private homes), there was, as compared with non-EBPS private homes, a higher percentage of EA2 having the intention to upgrade to EA1 and be ready to

[73] A tentative date of September 2015 was given in the questionnaire.

become an RSP. Over one third of the responding EA2 homes stated their intention to do so while only 20% of the non-EBPS private homes reported such intention. Among self-financing homes, 25% said that they intended to upgrade to EA1. However, it should also be noted that around one third of EA2 and non-EBPS private homes had not decided. As regards the time needed for the upgrading, among those who said they intended to do so, around 40% of the non-EBPS private RCHEs stated that they needed 6 months and around 77% from EA2 homes stated that one year was required. (Appendix IV, Table VII)

Participation in local accreditation scheme(s)

179. To explore the extent of the participation of RCHEs in local accreditation schemes, two questions on their current and planned participation were asked. Again, only those who indicated interest or not yet decided on their participation in the voucher scheme answered this question. Among the responding RCHEs, 75% of EA1 homes and 45.7% of EA2 homes were currently a participant of local accreditation scheme. The participation rates among subvented/contract/self-financing homes and non-EBPS private homes are much lower (around 16% or less). However, it seemed for those who had not yet participated in any, most did not aspire to do so. (Appendix IV, Table VIII)

<u>Summary on questionnaire survey on RCHEs providing non-subsidised places</u>

180. Since EA1 standard was assumed as the threshold for service providers of RCSV, in the private sector, it was viewed with varying degrees of enthusiasm depending on the differences between their own standard and the EA1 one. However, it is important to note that even for private homes not meeting the EA1 standard, a considerable percentage of respondents still showed interest in becoming an RSP. Furthermore, quite a number have stated their intention to do upgrading accordingly. It seemed RCSV could incentivise some private homes to improve their quality of service. However, some of the private RCHE operators were still cautious in taking up the new initiative of RSCV by becoming an RSP, as it would incur expenses in renovation and employment of additional staff, amidst the uncertainty of attracting sufficient RCSV users.

181. It is also worth noting that among RCHEs providing non-subsidised places in the non-profit making sector, there was still considerable interest (in particular subvented and contract homes). Therefore, it is expected that, in line with the spirit of offering more choices for the elderly persons, if RCSV is introduced, the spectrum of potential RSPs could be found in both private and the non-profit

sector. Furthermore, with the expected number of new subvented homes under the Special Scheme on Privately Owned Sites for Welfare Uses, providing both subsidised and non-subsidised places, the share of non-subsidised places in the non-profit sector in the provision of voucher places will likely continue to increase.

Summary of views gathered from informant interviews and public engagements/ written submissions on the preliminary recommendations

182. Views collected from the semi-structured interviews and findings from preliminary data analysis on the questionnaire surveys[74] were used to formulate tentative recommendations on the pilot scheme on RCSV in early 2015. The consultant team then collected views on the tentative recommendations from various stakeholders through a multitude of means including:
    a) two public engagement events with a total of 246 representatives from 153 organisations/units (11th and 14th February, 2015);
    b) presentation at the Panel on Welfare Services, Legislative Council (9th February, 2015);
    c) two deputation sessions at the Panel on Welfare Services, Legislative Council (23rd and 28th March 2015);
    d) further meetings with representatives from interest groups (26th March 2015 and 20th April 2016); and
    e) 13 written submissions.

183. A summary of the views gathered from the informant interviews and the public engagement exercise is attached as (Appendix VIII). Major views expressed by stakeholders are listed in the ensuing paragraphs and the consultant team's considerations are discussed in Chapter V. The views have also been taken into account in drawing up the recommendations in Chapter VI.

<u>Eligibility of RSPs and voucher users</u>

184. One of the preliminary recommendations proposed was that the minimal staffing and space standards of RSPs should meet those of EA1 homes under EBPS. Views from the stakeholders were diverse. Some stakeholders, in particular interest groups and NGO representatives suggested that higher staffing and space standards should be set, as potential voucher users might find the proposed minimum requirement of EA1 standards not attractive

[74] The preliminary data analysis was based on a dataset of 612 successful cases.

enough. Service quality of homes in the private sector was of concern. Other stakeholders took the opposite view and suggested setting a lower standard (e.g. EA2 standards and standards adopted in statutory licensing requirements) so that more operators could join the scheme as RSPs and voucher users would have more choices.

185. There were concerns regarding the proposed applicability of RCSV to C&A homes only. Some stakeholders suggested that elderly persons with severe impairment would have more urgent need for RCS and the voucher should also be used for NH.

Means test and co-payment

186. The preliminary recommendation proposed means test with co-payment on a sliding scale depending on the affordability of the older person. Views were also quite diverse. Some stakeholders accepted the need for means testing and co-payment for long-term financial sustainability of LTC while a number were of the view that elderly services should be a universal benefit for all disregard of their financial situation.

187. There was also some concern on the need for reassessment if the financial status of the elderly person changed.

188. For elderly persons who were on CSSA, the preliminary recommendation to withdraw from CCSA after taking up the RCSV was considered by some stakeholders as useful in allowing co-payment/top-up measures for better quality service. However, there were concerns if the voucher value would be able to cover supplements/allowances previously covered by CSSA.

Status on CWL

189. Preliminary recommendation proposed a trial period of six months for voucher users to decide if they would opt for RCSV to received subsidised RCS. Some stakeholders suggested that status on CWL should be kept and the voucher should be used as an interim measure while waiting for a traditional subsidised place.

Provision of case management services

190. It was tentatively proposed as part of the preliminary recommendations that case management services to voucher users be provided by RWs. During the

engagement sessions, stakeholders generally welcomed the suggested provision of case management services, but quite a number of stakeholders also expressed reservations on whether case management services should be provided by RWs in view of their heavy workload (especially for those working in District Elderly Community Centres and Neighbourhood Elderly Centres). Some expressed concern about the potential role conflict of RWs as a significant number of RWs were employed by NGOs that also provide RCS.

191. Some stakeholders suggested that the case management services should be provided by SWD. The trial period could be shortened while continuous support should be provided after the trial period.

Measures to ensure service quality and monitoring of services

192. Initial recommendations proposed a monitoring mechanism including visits, random checks, audit on files and records and complaint investigations. Breaching the service agreement may result in warning and sanctions including suspension or termination of RSP status. Regular outcome evaluation including user satisfaction survey was recommended.

193. It was suggested that stakeholder involvement, including voucher users, should be enhanced and a higher degree of transparency on the performance record (e.g. number of warnings, prosecution) of the RSPs should be available for public scrutiny.

194. It was proposed in the preliminary recommendation that RSPs should be encouraged to join recognised accreditation scheme(s) and in the long-term, accreditation should become an integrated part of the eligibility criteria. Some stakeholders suggested that incentives should be made to encourage joining such scheme.

195. There were doubts expressed about the effectiveness of RCSV in improving the service quality of RCHEs in the private sector. Some worried that private operator participating in the scheme would reap the profits provided by a voucher without correspondingly enhancing the quality of their services. There was a suggestion that profit control be implemented for quality assurance, while others suggested that SWD should play a role in setting up the guidelines for accreditation bodies and that service users should also be involved in the monitoring process.

196. Assurance of service quality of RSPs in the private sector was a common concern among stakeholders. Many pointed out that one of the main challenges to improving service quality was the manpower shortage faced by the elderly service sector.

Voucher allocation mechanism and scheme design

197. The initial recommendation in allocation of the voucher during the pilot scheme was by invitation using systematic samples drawn from potential voucher users categorised and weighted by their duration on the waiting list. Stakeholders felt that this would not be fair for those who had the need but were not selected. Workload that might incur for the case workers in selecting and processing the invited cases was also a concern. Instead, some stakeholders suggested setting up a central hotline to deal with application matters and enquiries.

198. In the preliminary recommendations, it was proposed that RSP cannot refuse admission and/or arbitrarily discharge a voucher user. However, some stakeholders were concerned that elderly persons with condition affecting their behaviour (e.g. dementia) may be difficult for private homes to manage due to lack of manpower/professional staff, resulting in rejection and /discharge.

Premature and unnecessary institutionalisation

199. A number of stakeholders expressed concerns that the introduction of RCSV might result in more cases of premature or unnecessary institutionalisation given the tendency of elderly persons to queue up for subsidised RCS. Some also expressed concerns that the introduction of RCSV might attract elderly persons receiving CCS shifting to RCSV. There were views that CCS should take a much higher priority and RCSV should not be considered before the completion of the evaluation on the pilot scheme on CCSV.

Other views

200. A number of stakeholders commented that the policy objective in launching the RCSV was not clear. Some expressed concern that for the elderly, they might find it confusing with other type of vouchers, e.g. CCSV, or even with the EBPS available in the private sector. Some suggested that RCSV should not be launched before due consideration be given to findings of the CCSV review.

201. Some stakeholders were concerned that the RCSV might induce a price raise in the private sector, affecting those with lesser means but not interested to use the RCSV. There were also worries about the 'marketisation' or 'privatisation' of the provision of subsidised RCS.

CHAPTER V: DISCUSSION ON FEASIBILITY AND DESIRABILITY

Feasibility and desirability of introducing RCSV

202. One of the key objectives of the RCSV is to offer an additional choice to elderly persons on the CWL waitlisting for subsidised RCS. The applicant can consider the RCSV as an alternative that allows them a greater freedom to choose and obtain subsidised services from an RSP in a shorter period of time. In addition, based on the principle of 'money-following-the-user', if the services provided do not meet their expectations, the voucher users are entitled to changing service provider. With the level of subsidy determined by a sliding scale that has made due regard to the affordability of the user, RCSV could also ensure that public resources would be channelled to those most in need. Furthermore, by encouraging the elderly persons to exercise their choice in choosing a service to their satisfaction, it can promote competition and incentivise service providers to improve their service quality.

203. To explore the level of interest for the proposed RCSV among potential voucher users[75], key proposed features of RCSV were described in the questionnaire and were read out during the interview, i.e. RCHEs at EA1 standard or above, co-payment on sliding scale based on affordability, possibility of topping-up, quality control by the Government, flexibility to change to another home, and that users would no longer be on CWL after opting for RCSV. After considering these parameters, findings from the questionnaire survey suggested that the idea of RCSV did appeal to some elderly persons on CWL as an alternative to the traditional mode of allocation of service. Slightly over one-third of those interviewed were willing to consider the RCSV while 14% would consider when needs arose. When they were asked to answer specific questions on agreement to means test and whether means test might affect their inclination toward RCSV, 11.8% of the respondent remained interested and another 3.4% would consider when needs arose. That is to say, a total of 15.2% of respondents found the whole 'package' of the scheme attractive, while the

[75] Some of the stakeholders were concerned about the role of family members in deciding the care plan of the elderly and whether response in the questionnaire reflected the view of the elderly only or would the view of the family members be taken into consideration. Over 80% of the questionnaires were answered with the involvement of proxies, who in most cases were family members of the older persons interviewed. In other words, the views of family members were taken into account in at least 80% of the cases.

actual interest of another 35.3% of the respondents would depend on the actual design, in particular the means test[76], of the scheme.

204. In general, the interest on the RCSV was found to be moderate among all respondents. Survey results showed that ageing at home was still a preference for many respondents. For some elderly persons with no immediate need for RCS, remaining on the CWL might not be a problem. However, for those interested, shortening the waiting time, and the flexibility/choices allowed were attractive elements, enough for them to consider RCSV as an alternative to waitlisting.

205. The RCSV should provide enough incentives for elderly persons on CWL who might otherwise have to remain on the CWL for subsidised places in the non-profit sector/EBPS or have to use their own means to reside in a non-subsidised RCHE until a subsidised place is allocated. If a prudent approach were to be adopted and the 11.8% figure were to be projected onto the sampling population of elderly persons waiting for a subsidised C&A place (N=25 525 as at July 2015), it could be assumed that roughly 3 012 elderly persons would have a clear inclination to consider RCSV at its commencement. Based on the number of new applications for C&A places in the year before July 2015 (n=15 525), it is estimated that each year, an additional 1 832 older person might be interested in the RCSV. Both figures above have yet to take into account the 3.4% elderly persons who would be expected to take up the voucher consider when needs arose.

206. Some stakeholders were of the view that since most of the respondents did not indicate interest in taking up the RCSV at time of the interview, a pilot scheme should not be launched. While it is understandable that one of the concerns behind was the cost-effectiveness in introducing the RCSV if the number in taking up the voucher was too small, the preliminary interests shown by the respondents seemed to be adequate to eventually absorb at least 3 000 vouchers for pilot purpose. Nevertheless, results from the survey were based

[76] As mentioned in paragraph 130 of Chapter IV, interviewees were provided with information of the key features of an RCSV before answering the relevant questions. In the case of the means test and co-payment arrangements, the older persons (and their proxy/carers) were informed that RCSV might include a variable co-payment arrangement, with the amount of subsidy to be determined based on the financial situation of the applicant as an individual or the family. Detailed recommendations drawn up subsequent to the questionnaire survey might affect the interest of older persons in RCSV. For instance, the recommendation that CSSA recipients would not be required to make any co-payments would likely increase the interest of CSSA recipients, which accounted for some 35.2% of the older persons interviewed, in joining the scheme.

on a hypothetical scenario, the actual receptiveness of the voucher has to be tested out with a pilot scheme designed to optimise its benefits as an additional option to remaining on the CWL.

207. One of the key objectives in the introduction of a pilot scheme for RCSV is to use demand-side subsidies as an incentive to improving the service quality in the private sector. The hypothetical scenario depicted in the questionnaire was a selective subsidy through RCSV to recognised providers who are able to meet certain quality standards (i.e. EA1 or above). For the potential service providers, informant interviews revealed that operators in general welcome the idea, while their enthusiasm to be an RSP varied by their perceived cost-effectiveness and barriers to participating in the RCSV scheme. It is worth noting that a fair number of RCHEs currently at a standard below EA1 had indicated their intention to upgrade; and a considerable percentage of RCHEs in the non-profit sector also showed their interest as a service provider. Therefore, our initial findings did suggest that RCSV could offer an opportunity for RCHEs to improve their service quality. In addition, the spectrum of service providers for users to choose from has also widened.

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

Considerations on potential undesirable effects

209. As mentioned in the previous chapter, there might be some potential undesirable effects of the RCSV. Some of them have been echoed by stakeholders in various public engagement events.

<u>Premature or unnecessary institutionalisation</u>

210. There have been concerns that introducing RCSV would run the risk of 'inducing demand on RCS', i.e. 'encouraging' elderly persons not having pressing need for institutional care to use RCS. The concern stems from the observation that there is a tendency for elderly persons who are assessed to have LTC needs to opt for RCS on the CWL in view of the long waiting list for subsidised residential service. Given that subsidised services would be provided under a voucher

scheme, some suggested that the introduction of RCSV might, similar to other means for providing subsidised RCS, may induce premature or unnecessary institutionalisation. This concern is well considered in the Study.

211. Findings from the survey revealed that the response to the proposed RCSV with means-test and co-payment mechanism was moderate and not extraordinarily high. As shown in the survey findings, when asked if they were offered a subsidised RCS place (i.e. be it RCSV or a subsidised place in contract/subvented/EBPS homes) now or in the near future, a majority of them (54.5%) indicated that they would not; or probably would not take the offer. Further examination of the results revealed that the percentage is higher for elderly persons who are currently living in the community (69.1% for Type A interviewees who were receiving CCS and 66.8% for Type B interviewees who were not receiving CCS) and lower for those already institutionalised (33.0% for Type C interviewees). This reflects a strong preference for ageing at home should circumstances allow. In actual fact, the non-acceptance rate when being offered a subsidised C&A place was 22.3%, reinforcing the understanding that most CWL applicants would still prefer living in the community. In addition, only 11.8% of the respondents indicated a strong preference for a means-tested RCSV. While the RCSV does appear to meet the needs of this group of elderly persons, it does not appear that elderly persons would be enticed to premature or unnecessary institutionalisation. This is particularly true given that elderly persons interviewed in the questionnaire survey demonstrated a preference for ageing in place even when the alternative available was subsidised RCS in contract or subvented homes, which in general had higher staffing and space requirements.

212. As elderly persons have to be assessed for their level of care needs through the SCNAMES, before they are eligible for RCSV, no one could be drawn to the scheme without being assessed to have such need. RCSV therefore only serves to provide an additional choice for CWL applicants whose level of frailty would render them necessary to move to an RCHE, especially if they do not have viable support from family caregivers, and are therefore not suitable or safe to rely on CCS.

213. It is noted that in some cases, institutionalisation could be delayed with the provision of adequate CCS support. An accurate care need assessment mechanism, together with a more intensive follow-up service, should be in

place to ensure an appropriate service matching. In this regard, we note that the SCNAMES is under review[77] with the objective of developing a more effective assessment system for better LTC service matching. In terms of CCS, the number of day care places has increased from 2 799 in July 2014 (the time when this study commenced) to 3 011 in December 2015, while another 748 additional places are in the pipeline and will come into operation from 2016-17 onwards. The supply of subsidised home-based CCS has been increasing as well. In March 2015, the major service content of the Pilot Scheme on Home Care Services for Frail Elders (including elder-sitting and on-site carer training) was integrated with that of Enhanced Home and Community Care Services (EHCCS), and additional resources for 1 666 additional places was provided. On top of the above measures, the Government launched the first phase of the CCSV Pilot Scheme in September 2013 and is planning to launch the second phase in 2016, which would provide a total of 3 000 subsidised CCS places to strengthen support for frail elderly persons living in the community. It is also expected that a further 2 000 additional CCS places would be provided under the Special Scheme on Privately Owned Sites for Welfare Uses.

Impact on pricing and service quality

214. There were concerns that private RCHEs might just mark up the price level without providing commensurate quality service to voucher users.

215. To avoid this undesirable effect and ensure the service quality reaching the required standard, it would be important for SWD to ensure that participating RSPs could meet the space and staffing standard and provide a 'standard service package' under service agreement for RSPs and effective control and monitoring be implemented.

216. In addition, by setting the standard of service at a level higher than the basic requirements as stipulated in the RCHE Ordinance, it would allow room for improvement in service quality. As at end-September 2014, 89% of the 622 RCHEs providing non-subsidised places are in the private sector, among them, 10.8% have participated in the EBPS at EA1 level and 14.8% at EA2 level; while 74.3% did not participate in EBPS. Our survey findings revealed that on average, 24.2% of RCHEs currently not reaching EA1 standard intended to

[77] Project on Enhancement of the Infrastructure of Long-term Care in Hong Kong (including a review of SCNAMES).

upgrade in order to join the voucher scheme. There are also a number of RCHEs that might do it later as 33.3% stated that they have not decided. Therefore, among service operators, there was intention to upgrade with the economic incentive provided by RCSV.

Cream-skimming problem

217. 'Cream-skimming' or 'shunting' may result if the service providers select the users strategically, preferring those with lower care needs over those with higher needs relative to costs. This undesirable effect can be minimised by specifying clearly the service requirements and output measures in the service contracts, including criteria in admission and rejection of voucher users, detailed specifications on the service package to be provided etc. Furthermore, supplementary payments can be made to make the service contract more cost contingent, such as provision of supplementary allowances for additional care needs, allowance for top-up payment, etc.

Supply and demand

218. To estimate the possible number of places suitable for RCSV in the market, the consultant team has assumed EA1 as the benchmark when designing the two questionnaire surveys and the findings were based on the respondents' understanding of the hypothetical situation based on an 'EA1-equivalent' service standard.

219. In our subsequent public engagement events with stakeholders, the consultant team was well aware that the eligibility of RSP and the quality of service of private RCHEs were one of the major concerns raised by the participants. Some alleged that as the expectations of the society on the quality of services for the elderly are changing, the eligibility for RCSV should aim at a level higher than that of the current EA1 standard. On the other hand, some private operators had expressed their difficulties in making improvement without additional support from the government.

220. We note that it is the Government's policy direction to upgrade EA2 places to EA1 places[78] and the Government has placed additional resources to assist

[78] Provision of subsidised residential care places for the elderly and persons with disabilities and provision of healthcare services to patients in residential care settings (2013). Information for the Panel on Welfare Services cum Panel on Health Services, Legislative Council on 29 January, 2013. Retrieved from: http://www.legco.gov.hk/yr12-13/english/panels/ltcp/papers/ltcp0129cb2-548-1-e.pdf

RCHEs in conducting such upgrading. In addition, the government has stopped purchasing new EA2 places under EBPS since 2011-12. Therefore, in the long term, it would be a retrograde step if the service standard is at below EA1 level. On the other hand, setting a standard equivalent to subvented/contract homes would also be unrealistic. Appendix V illustrated the spacing and staffing requirements of various types of RCHEs. Given the high rent and the unavailability of suitable premises, it would be extremely difficult for RCHEs in the private sector to improve merely the spacing requirement ($16m^2$ to $18m^2$), let alone other requirements in staffing. Without such incentive, it would defeat the purpose of RCSV in providing users with more choice and improving service quality of private RCHEs.

221. While the consultant team would agree that the Government should aim at continuously improving the standards of private RCHEs services via increasing standard of requirements for EBPS, it is not practical or feasible to require private RCHEs to upgrade their standard to subvented service level in a couple of years' time. As a matter of fact, the Bought Place Scheme was introduced in 1989 and its enhancement, i.e. EBPS, could only be introduced 9 years later in 1998, at a two-tier standard, i.e. EA1 and EA2. The proposed RCSV would immediately improve the quality of service of some of the private RCHEs, especially for those CWL applicants who are CSSA recipients currently living in those private RCHEs. If there is no incentive for the private RCHE operators, the possibility of improving the quality of service (especially for those CSSA CWL applicants) would even be lower in the short run. Having regard to the views of stakeholders and taking into consideration the actual situation of the non-subsidised RCS market, as well as the expressed interest of the RCHEs, the consultant team has decided to base the estimate on the availability of vacancies for RCSV at an EA1 level.

<u>Availability of vacancies at EA1 standard or above</u>

222. As at 31 July, the number of vacancies in non-subsidised C&A places in self-financing/subvented/contract homes was 865. As for EA1 homes, the number of vacancies was 738. These would mean a total of 1 603 vacancies at EA1 level or above. In addition, the number of non-subsidised vacancies at EA2 level was 601 and at non-EBPS private homes was 9 469 (Chapter II, Table 2.5).

223. That is to say, if EA1 level was set as the standard for RSPs and assuming the places at self-financing/subvented/contract homes could meet the EA1 level,

the existing number of readily available and suitable vacancies in the market is 1 603. Some stakeholders were concerned that the spectrum of RCHE type available for voucher users to choose from was not wide or diversified enough. Our survey findings indicated that both NGOs and private operators showed interest in joining the scheme although at the initial stage of the pilot scheme, some operators might adopt a wait-and-see attitude. In the long-run, with more suitable places in the NGO sector entering service, it is expected that the choices available for vouchers users would be more diversified.

224. Given that one of the key objectives of RCSV is to induce service improvement, it is also necessary to consider if other categories of operators will likely be encouraged to improve their quality of service and hence increase the number of RSPs. In particular, operators of EA2 homes and non-EBPS private homes should be allowed and encouraged to raise their standard and apply to become an RSP. Preliminary findings from service providers showed that there was some interest among EA2 and non-EBPS private homes in admitting RCSV users; 63.0% and 33.6% respectively. It was also noted that quite a number of homes among EA2 and non-EBPS private RCHEs have not decided (15.2% and 14.0% respectively) (Chapter IV, Table 4.2). The reasons these RCHEs provided for not having decided suggested that some could not make a decision yet at this point because they thought they did not have enough information.

225. A detailed analysis on the availability of places suitable for RCSV is provided in Chapter VI and Appendix VI.

Factors that may have a bearing on the feasibility of the voucher scheme

226. From the above analysis, assuming that the standard for RSPs was set at EA1, it was noted that a substantial number of homes not currently meeting EA1 standard have to be upgraded to increase the supply and to ensure enough competition for potential improvement in service quality. However, we learn that from the two phases of EBPS upgrading exercises (EA2 to EA1), private homes might have concerns in making the corresponding investment. In the first phase of the exercise, among the 19 EBPS homes approved, 6 had not implemented the upgrading[79]. In the second phase of the exercise where a

[79] Among these 6 homes, 5 of them had their existing bought places above 50% of their capacity and hence had to have the existing number of purchased places reduced if upgrading were implemented.

'cost-neutral' approach[80] was used, there were 10 applications, among them, 5 were rejected and 2 did not implement the upgrading.

227. From the questionnaire survey on service providers, findings showed that among the EA2 respondents, 36.1% stated that they have intention to upgrade to EA1 and the estimated time needed for the upgrading is 6 months to 1 year. Among non-EBPS private RCHEs, 20.2% reported their intention to upgrade to EA1 and the time needed was within one year. However, in both types of RCHEs, around one-third stated that they had yet to decide whether to upgrade or not (Appendix IV, Table XI). Therefore, the figures have to be interpreted with caution as quite a considerable number of operators were still contemplating the business viability of taking in RCSV users.

228. The RCSV is to provide an additional choice for applicants on the CWL. And as stated in the 2013 Policy Address of the Chief Executive, the policy direction is on 'diversified choices', '[offering] elderly people more diversified choices through a wide range of new and flexible modes of subvention and service delivery'[81]. We learnt from the questionnaire survey that the proportion of applicants willing to consider subsidised place in the private sector through RCSV was roughly three times more as compared with those willing to consider EBPS on the CWL. And it has been very clear in the survey finding that the opportunity to shorten waiting time and the choice they can exercise were the major appeal for this group of applicant.

229. Therefore, in designing the pilot scheme, the voucher should be attractive enough so that the advantage of receiving immediate subsidised RCS through RCSV can outweigh the loss of the potential benefits in continuing the waitlisting status on CWL. Mechanisms to ensure quality of service of the RSPs, respect of users' choices, and the assurance that the voucher would have minimal impact on the potential benefits for those with limited means should be considered in designing the voucher scheme.

Other issues

230. Manpower shortage is a concern for many RCHEs. Although this is not within the scope of the current study, it has to be addressed at a practical level.

[80] An approach whereby SWD commits to purchase EA1 places from the upgraded RCHE, and where the total cost for purchasing the EA1 places remains the same as that for the previous EA2 places.

[81] 2013 Policy Address. Retrieved from: http://www.policyaddress.gov.hk/2013/eng/p106.html

While the implementation of the RCSV would provide additional resources to the participating RCHEs, it would also bring about increase in demand for various levels of staff including personal care workers, health workers, nurses and PT. Considerations should be made to increase the quota for projects such as the 'Navigation Scheme for Young Persons in Care Services', and the 'first-hire-then-train' pilot scheme, which targeted at young persons to work in the elderly services. It is noted that, the Employment Programme for the Middle-aged, which provides a training allowance for employers, also covers the elderly services sector. Additional measures to make use of this channel or other initiatives in encouraging middle-aged persons in joining the sector and serve as a potential source of manpower can be explored in the longer term.

231. The Government has also adopted several measures to tackle the problem, including the launching of a strategic review of healthcare manpower planning and professional development in Hong Kong, increasing the student intake for OT, PT and nursing programme in the 2012-15 triennium, continue with the Enrolled Nurse Training Programme for the Welfare Sector, the Training Sponsorship Scheme and to develop a clearer career prospect in the elderly care service industry[82].

[82] Information provided by LWB in consideration of Chapter 1 of the Director of Audit's Report No. 63. Retrieved from: http://www.legco.gov.hk/yr14-15/english/pac/reports/63/app_15.pdf

CHAPTER VI: RECOMMENDATIONS

A proposed pilot scheme on RCSV

Scope of the design

232. The scope of the pilot scheme design includes eligibility criteria, types of service providers and scope of services to be covered by the pilot scheme; voucher value; co-payment mechanism and means-testing mechanism; service quality assurance requirements; and how the pilot scheme should be implemented and assessed.

Objectives of the RCSV scheme[83]:

233. The main objective of the pilot RCSV scheme is to test the "money-following-the-user" approach in non-subsidised RCS. Having regard to the analysis on the potential benefits of RCSV, this means that the pilot scheme should be designed in order to test whether RCSV can:
    (a) provide elderly in need with a viable alternative for financial support other than CSSA so that they may receive RCS from eligible private or self-financing RCHEs;
    (b) allow those financially more capable elderly and their families to share part of the service costs in accordance with their financial ability;
    (c) offer eligible elderly a wider choice of RCS, thereby better utilising the capacity of private RCHEs and enhancing their service quality; and
    (d) encourage the overall participation of private and self-financing RCHEs in the provision of elderly services, with a view to making available more quality care places in the medium to long term.

Recommendations

RSPs and scope of services

234. There are four different standards applicable to C&A Homes in the market by spatial and staffing requirements:
    (a) Standard and requirements stipulated in the RCHE Ordinance (Cap 459);
    (b) EBPS EA2 level;
    (c) EBPS EA1 level; and
    (d) Standards above EBPS EA1 level (note: this includes the standard and requirements for most of the contract/subvented homes).

[83] Press conference by the Secretary for Labour and Welfare (17 January, 2014). 2014 Policy Address Care for the Elderly and Support for the Disadvantage. http://gia.info.gov.hk/general/201401/17/P201401170730_0730_123563.pdf

235. Appendix V illustrates the staffing and floor space requirements of various RCHEs providing non-subsidised places. The basic statutory requirements are set for all licensed RCHEs. A higher standard in floor space and staffing is required for private homes under the EBPS. Specifically, there are requirements on nursing staff and PT for EA1 homes. Subvented/contract RCHEs have additional requirements for registered social worker, qualified nurse and therapists (PT or occupational therapist (OT)).

236. Apart from statutory regulations, there are other society-based accreditation and non-statutory schemes to set standards in the provision of elderly services. Participation in these accreditation schemes is voluntary and usually, a fee is involved. Instead of using input control, these schemes often include criteria regarding quality of service provision process.

237. The voucher scheme should be able to allow more choices for eligible users and be able to induce competition for improvement in service quality. If the requirements for RSPs are set at the basic level, i.e. non-EBPS private RCHEs, although eligible voucher users could have more choices, incentive for RCHEs to improve their quality of service would be low. In view of the objective of incentivising more supply of quality RCS places, it would be desirable to set it at a level higher than the basic standard.

238. On the other hand, standards for contract/subvented homes which require more stringent staffing input and floor space per capita, may be difficult for operators to meet. Adopting such standards may thus limit the number of choices for the elderly. A balance has to be struck in setting the threshold.

239. Among the two categories of EBPS places, EA1 requires a higher per capita net floor area as well as nursing and PT input. Pegging the RSP standard at the higher standard of EA1 is likely to give more assurance in service quality and be more attractive to the elderly. Furthermore, it will incentivise private home operators to improve their service quality. As mentioned, survey findings suggested that a 'wait-and-see' attitude towards the RCSV. In other words, these EA2 and non-EBPS private RCHEs will probably be willing to consider upgrading to EA1 standard or above in order to join the voucher scheme.

240. As the majority of potential voucher users are waitlisted for C&A places, if the scope of services provided by the RCHEs are comparable to that of subsidised

C&A places[84], it should be sufficient in meeting the basic care needs of the elderly at large.

241. There were views suggesting that the proposed voucher should also be applicable to elderly persons waiting for NH on the CWL due to their higher level of impairment and thus, more urgent need for RCS. Contrary to that of the C&A homes, currently there is only a limited supply of NH places (especially non-subsidised places) in the market[85]. As such, there would be very limited choices for voucher users looking for NH places and the effectiveness and potential merit of applying voucher in the NH service could be rather limited at this stage. It would be more feasible to target at those waitlisting for C&A homes because of the much larger numbers in both supply and demand as compared to those of NH. Therefore, it is recommended that the voucher should only be offered to those waitlisting for C&A homes under the pilot scheme. The possibility of extending the application of voucher to NH places may be explored taking into account the experience of the pilot scheme.

242. Another consideration on RSPs is whether the past performance records of the operators should be taken into account on top of the space and manpower requirements. It is noted from the public engagement exercise and the society's discussion on quality of RCHEs that, stakeholders generally prefer having more measures to ensure the quality of service providers. As discussed in previous chapters and as revealed in the questionnaire survey with elderly persons, one of the factors affecting user's willingness to participate in RCSV is their confidence on the quality of RSPs. While the proposed space and manpower requirements should be sufficient to meet the care needs of voucher users, as well as provide input control to ensure quality services to be provided, there may still be a need to take into account the track record of RCHEs in

[84] Subsidised C&A homes are required to provide the following services in general:
(a) accommodation within shared rooms;
(b) provision of at least 3 meals a day plus snacks;
(c) laundry service;
(d) nursing services, including administration and supervision of medication;
(e) staff on duty 24 hours per day;
(f) regular visits by a registered medical practitioner;
(g) personal care services, including assistance with activities of daily living;
(h) therapeutic exercise and treatment, on a group or individual basis, to maintain or improve the functioning of residents; and
(i) activities organised on a regular basis to meet the social and recreational needs of residents, to encourage residents to pursue their interests, and to maintain residents' contact with the community and families.

[85] For example, in July 2015, there were only a total of 1 375 non-subsidised NH places.

deciding their eligibility to participate in the pilot scheme, so as to strengthen the confidence of users. The detailed track records proposed to be considered are listed in recommendation 1 below. It should be noted that apart from track records, other eligibility criteria for joining as RSPs (in particular the space and manpower requirements) should only focus on the standard attained by an RCHE at the time of the application (i.e. after any possible conversion) without considering which type of RCHE the applicant was.

243. The government may consider providing incentive for RCHEs to obtain accreditation from a scheme certified by the Hong Kong Certification Body Accreditation Scheme. For example, RSPs that make the application for the first time can be reimbursed with 50% of the fee after completion of the procedure. In the long run, accreditation scheme(s) should be considered an integral part of the eligibility criteria to serve as an additional quality control measure that focus on the process and procedures in service provision rather than service input.

244. SWD should be the approving authority of RSP applications. SWD may reject an application despite the applicant has no conviction or warning record. Circumstances that may warrant such rejection include serious misconduct of the applicant which is not prosecutable under the RCHE Ordinance or cases of fatal/serious injury that are still waiting LORCHE/police investigation.

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

(i) have no record of conviction under Residential Care Homes (Elderly Persons) Ordinance (RCHE Ordinance) (Cap 459) or other criminal offences directly related to operation of the RCHE in the last five years prior to the date of application for RSP; and

(ii) in one year prior to the date of application for RSP, have received no more than two warning items from SWD and a clean record in the past 6 months.

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

recognised accreditation scheme(s).

245. The location of the RCHE is a significant factor for the elderly in choosing an RCHE and 99.5% of the applicants for C&A places had indicated preferences on District/Regions/Homes. In the questionnaire survey on applicants, 66.4% among those who indicated their interest in RCSV either now or when need arose also stated the location of the RSP as an important factor (Appendix III, Table XXXVIII). In view of the elderly persons' preferences on RCHE choices in terms of their location, it would be useful to include RHCEs across the 18 districts.

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

246. To ensure that public funds are channelled to voucher users properly, the scope of services to be provided by the RSP should be clearly specified in the service contract. In the long-term, health condition of those living in C&A places would deteriorate and it is likely that they will need to be waitlisted for a higher level of care eventually. There has been concern regarding provision of additional care to voucher users while waiting for a facility providing higher level of care.

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

An analysis on the availability of EA1 equivalent places for RCSV

247. This section explains the methodology adopted for analysing the number of available EA1 equivalent places for RCSV. Detailed calculations can be found in Appendix VI.

248. To estimate the availability of EA1 places, the number of vacancies of non-subsidised places was used as the basis for subsequent estimates. Table 6.1 illustrates the number of vacancies of various types of RCHEs as at July 2015.

Table 6.1: Number of vacancies of non-subsidised C&A places

Non-subsidised places as at 31.7.2015[86]	**Capacity**	**Vacancies**	**%**
Self-financing homes	3 097	733	23.7
Subvented homes	358	37	10.3
Contract homes	1 262	95	7.5
Sub-total	***4 717***	***865***	***18.3***
EA1 homes	4 148	738	17.8
EA2 homes	3 944	601	15.2
Sub-total	***8 092***	***1 339***	***16.5***
Non-EBPS private homes	33 878	9 469	28.0
All private homes (i.e. EBPS and non-EBPS homes)	41 970	10 808	25.8

249. While the number of vacant places in each type of RCHEs is already available, these numbers do not translate directly into places that that will be available for RCSV on day 1 of its implementation, since: (i) some vacancies might be from RCHEs that will not be interested to join RCSV; (ii) for some RCHEs, the reduction in places[87] arising from their upgrade to EA1 or above space standard means that it will not be financially viable for them to join RCSV; (iii) for RCHEs willing to upgrade, the expected number of vacancies available after upgrading will likely be smaller than the existing one; and (iv) it takes time for RCHEs to upgrade.

[86] Information provided by SWD.
[87] The reduction of places is resulted from the difference in required net floor area per capita.

250. To take the above considerations into account, the following adjustments were made to vacancy figures detailed in Table 6.1:
    a) to address consideration (i), reference was made to the findings of the questionnaire survey for operators to estimate the proportion of RCHEs interested and ready to join the scheme. Paragraphs (i) to (vi) of Appendix VI provide further details of the adjustment;
    b) to address considerations (ii) and (iii), an estimation was made to assess the number of homes that will find it financially viable to upgrade, as well as the number of remaining vacancies after the upgrading to EA1 space requirements. Paragraph (ii)(c) of Appendix VI provides further details of the adjustment ; and
    c) to address consideration (iv), a model was developed to simulate the number of RCHEs that would be able to complete the necessary upgrades at different time points after the launch of the scheme. Paragraphs (vi) to (xi) in Appendix VI provide further details of the adjustment.

251. In estimating the number of vacancies available for RCSV, it should also be noted that some elderly persons waitlisted for subsidised C&A are already living in RCHEs that will become RSPs. If these elderly persons decide to opt for RCSV and remain in the same RCHE, they will not require a separate vacant RCSV place. In other words, the actual number of places needed will likely be less than the number of voucher users/vouchers issued. To take into account this consideration, an estimation was made on the expected proportion of vouchers that will be issued to CWL waitlistees that are already residing in an RCHE that will become an RSP. Paragraph (xii) and onwards in Appendix VI provide further details of the adjustment.

252. After making the above adjustments, it is estimated that by the end of the third year of the pilot scheme, a total of 2 043 RCSV places will be available from the existing pool of vacant places shown in Table 6.1 above. On top of these 2 043 places, another 439 places will be from vouchers issued to existing CWL applicants living in would-be RSPs, assuming a total of 3 000 vouchers are issued by the third year. Table 6.2 below shows the estimation on when the 2 043 places will become available. A detailed breakdown of the 2 043 places is provided in paragraph (x) of Appendix VI. As for the 439 places from existing CWL applicants living in would-be RSPs, when these places become available will depend on the arrangements for issuing vouchers.

Table 6.2: Estimated number of EA1-equivalent places from existing pool of vacancies at different time points

Point in Time (Months)	Number of places (cumulative)
1-6	952
7-12	1 489
13-18	1 784
19-24	1 931
25-30	2 005
31-36	2 043

253. The total number of places available from the existing pool of vacant places (i.e. 2 043) and places available from vouchers issued to CWL applicant living in would-be RSPs (439) is 2 482. While this number is smaller than 3 000, it is noted that the estimated total has yet to take into account the following: (i) the additional number of non-subsidised places that will become available from new contract homes and the Special Scheme on Privately Owned Sites for Welfare Uses in the coming years; and (ii) turnover of non-subsidised places. The second factor will likely be able to affect the total number of RCSV places available significantly. As deducible from Table 6.1 above, as of 31 July 2015, a total of 7 262 elderly persons are residing in non-subsidised places in contract homes, subvented homes, self-financing homes and EA1 EBPS homes. From the survey with RCHEs, the average turnover rate is around 15.6% per year. This means that on average, from these four types of homes alone, around 1 133 vacant places will become available each year. Considering the estimated number of 2 482 mentioned above, as well as the two additional sources of RCSV places detailed above, it is expected that by the end of the third year, the pilot RCSV will be able to at least meet the demand of 3 000 voucher users.

254. Since it takes time for RCHEs to upgrade their services, the vouchers of the pilot RCSV should be issued in batches. As shown in Table 6.2 above, it is estimated that on day 1 of the implementation of the pilot RCSV, 952 EA1-equivalent places will be available from the existing pool of vacant places. Given time, more places will become available from homes that are able to upgrade, new non-subsidised places from new contract and subvented homes, and from turnover of existing places. While it is possible to simply follow the figures in Table 6.2 in drawing up the arrangements for issuing vouchers, it will also be

advisable to consider other factors not related to supply and demand forecasts.

255. In particular, it is noted that as RCSV involves the implementation of the new "money-following-the-user" concept in the provision of subsidised RCS, relevant parties including elderly persons and their carers, service providers, SWD, as well as other stakeholders from the welfare sector may need time to adapt to the new model. Furthermore, the pilot RCSV is also recommended to provide case management services for voucher users (see Recommendation 6), which is a relatively new concept for subsidised RCS, as this will include service elements such as helping elderly persons in making informed choices in RSP selecting/switching, service monitoring, as well as providing other support services.

256. Given the considerations above, it is recommended that the pilot RCSV should be implemented in a phased approach. This could help the stakeholders to familiarise themselves with the scheme and the administrative procedures, test out the receptiveness of RCSV in the market by stages and to allow time for RCHEs to upgrade to the required EA1-equivalent standards.

257. The proposed phased approach involves three stages. In Phase 1, all subvented homes, contract homes and self-financing homes would be invited to apply as RSPs. Invitation to join Phase II, roughly in the second year after commencement of the pilot scheme, would be extended to existing EA1 EBPS homes. The third and final phase would be extended to all RCHEs that have reached EA1-equivalent standards and other RSP requirements. Subject to take up rate and successful matching of the vouchers available, Phase III of the pilot scheme is estimated to be launched in the third year after implementation of the RCSV.

258. The following table illustrates a snapshot of the EA1-equivalent vacancy situation at different timeline during the pilot period and the proposed number of RCSV to issue.

Table 6.3: Proposed number of RCSV and snapshot of EA1-equivalent vacancy situation at different timelines

Phase	Month	Types of RHCE	Batch	Estimated places from existing vacancies	RCSV issued to RCHE residents	RCSVs issued to others
I	1-6 (preparatory work)	Subvented/ Contract/ Self-financing homes	NA	NA	NA	NA
	7-12		1	214	42	250
II	13-18	Subvented/Contract/ Self-financing homes+ EBPS EA1	2	979	164	750
	19-24		3	992	167	1250
III	25-30	All homes meeting RSP requirements	4	2005	373	1750
	31-36		5	2043	439	3000

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

- ***Phase I[88]: limited to all eligible subvented/contract and self-financing homes;***
- ***Phase II: limited to homes eligible for Phase I plus EA1 EBPS homes that have met the requirements of RSP***
- ***Phase III: limited to homes eligible under Phase I and II, plus any other RCHEs that have met the requirements of RSP.***

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

[88] Allowing 6 months for preparatory work after commencement of the pilot scheme, the first phase will take around one year.

Assurance of informed choices

259. To ensure that the choice made by the elderly persons is well-informed, information about the RSPs should be made transparent, easily accessible either in written form or on the internet. The elderly persons and their family caregivers, if appropriate, should also be educated on how and where to find such information.

260. Given the variation in choices of elderly persons and the variety of RSPs, there is a need to provide sufficient professional assistance to the elderly persons to make informed choices. At the initial stage of the study, the idea of having the RWs serve as case managers has met with strong objections from RWs. Apart from the workload considerations, the possibility of conflict of interest due to the fact that the respective RWs may be working in NGOs which are also RSPs for RCSV is raised. After careful consideration, it is proposed that SWD should be the agent in provision of case management service under the pilot scheme.

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

261. Another major concern with respect to ensuring informed choices for elderly persons relates to the accessibility and transparency of information that may assist voucher users in making consumption choices.

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

262. The RSPs should be responsible for providing updated information related to number of beds, vacancies, fees and charges[89] and the system should be maintained by the LORCHE.

Target recipients

263. In view of the limited number of NH providing non-subsidised RCS places, the large number of applicants waitlisting for C&A places on CWL and the larger availability of vacant non-subsidised C&A places in the market, it would be desirable to provide RCSV to applicants who are applying for C&A places under the pilot scheme.

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

264. Our survey findings have suggested that factors such as the duration on the CWL, current care arrangement of the applicant and CSSA status might affect the receptiveness of the RCSV. Options for offering vouchers to eligible clients considered by the consultant team include by open application and by invitation by systematic sampling. The merit of inviting applications by systematic sampling is that for a pilot scheme, this could test hypotheses derived from the survey findings in regard to the receptiveness of the RCSV to various categories of applicants, and the results could be used for further developing the scheme with a view to better targeting potential voucher users in the future. However, this may be perceived as lacking transparency and those with more immediate need might not be invited. Open application might have the potential disadvantage of being unfair to those who are relatively disadvantaged; such as those who are more frail while lacking family/social support and may not know how to apply; though it has the advantage of being available to all who think they have immediate need for service. In consideration that the concern regarding those who are relatively disadvantaged could be managed by broadening the publicity, open application is recommended. In addition, if the number of applications exceeds that of the vouchers issues, priority could be set for those with more immediate need. From the survey, we know that the respondent who are currently residing an RCHE and on CSSA are most likely to be interested in RCSV. Assuming that interest in RCSV is an indicator of their

[89] SWD will require RSPs to make their price lists for top-up items itemized charges transparent to voucher holders and the public and SWD may give directions in the regard as necessary

perceived immediate need for RCS, residency in an RCHE and CSSA status could be considered as parameters for prioritising the allocation. Another factor to consider is the longer duration on CWL, which may imply a further deterioration of the applicant's health condition. These parameters should be considered with their relative weight of importance in the allocation of the voucher, so as to ensure quality of life of the elderly.

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

Status on CWL

265. To encourage the use of the voucher and to allow time to build up confidence, it is recommended that a trial period be allowed for applicants to make up their mind if they choose to switch to and stay in the voucher scheme. This measure can allow the voucher user a 'trial period' to build up their confidence in an environment they are likely to stay for a considerable period of time.

Recommendation 10: ***A period of 6 months[90] (counting from the date of issue of the RCS voucher to the applicant on CWL) should be allowed as a trial period for an applicant opting for RCSV. RCSV users can switch between RSPs during and after the trial period. If an RCS voucher user chooses to opt out of pilot scheme and return to the community after the trial period, he/she will be offered a CCSV as an alternative subject to availability.***

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

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

Voucher value

266. The price range of various types of non-subsidised RCS was reviewed. According to the record in September/November 2015, on average, licensed private homes charged between $5,445 to $8,792 per month, which is the lowest priced group of operators, as compared with those offering non-subsidised places in self-financing homes (average charge ranged from $8,848 to $20,943 per month) and subvented and contract homes (average charge ranged from $9,014 to $15,137 per month). The price range of non-subsidised places in EBPS homes is from $5,822 to $9, 559 which is similar to that of other licensed private homes (Appendix VII). The wide price range of non-subsidised RCS allows users to choose services of various levels of quality by co-payment and/or topping-up.

267. Assuming that the standard of RSPs is set at EA1 level or above, the voucher value should be pegged at purchase price level (i.e. total amount of the subsidy and user fee) for a EA1 bought place in EBPS.

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

268. There can be two possible ways of administering the subsidy for voucher; a) by proportion or b) by fixed amount. The first option, i.e. by proportion, means that the amount of subsidy provided will be at a fixed percentage of the total expenses incurred. Since the amount of subsidy will increase with the total expenditure, it encourages those who could afford to pay for better services in the market; and would in turn stimulate improvement of services. However, the administration of a 'proportion' approach could incur higher costs as the tendency would be for the users to choose higher-end services. In addition, the Government would have difficulties in predicting and projecting the total expenditure as there could be variations in the fees charged by service providers. Thirdly, this would also likely induce the service providers to mark up their fee levels.

269. The 'fixed amount' approach adopts a flat rate that is payable to all eligible beneficiaries. This approach has the merits of administrative simplicity and cost-efficiency. This would also enable the Government to estimate the total expenditure involved based on the total number of beneficiaries. However, it

works as a disincentive to using higher-end services as the amount of subsidy is the same irrespective of the service fee. Nevertheless, if top-up payment is allowed, it could still encourage the purchase of higher-end services.

270. To balance the relative benefits and pitfalls of these two approaches, a 'sliding scale' could be used to reflect the possible wide range of difference in affordability. Findings from the questionnaire survey also suggested that a 'sliding scale' would be acceptable to most of the respondents agreeing to means test (62.6%). It is also noted that CCSV also adopts the "sliding scale" approach.

Means-test, RCSV values and sliding scale

271. Existing means-test related to elderly: There are quite a number of means-tests used within social welfare that are related the elderly. The three most relevant means-tests are those used by CSSA, OALA and the First Phase of CCSV. For comparison purpose, the standard for single person is adopted.

Table 6.6: Comparison of means-test for single person by CSSA, OALA and First Phase of CCSV[91]

	Income-test	Asset test
CSSA	Depends on need level, the average will be about $4,935[92] per month	$45,500
OALA	<$7,340	$219,000[93]
CCSV I (≤75% MMDHI)	≤$7,500	No asset test
CCSV II (>75% - 100% MMDHI)	$7,501 - $10,000	
CCSV II (> 100% - 150% MMDHI)	$10,001 - $15,000	
CCSV IV (> 150% - 175% MMDHI)	$15,001 – $17,500	
CCSV V (>175% MMDHI)	> $17,500	

[91] As of mid-2016 unless otherwise stated, based on information provided by SWD.

[92] Estimated by the basic rate of $3,200 for a singleton elderly CSSA recipient starting from February 2016 and monthly rental at $1,735, making up the total of $4,935.

[93] Owner occupied property, columbarium niche for self-use in future, and the cash value of insurance schemes are excluded

272. Existing co-payments in subsidised elderly services: there are different levels of co-payments for different types of services. For the First Phase of CCSV[94], there are five different levels, ranging from $500 to $2,500, constituting, 8.3%, 12.5%, 16.6%, 25% and 41.7% respectively for each level.

Table 6.7: Level of co-payment of CCSV First Phase and user fee for subsidised RCS[95]

Type of service/Scheme	Co-payment/User Fee
User fee for subsidised RCS	
C&A homes	$1,813 for DA recipient $1,605 for non-DA
CoC homes	$2,000
Nursing Homes	$1,994
EBPS EA1	$1,707
EBPS EA2	$1,603
NHPPS	$2,000
Co-payment for CCSV First Phase	
CCSV I	$500
CCSV II	$750
CCSV II	$1,000
CCSV IV	$1,500
CCSV V	$2,500

273. In making reference to the existing co-payment system, consideration has to be taken that service users can apply for CSSA, OALA or OAA at the same time. For instance, CSSA recipients living in subsidised RCHE can still receive the standard rate and other special allowance within the CSSA system.

Table 6.8: Standard rate by benefit schemes[96]

Scheme	Rate
CSSA Standard rate	$3,200/$3,870/$5,450 for abled/ disabled/ requiring constant attendance
OALA	$2,390
OAA	$1,235
DA	$1,580
Higher Disability Allowance (HDA)	$3,160

[94] The CCSV value is $6,250 including the co-payment.
[95] As of mid-2016, based on information from SWD website
[96] As of mid-2016, based on information from SWD website.

274. In the First Phase CCSV scheme, there are five different levels of co-payment:

Table 6.9: CCSV scheme by levels of co-payment[97]

Levels	Co-payment ratios	Co-payment ($)
I (≤75% MMDHI)	8.0%	500
II (>75% - 100% MMDHI)	12.0%	750
III (> 100% - 150% MMDHI)	16.0%	1,000
IV (> 150% - 175% MMDHI)	24.0%	1,500
IIV (>175% MMDHI)	40.0%	2,500

275. In designing the co-payment arrangements for RCSV, the following factors were taken into account:

a) As noted in paragraph 21, a significant number of elderly persons living in non-subsidised places, in particular those provided by private RCHEs, are on CSSA. Since CSSA has no room for elderly persons and their carers to make top-up payments and many RCHEs had to peg their services to the amount of CSSA payments, this has the undesirable effect of limiting the room for service improvement. One of the main objectives of RCSV is therefore to serve as an alternative for elderly persons on CSSA in obtaining subsidised RCS. Since elderly persons on CSSA generally can fully pay for the cost of RCS with CSSA payments[98], the sliding scale of RCSV should be designed in a way such that those with income and asset levels similar to CSSA recipients should not be required to make any co-payments.

b) Another objective of RCSV is to channel public resources to those most in need, and thus the amount of subsidy should focus primarily on those with less financial means. For those with the most financial means, it is considered that their co-payment ratio should be higher, though the Government should still provide a certain level of subsidy. This principle is also adopted in the design of the First Phase of CCSV, which requires users with the highest income level to co-pay the most, at around 40% of

[97] As of mid-2016. The Pilot Scheme on Community Care Service Voucher for the Elderly is implemented in two phases and the first phase of the pilot scheme is ongoing. The voucher value in 2015-16 is $6,250 per month and the co-payment value in the first phased is fixed. Source: SWD website http://www.swd.gov.hk/en/index/site_pubsvc/page_elderly/sub_csselderly/id_psccsv/

[98] On top of the standard payments, CSSA also offers special grants to elderly persons with proven needs for items such as diapers, medical consumables, etc. Furthermore, CSSA recipients also enjoy full medical waiver from public hospitals and are eligible for full subsidies under assistance schemes such as the Samaritan Fund. Recommendations 14 and 15 attempt to address these factors.

the voucher value. In the case of RCSV, given that the value of the RCSV (and the cost of RCS) is relatively high, there is a need to consider higher levels of co-payment. For elderly persons from the highest income group (say > 300% MMDHI), the co-payment ratio should be set at 75%;

c) For elderly persons between the highest and lowest income groups, it is recommended that the co-payment amount should increase gradually with income level.

276. In addition to the income level of the voucher applicants, it is also considered that the amount of co-payment to be made should also depend on the amount of assets held by the user, since the means test for the pilot scheme will cover both income and asset tests. Considerations behind the inclusion of the asset test and the determination of the asset limits are detailed in paragraph 283 and Recommendation 16.

<u>Recommendation 13:</u> Given a voucher value of $12,134, benchmarked at EA1 level, the recommended levels of co-payment[99] is:

Table 6.4: Recommended levels of co-payment

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

277. As mentioned above, one of the main objectives of RCSV is to serve as a viable alternative for CSSA recipients, or those who would otherwise apply for CSSA, to receiving subsidised RCS. It is noted that in addition to standard monthly payments, elderly persons with proven needs may also apply for special grants

[99] The co-payment arrangement recommended is applicable to the voucher value only.

[100] Latest figures (Q1 2016) as of mid-2016. When implementing the pilot scheme, SWD should regularly update the income limit with reference to the statistics on MMDHI released. The asset limits should also be updated if the corresponding amounts under CSSA and the applications for public rental housing are revised (see Recommendation 16).

to cover the cost of items such as diapers, special diet, rehabilitation consumable items, etc. In addition, CSSA recipients are also given medical waiver by public hospitals. To ensure that RCSV is indeed a viable alternative, it is necessary to consider how the medical expenses and costs of the consumable items mentioned above can be met under RCSV. This consideration is echoed by the questionnaire survey with elderly persons, which found that even though CSSA recipients displayed a moderate interest in opting for RCSV over CSSA (47.4% willing to choose RCSV over CSSA), many expressed concerns about whether the various needs currently covered by CSSA, including consumable items such as diapers, special diet, rehabilitation consumable items, medical expenses and other possible expenses such as funeral cost, would adequately be addressed after switching to the RCSV.

278. Given the above, it is recommended that the SWD will continue to provide subsidy to "Level 0"users additional/supplementary expenses (i.e. "care supplement") incurred while staying in an RCHE, i.e. consumables including diapers, special diet and rehabilitation items. For those assessed to be at 'level 0', it is recommended that they would be automatically eligible for the Medical Fee Waiver Mechanism of Public Hospital. This recommendation should address the concern of CSSA recipients mentioned above, as they will likely be categorised as 'level 0' in the proposed 8-level subsidy mechanism. On top of the voucher subsidy, CSSA recipients are likely to be eligible for OALA, which could be kept by the elderly persons as 'pocket money' or for their irregular expenses. For other miscellaneous expenses such as funeral costs, subsidy for eye-glasses, the availability of other subsidies (e.g. OALA) and charitable funds from SWD's IFSCs should provide them with the means in paying for these items. As for dental expenses, their need should be covered by the Department of Health's Outreach Dental Programme for the Elderly.

279. It is recognised that for elderly persons from other income levels, they may have need for the consumables and expenses mentioned above. However, given their monthly income and the availability of other subsidies (e.g. OALA) and charitable funds, they should have sufficient means to pay for these costs.

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

provided[101].

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

280. In the means-test, it is imperative to consider what 'income' should be taken into account. Our view is that DA, OAA, and OALA should be excluded.

281. In many other income tests, family members' contribution is usually taken as part of income. However, to be consistent with the objective of encouraging family members to contribute to the LTC of their elderly family members, it should be excluded for the purpose of the RCSV.

282. Other regular sources of income such as rental income, interest income and dividend income are normally included in income tests and should continue to be counted as part of income in RCSV.

283. As for the asset test, given the residential element of RCS, reference could be made to the asset test for public rental housing for singleton elderly households. This rate, which stands at $484,000 as of mid-2016, is also the highest among Government assistance schemes such as CSSA ($45,500), Work Incentive Transport Subsidy Scheme ($123,500), Medical Fee Waiving Mechanism ($150,000), OALA ($219,000), etc. Other arrangements of the asset test should be modelled from that of CSSA where appropriate.

284. One major issue to consider in designing RCSV is whether the means-test should be individual based or family based. If an elderly is to live in an RCHE, she/he will be living separately from the family. Moreover, most of the existing elderly persons living in RCHEs are on CSSA and are assessed on individually basis already. Means test on individual basis is also the expectation of around half of the respondents in the questionnaire survey.

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[101] Based on the sampled cases in the survey, the average special grant payment per CSSA case was $1,370 per month. Detailed design can be drawn up to the decision of the SWD, subject to various administration considerations.

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

285. Given that Level 0 users will not be required to make any co-payment and that care supplement and medical fee waiver will be available, the proposed RCSV should offer a better alternative to CSSA recipients that are waitlisted for subsidised C&A. To avoid double benefit, it is recommended that CSSA recipients opting for the RCSV should withdraw from CSSA. They will however still be eligible for other forms of social security assistance such as OALA.

<u>Recommendation 17:</u> CSSA recipients opting for the RCSV should withdraw from CSSA.

<u>Top-up payment for enhanced/value-added services</u>

286. Operators in the private sector would also be incentivised to improve service quality if more people are willing to purchase enhanced/value-added services. To this end, voucher users should be allowed to top up for enhanced/ value-added services, with a cap set on the amount. In fact, survey findings also suggested that for those who were interested in the RCSV, 78.9% of non-CSSA recipients and 53.2% of CSSA recipients alleged that they were willing to top up for enhanced/value-added services. However, given that public revenue and resources should be used equitably and efficiently to targeted recipients who are most in need, there should be a cap at the top-up payment to avoid RCSV users whose financial condition is so favourable that they pay an extraordinarily high level of co-payment and enjoy a very high-end RCS at some up-market RCHE operators.

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

Quality assurance and monitoring

287. In order to administer and monitor the service providers under the pilot scheme, an RSP will be required to sign a 'service agreement' (SA)[102] that stipulates in detail the service requirements. The SA will include the basic and required services commensurate with the EA1 level of care at C&A homes. The LORCHE of SWD would inspect RSPs to ensure compliance with the required EA1 service standard. In addition, SWD's case management service will be able to help strengthen the quality assurance through the case work provided to voucher users throughout the pilot scheme.

288. As mentioned in Recommendation 1, applicants of RSP would be encouraged to join recognised accreditation scheme(s) for continuous service improvement. Survey findings showed that the level of participation in local accreditation scheme(s) varied among different types of RCHEs, from the highest of 75% among EA1 RCHEs to the lowest of 11.1% among self-financing homes. One of the merits of these accreditation schemes is their emphasis on the process quality and the Government should consider using them as an integral part of the eligibility criteria for RSP.

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

289. As mentioned in Recommendation 19 above, SWD may issues warnings to and impose sanctions on RSPs. Details of the proposed warnings and sanctions are provided in Recommendation 20 below. In addition, to provide greater confidence to elderly persons and carers in joining the voucher scheme, SWD may suspend an RSP from accepting new vouchers despite having no conviction or warning record. Circumstances that may warrant such sanctions include serious misconduct of an RSP that is not prosecutable under the RCHE Ordinance or cases of fatal/serious injury that are still awaiting LORCHE/police investigation.

[102] Reference could be made to the Pilot Residential Care Services Scheme in Guangdong.

<u>Recommendation 20</u>: If an RSP has received a total of three warning items in one year, its status as RSP will be suspended[103] for a period of at least 6 months until it meets the qualification requirement again, i.e. no more than 2 warning items in one year. If an RSP is convicted under the RCHE Ordinance or other criminal offence(s) which is(are) directly related to the operation of RCHE, its status as RSP will be suspended for three years. Its status of RSP would be resumed only after the expiry of the suspension and when it meets the qualification requirements of RSP again, i.e. no more than 2 warning items in one year and/or conviction record in three years. SWD should reserve the right of final decision and may suspend the status of an RSP even if the RSP has no conviction or warning record.

290. SWD reserves the right to terminate the status of an RSP despite the RSP has no conviction or warning record. Circumstances that may warrant such sanctions include serious misconduct of an RSP that is not prosecutable under the RCHE Ordinance or cases of fatal/serious injury that are still awaiting LORCHE/police investigation.

<u>Recommendation 21:</u> The RSP status will be terminated[104] if the license of an RSP is being terminated or not renewed upon expiry. SWD should reserve the right of final decision and may terminate the status of an RSP even if the RSP has no conviction or warning record.

291. Regular outcome evaluation should be an integrated part of the quality assurance mechanism. As voucher users (and/or their family caregivers, if available) should also be involved in the monitoring of service, user satisfaction survey should be included as part of the regular outcome evaluation. This could empower the elderly in getting the services to meet their needs. Data of the outcome evaluation could either be collected by staff of the RSPs, SWD or outsourced to an independent agent. Either SWD or an independent third party would be a more appropriate choice to avoid conflict of interest.

<u>Recommendation 22:</u> Regular outcome evaluation should be introduced as an integrated part of the RCSV scheme.

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

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

Other issues

292. Manpower shortage is a concern for many RCHEs. Although this is not the scope of the current study, it has to be addressed at a practical level. The implementation of the RCSV would mean an increase in demand for various levels of staff including personal care workers, health workers, nurses and PT. Considerations should be made to increase the quota for such projects as the 'Navigation Scheme for Young Persons in Care Services', which targeted at young persons to work in the elderly services. It is noted that, the Employment Programme for the Middle-aged, which provides a training allowance for employers, also covers the elderly services sector. Additional measures to make use of this channel or other initiatives in encouraging middle-aged persons in joining the sector and serve as a potential source of manpower can be explored in the longer term.

CHAPTER VII: CONCLUSION

293. The previous chapters discussed the desirability and feasibility of introducing RCSV in Hong Kong. Since the concept of providing subsidised RCS through vouchers is still new to local stakeholders, it is recommended that a pilot scheme on RCSV be considered first before RCSV becomes a formal/regular service. In this connection, a number of recommendations on how a pilot scheme should be designed have been drawn up. As a conclusion of the study, the following paragraphs discuss how the pilot scheme should be evaluated so that the way forward for RCSV could be determined.

Evaluation of pilot scheme

294. Evaluation should start at least one year prior to the completion of the pilot scheme. This would include around 6 months for the evaluation and 6 months to prepare/fine-tune the scheme for launching the full-fledged programme if continuation of the scheme is recommended.

295. Effectiveness of the pilot scheme should be evaluated against the hypotheses made in designing the scheme by analysing:

(a) A means-tested voucher scheme for RCS can channel public resources to those most in need.

- distribution of vouchers by different co-payment levels and the total amount of Government subsidy involved

(b) The application of 'money-following-the-user' can increase the choice and flexibility of elderly in RCS and shorten their waiting time for subsidised RCS.

Choice and flexibility:

- the number of RSPs joining the scheme and variety of services offered;
- the number of RSP choices made by elderly in selecting or switching RSPs
- the number of applicants opting for RCSV at the end of the 6 month trial period
- results of the user satisfaction survey discussed in paragraph 291 above, in particular information on why voucher users leave the scheme before and/or after the trial period.
- the level of satisfaction of those opting for RCSV

Shortening of waiting time:

- the distribution of voucher by category of waiting time on CWL
- the waiting time of other remaining applicants at the various stages of implementation of the scheme

(c) RCSV can incentivise quality improvement of the provider.

- the number of RCHEs upgraded to EA1 level
- the level of satisfaction of RCSV users residing in the RCHEs above
- the extent to which outcome indicators set in the service agreement is achieved

(d) The use of co-payment and topping-up mechanisms encourages shared responsibility among individuals, their families and the society.

- the distribution of RCSV users by co-payment levels and top-up amount

(e) The voucher scheme can serve as an alternative for current CSSA recipients to obtain subsidised RCSV and leave CSSA.

- number of CSSA recipients switching to RSCV
- number of potential CSSA recipients opting for RCSV instead of CSSA

(f) The voucher scheme can encourage contribution from family member on co-payment and top-up elderly previously relying solely on CSSA to finance their proven RCS needs.

- CSSA recipients opting for RCSV will encourage contribution from family member on co-payment and top-up.
- number of CSSA-opting-to-RCSV by co-payment amount and top-up amount

Appendix I

List of informants

1. SME Global Alliance Ltd. (Elderly Affairs Committee)
2. The Elderly Services Association of Hong Kong
3. Hong Kong Association of Gerontology
4. Hong Kong Council of Social Services
5. Caritas Hong Kong
6. RWs from both SWD and NGOs
7. Representatives from the Elderly Branch of SWD

Appendix II

Explanation on sampling frame for the questionnaire survey for elderly persons on the CWL

1. As specified in the consultancy brief, there are six categories of cases on the CWL kept by the SWD for subsidised RCS to be surveyed:

1	Non-CSSA Recipients	Living in domestic households	Receiving subsidised or self-financed CCS
2			Not receiving CCS
3		Living in non-subsidised RCS	
4	CSSA Recipients	Living in domestic households	Receiving subsidised or self-financed CCS
5			Not receiving CCS
6		Living in non-subsidised RCS	

2. In the study proposal submitted by the consulting team, the following sampling frame is proposed:

	Categories				Sample size[#]
1	Those waiting for subsidised RCS	Non-CSSA recipients	Living in domestic households	Receiving subsidised CCS	100
2				Receiving self-financed CCS	100
3				Others	100
4			Living in private places of RCHE	EBPS/ NHPPS	100
5				NGOs: self-financed	100
6				Contract homes	100
7				Other private homes	100
8		CSSA recipients	Living in domestic households	Receiving subsidised CCS	100
9				Receiving self-financed CCS	100
10				Others	100
11			Living in private places of RCHEs	EBPS/NHPPS	*
12				NGOs: self-financed	*
13				Contract homes	*
14				Other private homes	100
15		Their care givers			400
					1 500

\# The proposed sample size is only tentative and subject to available data from SWD.

* The number of CSSA recipients living in private places in EBPS/NHPPS, self-financed and contract homes is expected to be very small.

3. After revisiting the data available as provided by the SWD and discussion with colleagues of SWD, we found a number of issues in using the CWL for sampling:

   (i) For those living in contract homes and private RCHEs, it is not possible from the CWL database, to tell if they are living in subsidised places or in self-financed places. Tough we can say that if they are waiting for care and attention homes (C&A homes) and are living in contract homes or private RCHEs, they should be living in self-financed places. However, for those who are waiting for nursing homes and are living in contract homes or private RCHE, we would not be able to tell from the data of CWL whether they are living in self-financed places or in subsidised places.

   (ii) Most of the data fields on the CWL were entered at the time of application and they are only updated when needed. While some updating have been made as a result of the invitations sent to those on the CWL for the pilot scheme on CCS voucher, carer allowance, and the pilot RCS scheme in Guangdong, many of the data fields can still be quite outdated. For many cases, we expect that their status on CSSA and the type of housing may have changed already. For instance, though at the time of application they were living in the community and not on CSSA, many of them may have moved into private RCHE and on CSSA by now.

4. Thus, some of the categories described in the study proposal cannot be clearly identified from the CWL and even for those categories that can be clearly identified, the data may not be up-to-date.

5. ***The case of inactive cases:*** for most of the publicly available information on CWL, the cases that are not active are usually omitted. For instance, there were 23 464 cases waiting for C&A as of June 30, 2014. The number of inactive cases is not included. We would expect that most, if not all, of these inactive cases are receiving subsidised CCS, and likely their readiness to take up RCS is low, even lower than that of active cases and those receiving CCS. To test this hypothesis, we would need a sub-sample of inactive cases. This element is not included in the consultancy brief or the study proposal.

6. The proposed sample size for inactive cases is 200. Assuming the overall consent and success rate of interview is 50%, 400 samples will be selected using systemic sampling based on a sequential sampling frame listed in ascending application number. According to the SWD, as of June 30, 2014, there were 6 946 inactive cases, i.e. a sampling ratio of 17:1 will be used.

7. Though with a certain degree of inaccuracy, the original categories spelt out in the consultancy brief will be used with slight modification. As of June 30, 2014, the distribution of such cases in the CWL was as follows:

			Waiting for	
			C&A	**Nursing**
Non-CSSA	Domestic	Not receiving CCS	9 292	1 005
		Receiving CCS	2 097	606
	Institutional		4 009	2 257
	Others		113	20
CSSA	Domestic	Not receiving CCS	2 958	174
		Receiving CCS	566	98
	Institutional		4 385	2 097
	Others		44	18
Total			**23 464**	**6 275**

8. In the study proposal, there would be a separate sample of 400 carers. However, judging from the previous study, we would already be interviewing a substantial number of carers because some elderly persons may not be able to answer our questions[105]. Thus, we will instead be incorporating some of the questions for carers into the questionnaire for elderly persons when the informant is the carer. In other words, there is no need to obtain a separate sample of carers. We expect to obtain about 750 samples of carers in the survey.

9. In total, there will be 200 samples of inactive cases and 1 300 samples for active cases. In the case of active cases, there would be 12 categories, i.e. to obtain an adequate sample size for analyses, there would be 108.3 samples (theoretically) per category.

[105] In the 2009 Study on RCS, the percentage of proxy (family carers) for the samples for 'only waiting for RCHE' (including community living and living in private RCHE) is 64.5% and those waiting for RCHE and using CCS is 54.2%.

10. As we are not completely sure how outdated the information of the CWL could be, we have to base some form of guesstimate on the following parameters in order to work out the actual number of samples for each category that we should select from the sampling frame:

% of those indicated as living in domestic household but in fact institutionalised at the time of survey	10%
The product of consent rates and success rates for interview	50%
% of those in institutional care not on CSSA in the CWL data base but on CSSA at time of survey	40%
% of those in living community not on CSSA in the CWL data base but on CSSA at time of survey	5%
% of those not receiving CCS as indicated in the CWL data base but at the time of survey receiving CCS	10%

11. Based on the above parameters, to obtain 108.3 sample for each category, the sample size needed would be:

			Waiting for	
			C&A	**Nursing**
Non-CSSA	Domestic	Not receiving CCS	282	282
		Receiving CCS	225	225
	Institutional		310	310
CSSA	Domestic	Not receiving CCS	253	253
		Receiving CCS	203	203
	Institutional		27	27

12. From the data provided by SWD as of June 30, 2014, and the required samples per category, the required sampling ratio used in system sampling will be as follows:

Sampling ratio*			**Waiting for**	
			C&A	**Nursing**
Non-CSSA	domestic	not receiving CCS	33	3
		receiving CCS	9	2
	Institutional		12	7
CSSA	domestic	not receiving CCS	11	1#
		receiving CCS	2	1#
	Institutional		164	78

* Meaning of sampling ratio: for instance, with a sampling ratio of 33, 1 in each 33 samples will be selected with a random start in between 1st and 33rd cases in the sampling frame, followed by 1 sample selected for every 33 cases along the sampling frame.

A sampling ratio of 1 means that all cases in the sampling frame of that particular category will be selected.

13. Based on the above sampling ratios, the expected number of cases to be obtained from the sampling frame would be:

			Waiting for	
			C&A	**Nursing**
Non-CSSA	Domestic	Not receiving CCS	282	335
		Receiving CCS	233	303
	Institutional		334	322
CSSA	Domestic	Not receiving CCS	269	174
		Receiving CCS	283	98
	Institutional		27	27

14. Based on the parameters spelt out above, the resulting samples that we would expect to be able to be successfully obtained would be as follows:

			Waiting for	
			C&A	**Nursing**
Non-CSSA	Domestic	Not receiving CCS	108	129
		Receiving CCS	113	145
	Institutional		116	116
CSSA	Domestic	Not receiving CCS	115	77
		Receiving CCS	145	59
	Institutional		118	104
Total			715	630

Note: in addition to the 1,345 samples for active cases above, there will be another 200 samples for inactive cases as indicated in paragraph 9 above, making a total of 1,545 samples.

Appendix III

List of Tables: Questionnaire survey for elderly persons on CWL

Table I: Distribution of cases by category

Description	Status on CWL	Self-reported status (%)	% of cross-tab of self-reported status x status on CWL	Population by cat.	Estimated population by cat.	Weight	Weighted frequencies appeared in this report
Waitlisted for C&A, Non-CSSA							
1. Domestic without CCS (B)	91	101 (9.8)	71.4	9 691	7 707 (20.7)	2.109	213
2. Domestic with CCS (A)	67	113(11.0)	76.1	2 061	2 956 (7.9)	0.723	82
3. Institutional (C)	114	101(9.8)	54.4	4 106	4 414 (11.9)	1.208	122
Waitlisted for C&A, CSSA							
4. Domestic without CCS (B)	81	45(4.4)	43.2	3 081	1 377 (3.7)	0.846	38
5. Domestic with CCS (A)	119	128(12.4)	78.2	553	1 947 (5.2)	0.421	54
6. Institutional (C)	9	71(6.9)	77.8	4 552	6 438 (17.3)	2.507	178
Waitlisted for NH, Non-CSSA							
7. Domestic without CCS (B)	78	57(5.5)	52.6	1 050	832 (2.2)	0.404	23
8. Domestic with CCS (A)	122	96(9.3)	58.2	593	998 (2.7)	0.287	28
9. Institutional (C)	117	75(7.3)	47.0	2 323	1 543 (4.1)	0.569	43
Waitlisted for NH, CSSA							
10. Domestic without CCS (B)	40	20(1.9)	30.0	180	215 (0.6)	0.297	6
11. Domestic with CCS (A)	23	24(2.3)	39.1	97	115 (0.3)	0.133	3
12. Institutional (C)	9	39(3.8)	55.6	2 153	1 899 (5.1)	1.346	53
13. Inactive Cases	159	159(15.5)		6 781	6 781(18.2)	1.179	187
Total	**1029**	**1029 (100)**		**37 221**	**37 221(100)**		**1 029**

Table II Demographic characteristics of respondents (n=1029)

	f	%
Gender		
Male	383	37.2
Female	646	62.8
Marital status*		
Single	27	2.6
Married/Cohabitation	425	41.3
Widowed	548	53.2
Divorce/Separated	26	2.5
Others	3	0.2
Education level**		
No schooling, illiterate	306	29.8
No schooling, but can read a little	116	11.3
Kindergarten	6	0.6
Primary school (P.1-P.3)	227	22.1
Primary school (P.4-P.6)	192	18.6
Lower secondary school (F.1-F.3)	75	7.3
Upper secondary school (F.4-F.5)	69	6.7
A-level (F.6-F.7)	4	0.4
VTC (Certificate)	0	0.0
Post-secondary with no degree (associate degree, Higher diploma)	10	0.9
Post-secondary with degree	19	1.8
Post-graduate	1	0.1
Others	1	0.1

* missing data=1; **missing data=1

Table III: Respondents by gender and age

Age	Type of questionnaire												Total*			
	A				B				C							
	M		F		M		F		M		F		M		F	
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*
60-64	7	5.6	4	1.8	7	7.0	2	1.1	6	3.9	4	1.6	20	5.2	9	1.4
65-69	8	6.3	11	5.0	7	7.0	6	3.3	5	3.2	5	2.1	20	5.2	22	3.4
70-74	12	9.5	14	6.4	6	6.0	11	6.0	20	12.9	9	3.7	39	10.2	34	5.3
75-79	19	15.1	24	11.0	25	25	26	14.2	16	10.3	18	7.4	59	15.5	69	10.7
80-84	37	29.4	59	26.9	37	29.4	59	26.9	39	25.2	76	31.3	102	26.8	188	29.1
85+	43	34.1	107	48.9	43	34.1	107	48.9	69	44.5	131	53.9	141	37	324	50.2
Total	**126**	**100**	**219**	**100**	**126**	**100**	**219**	**100**	**155**	**100**	**243**	**100**	**381**	**100**	**646**	**100**

*missing data=2

Table IV: Living arrangement of respondents residing in the community

Living arrangement	Type of questionnaire				Total	
	A		B*			
	f	*%*	*f*	*%*	*f*	*%*
Living together with family/friend	288	83.5	245	86.3	533	84.7
Living alone	57	16.5	39	13.7	96	15.3
Total	**345**	**100**	**284**	**100**	**629**	**100**

*missing data=2

Table V: Reasons to apply for subsidised RCHEs of respondents

Reasons to apply for subsidised RCHEs*	***Level of importance***					
	1st		***2nd***		***3rd***	
	f	*%*	*f*	*%*	*f*	*%*
Living alone without care support	110	10.7	76	7.4	15	1.5
Family members in same household are also older people, no care support	97	9.4	116	11.3	24	2.3
Living condition of subsidised RCHE better than current place of residence	60	5.9	106	10.3	40	3.9
Poor relationship with family members	8	0.8	11	1.1	9	0.9
Deteriorating health and family member not able to provide care	649	63.1	261	25.4	37	3.6
Was admitted to an RCHE since last hospitalisation (C only)	14	1.4	17	1.7	29	2.8
Others	91	8.8	84	8.2	66	6.4

*****respondents may choose more than one option

Table VI: Change in circumstances since waitlisted for CWL

Change in circumstances	*f*	*%*
Yes	216	21.2
No	805	78.8
Total	**1021***	**100**

*missing data=8

Table VII: Respondents by reasons for the change

Reasons for change in circumstances*	*f*	*%*
Health condition has improved	29	13.2
Health condition has deteriorated	168	76.4
Living circumstance has changed	4	1.8
Others	19	8.6
Total	**220**	**100**

*****respondents may choose more than one option

Table VIII: Respondents by duration on CWL of respondents

Duration on CWL (as at 31 Dec 2014)	Type of questionnaire						Total	
	A		B		C			
	f	%	*f*	%	*f*	%	*f*	%
<1 year	24	7.0	78	27.3	81	20.5	184	17.8
1 year --- <2 years	117	33.7	97	33.8	115	29.0	329	31.9
2 years -- <3 years	109	31.5	58	20.3	117	29.5	284	27.6
3 years -- <4 years	45	12.9	42	14.8	47	11.9	134	13.0
4 years -- <5 years	28	8.2	7	2.6	28	6.9	63	6.2
5 years -- <6 years	13	3.8	3	1.1	4	1.1	21	2.0
6 years -- <7 years	4	1.2	0	0.0	1	0.1	5	0.5
7 years -- <8years	5	1.4	0	0.0	3	0.6	7	0.7
>= 8 years	1	0.3	0	0.0	1	0.3	2	0.2
Total*	**346**	**100**	**285**	**99.9**	**397**	**99.9**	**1029**	**99.9**

*the sum may not add up to 100% due to rounding

Table IX: Duration on CWL by active/inactive status

Duration on CWL (as at 31 Dec 2014)	Inactive		Active		Total	
	f	%	*f*	%	*f*	%
<1 year	11	6.0	173	94.0	184	100
1 year --- <2 years	54	16.4	275	83.6	329	100
2 years -- <3 years	55	19.4	229	80.6	284	100
3 years -- <4 years	25	18.7	109	81.3	134	100
4 years -- <5 years	18	28.1	46	71.9	63	100
5 years -- <6 years	14	70.0	6	30.0	21	100
6 years -- <7 years	4	80.0	1	20.0	5	100
7 years -- <8years	5	62.5	3	37.5	7	100
>= 8 years	2	100.0	0	0.0	2	100
Total	**188**	**18.3**	**842**	**81.7**	**1030***	**100**

*the sum may not add up to the actual number of respondents due to rounding.

Table X: Person making the care decision

Person making the care decision	Level of importance					
	1st		2nd		3rd	
	f	%	*f*	%	*f*	%
Self	230	22.4	113	11.0	39	3.8
Spouse	115	11.2	89	8.6	20	1.9
Child(ren)	543	52.8	134	13.0	21	2.0
Relative	19	1.8	11	1.1	0	0.0
Friend	0	0.0	1	0.1	1	0.1
Professionals (e.g. doctor, social worker)	112	10.9	70	6.8	32	3.1
other	7	0.7	0	0.0	3	0.3

*respondents may choose more than one option

Table XI: Respondents by whether there are factor(s) affecting choice of RCHE

Whether there are factor(s) affecting choice of RCHE	*f*	%
Yes	931	90.5
No	98	9.5
Total	**1029**	**100**

Table XII: Respondents by factor(s) affecting choice of RCHE

Factor(s) affecting choice of RCHE	Level of importance					
	1st		2nd		3rd	
	f	%	*f*	%	*f*	%
Location	577	62.0	133	14.3	106	11.4
Service quality/ reputation	189	20.3	244	26.2	111	11.9
Health care support	75	8.1	234	25.1	149	16.0
Waiting time	49	5.3	69	7.4	71	7.6
Religious orientation	15	1.6	21	2.3	8	0.9
Diet preference	9	1.0	31	3.3	55	5.9
others	17	1.8	8	0.9	5	0.5

*respondents may choose more than one option

Table XIII: Respondents by reasons for not choosing non-subsidised places

Preferred subsidised RCHEs because:	*f*	*%*
Fees are lower	838	81.4
Staff are better equipped in caring skills	693	67.3
Facilities are better	689	66.9
Staffing ratio is higher	633	61.6
living environment is better	614	59.6
Better reputation	530	51.5
Decision of family members	399	38.8
Have more activities	359	34.9
At convenient location for visits from family members	320	31.1
Able to meet preference in diet	309	30.1
Capable to take responsibility should anything happens	285	27.7
Suggested by professionals	284	27.6
Others	39	3.8

*****respondents may choose more than one option

Table XIV: Respondents by ever refused an offer of subsidised RCHE place

Ever refused an offer	*f**	*%*
Yes	144	14.0
No	882	86.0
Total	**1026**	**100.0**

*missing data=3

Table XV: Respondents by reasons to refuse an offer of subsidised RCHE place

Reasons for refusing offer of subsidised place	*f*	*%*
Still able to manage at home, wished to use RCS later	58	46.0
Location not suitable	27	21.4
Decision of family	8	6.3
Poor service quality of the RCHE offered	5	4.0
Others	29	23.0

*****respondents may choose more than one option
*missing data=18

Table XVI: Respondents by readiness to take up a subsidised RCHE place now or in the near future

Readiness to take up a subsidised RCHE place	*f*	*%*
Yes	468	45.5
No/probably not	560	54.5
Total	**1028***	**100.0**

*missing data=1

Table XVII: Respondents by reasons in not taking up a subsidised place now.

Reasons for not ready/probably not ready to take up a subsidised RCHE place now or in the near future	*f*	*%*
Can still be taken care of at home	291	52.0
Location of the offer	169	30.2
Decision of the family	136	24.3
Service quality of the offer	128	22.9
Others	110	19.6

*****respondents may choose more than one option

Table XVIII: Duration in CWL of respondents currently living in community using CCS by duration in using CCS

Duration in using CCS	**Duration in CWL***											
	1 year or less		**1-2**		**2-3**		**3-4**		**4 or more**		**Total**	
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*
1 year or less	9	37.5	49	41.9	19	17.9	8	17.8	3	5.9	88	25.7
1-2 years	0	0.0	43	36.8	37	34.9	9	20.0	4	7.8	93	27.1
2-3 years	5	20.8	9	7.7	27	25.5	11	24.4	11	21.6	63	18.4
3-4 years	3	12.5	6	5.1	7	6.6	6	13.3	11	21.6	33	9.6
4 years or more	7	29.2	10	8.5	16	15.1	11	24.4	22	43.1	66	19.2
Total	**24**	**100.0**	**117**	**100.0**	**106**	**100.0**	**45**	**100.0**	**51**	**100.0**	**343**	**100.0**

*missing data=2; the sum may not add up to the actual number of respondents due to rounding

Table XIX: Respondents living in community and using CCS by type of CCS

Respondents by subsidised/non-subsidised CCS	*f**	*%*
Subsidised	260	84.1
Non-subsidised	49	15.9
Total	**309**	**100.0**

*missing data=37

Table XX: Respondents living in community and using CCS by preference over RCS

CCS Vs RCS	*f*	*%*
CCS	214	62.4
RCS	129	37.6
Total	**343**	**100.0**

*missing data=3

Table XXI: Respondents living in community using CCS by reasons for preference over RCS

Reasons for preference to use CCS instead of RCS now or in the near future	*f*	*%*
Able to take care of by family members	100	46.7
Could still take care of him/herself	76	35.5
Domestic helper could help	66	30.8
Existing CCS able to satisfy caring needs	46	21.5
Decision of family members	28	13.1
Others	39	18.2

*****respondents may choose more than one option

Table XXII: View of carer of respondents living in community and using CCS on usefulness of CCS

Carer's view on usefulness of CCS	*f*	*%*
Useful	210	81.8
Not-useful	32	12.6
No opinion	14	5.6
Total	**257**	**100.0**

Table XXIII: View of carer of respondents living in community and using CCS on measures to encourage CCS

Carer's view on measures to encourage CCS over RCS	*f*	*%*
Strengthen training in caring skills for carers	127	49.4
Provide carer allowance for those in need	103	40.1
Strengthen training in knowledge on ageing for carers	102	39.7
Strengthening home care services	91	35.4
Strengthen knowledge on ageing for the elderly persons	90	35.0
More publicity to increase awareness of relevant services	85	33.1
Strengthen day care services	84	32.7
Provide direct subsidy for elderly persons to choose suitable services such as the CCSV	83	32.3
Enhance training in knowledge on cognitive impairment for carers	83	32.3
Increase home care support services for people with cognitive impairment	71	27.6
Encourage the development of diverse services in the private sector	38	14.8
Others	23	8.9
Prefer RCS over CCS	68	26.5

*****respondents may choose more than one option

Table XXIV: Respondents living in community not using CCS by reason

***Reason for not using CCS**#*	*f**	*%*
Able to be taken care of by family	85	29.8
Able to be taken care by domestic helpers	59	20.7
Currently waitlisted for CCS	17	6.0
Waiting time for CCS too long	10	3.5
Current CCS not able to meet the needs of the elderly (e.g. service hours)	47	16.5
Do not know what CCS could offer	42	14.7
Others	93	32.6

*missing data=1

*****respondents may choose more than one option

Table XXV: Respondents interested in RCSV by agreeing to means test

Agree to means test	Type of questionnaire*						Total	
	A		B		C			
	f	%	*f*	%	*f*	%	*f*	%
Agree	81	44.8	52	43.3	92	42.0	225	43.3
Disagree	77	42.5	50	41.7	109	49.8	236	45.4
No opinion	23	12.7	18	15.0	18	8.2	59	11.3
Total	**181**	**100.0**	**120**	**100.0**	**219**	**100.0**	**520**	**100.0**

*the sum may not add up to the actual number of respondents due to rounding.

Table XXVI: Respondents agreeing to means test by impact on willingness to consider RCSV

Change inclination on willingness to consider RCSV	Type of questionnaire						Total*	
	A		B		C			
	f	%	*f*	%	*f*	%	*f*	%
Yes	25	31.6	6	12.0	29	33.3	60	27.8
No	54	68.4	44	88.0	58	66.7	156	72.2
Total	**79**	**100.0**	**50**	**100.0**	**87**	**100.0**	**216**	**100.0**

*missing data= 9

Table XXVII: Respondents interested in RCSV by views on unit of assessment

Views on the unit of financial assessment if means test is in place	Type of questionnaire						Total*	
	A		B		C			
	f	%	*f*	%	*f*	%	*f*	%
Older person only	75	51.7	51	50.3	83	58.0	209	53.7
Older person + family	39	26.9	30	29.8	33	23.0	102	26.2
Child(ren) only	30	20.7	20	19.9	25	17.4	75	19.3

*missing data=3

Table XXVIII: Respondents willing to consider RCSV by duration on CWL

Duration on CWL	Type of questionnaire						Total*	
	A		B		C			
	f	%	*f*	%	*f*	%	*f*	%
≤ 1 year	9	8.2	19	25.3	40	20.8	68	18.0
≥ 1 year to ≤ 3 years	73	66.4	43	57.3	116	60.4	232	61.5
≥ 3 year to ≤ 5 years	21	19.1	13	17.3	30	15.6	64	17.0
≥ 5 years	7	6.4	0	0.0	6	3.1	13	3.4
Total	**110**	**100.0**	**75**	**100.0**	**192**	**100.0**	**377**	**100.0**

* the sum may not add up to the actual number of respondents due to rounding

Table XXIX: Respondents willing to consider RCSV by reason(s)

Reasons for willing to consider RCSV	Type of questionnaire						Total	
	A		B		C			
	f	%	*f*	%	*f*	%	*f*	%
Able to choose a suitable RCHE	72	66.1	53	70.7	135	70.3	260	69.1
Able to obtain RCS in a shorter period of time	80	73.4	56	74.7	147	76.6	283	75.3
Flexibility to top-up for better quality service	64	58.7	37	49.3	107	55.7	208	55.3
Flexibility to change to other RCHE	65	59.6	45	60.0	98	51.0	209	55.6
Other	12	11.0	5	6.7	15	7.8	33	8.8

*respondents may choose more than one option

Table XXX: Respondents unwilling to consider RCSV by reason(s)

Reason(s) for not willing to choose RCSV[#]	Type of questionnaire						Total	
	A		B		C			
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*
Quality of subsidised RCHEs are better, because:	94	66.2	95	63.8	136	82.4	324	71.1
Staff are equipped with better caring skills	*77*	*54.2*	*58*	*38.9*	*114*	*69.1*	*250*	*54.8*
staffing ratio higher	*73*	*51.4*	*64*	*43.0*	*105*	*63.6*	*242*	*53.1*
facilities better	*66*	*46.5*	*70*	*47.0*	*104*	*63.0*	*240*	*52.6*
Fee is lower	*66*	*46.5*	*64*	*43.0*	*109*	*66.1*	*239*	*52.4*
living environment better	*69*	*48.6*	*60*	*40.3*	*103*	*62.4*	*232*	*50.9*
medical care better	*67*	*47.2*	*58*	*38.9*	*100*	*60.6*	*224*	*49.1*
Activities are more	*48*	*33.8*	*24*	*16.1*	*65*	*39.4*	*137*	*30.0*
Diet more suitable	*44*	*31.0*	*25*	*16.8*	*67*	*40.6*	*137*	*30.0*
Prefer waiting for subsidised RCHE, because	96	67.6	97	65.1	118	71.5	311*	68.2
Having immediate RCS need but still prefer to wait for subsidised RCHE	*42*	*29.6*	*42*	*28.2*	*110*	*66.7*	*194*	*42.5*
No immediate RCS need but prefer to wait for subsidised RCHE	*61*	*43.0*	*57*	*38.3*	*6*	*3.6*	*123*	*27.0*
No confidence in non-subsidised RCHE	86	60.6	80	53.7	115	69.7	281	61.6
Does not know how to choose quality non-subsidised RCHE	17	12.0	23	15.4	33	20.0	73	16.0
Prefer CCS over RCS	20	14.1	3	2.0	0	0.0	23	5.0
Up to the decision of my family	7	4.9	11	7.4	4	2.4	22	4.8
Applying for RCSV may be tedious	8	5.6	6	4.0	25	15.2	39	8.6
Other	28	19.7	29	19.5	25	15.2	82	18.0

[#]respondents may choose more than one option

*missing date = 11

Table XXXI: Respondents agreeing to means test by views on fixed amount or sliding scale of co-payment

Views on fixed amount or sliding scale of co-payment	Type of questionnaire						Total	
	A*		B		C**			
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*
Fixed amount	22	27.8	19	36.5	29	31.9	70	31.5
Sliding scale according to affordability	53	67.1	29	55.8	57	62.6	139	62.6
No opinion	4	5.1	4	7.7	5	5.5	13	5.9
Total	**79**	**100.0**	**52**	**100.0**	**91**	**100.0**	**222**	**100.0**

*missing date = 2, **missing data = 2

Table XXXII: Non-CSSA respondents interested in RCSV by individual income level

Individual income level of non-CSSA respondents	*f**	*%*
0-3999	456	74.4
4000-5999	67	10.9
6000-7999	35	5.7
8000-9999	16	2.6
10000-14900	27	4.4
15000-19999	4	0.7
20000-99999	8	1.3
Total	**613**	**100.0**

*missing data = 54

Table XXXIII: Non-CSSA respondents interested in RCSV by affordability in co-payment

Non-CSSA monthly income / % in co-payment affordability	Group 1： 0 -- 3999		Group 2： 4000 -- 5999		Group 3： 6000 -- 7999		Group 4： 8000 -- 9999		Group 5： 10000 -- 14999		Group 6： 15000 -- 19999		Group 7： >= 20000		Total*	
	f	%	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%
0-<5%	116	56.2	14	58.5	8	58.0	4	57.1	11	47.4	0	0.0	1	50.0	155	55.4
5%-<10%	22	10.6	3	11.1	0	0.0	0	0.0	4	17.4	0	0.0	0	0.0	29	10.2
10%-<15%	19	9.4	0	0.0	3	23.6	1	14.3	4	15.9	1	100.0	0	0.0	29	10.3
15%-<25%	40	19.3	6	26.8	2	11.4	1	14.3	1	3.8	0	0.0	0	0.0	50	18.0
25%-<50%	9	4.2	1	3.6	1	7.0	1	14.3	2	7.7	0	0.0	0	0.0	14	4.8
50%-<75%	0	0.0	0	0.0	0	0.0	0	0.0	1	5.3	0	0.0	0	0.0	1	0.4
>=75%	1	0.0	0	0.0	0	0.0	0	0.0	1	2.5	0	0.0	1	50.0	2	0.8
Total	**207**	**100.0**	**24**	**100.0**	**14**	**100.0**	**7**	**100.0**	**24**	**100.0**	**1**	**100.0**	**2**	**100.0**	**280**	**99.9#**

*missing data = 103

the sum may not add up to 100% due to rounding

Table XXXIV. CSSA status of respondents by asset level

CSSA status / Asset level	Non-CSSA recipient*		CSSA recipient **		Total***	
	f	*%*	*f*	*%*	*f*	*%*
0 < 50,000	385	78.7	266	98.9	651	85.9
50,000 < 500,000	69	14.1	0	0.0	69	9.1
>= 500,000	35	7.2	3	1.1	38	5.0
Total	**489**	**100.0**	**269**	**100.0**	**758**	**100.0**

*missing data= 178; **missing data = 94; ***missing data = 271

Table XXXV: Respondents interested in RCSV by willingness to pay top-up for higher service quality

Willingness to pay top-up or higher service quality	Type of questionnaire						Total	
	A		B*		C**			
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*
Non-CSSA recipient								
Willing	122	79.7	72	72.0	94	83.9	288	78.9
Not willing	31	20.3	28	28.0	18	16.7	77	21.1
Sub-total	**153**	**100.0**	**100**	**100.0**	**112**	**100.0**	**365**	**100.0**
CSSA recipients								
Willing	12	42.9	10	55.6	81	75.7	103	67.3
Not willing	16	57.1	8	44.4	26	24.3	50	32.7
Sub-total	**28**	**100**	**18**	**100**	**107**	**100**	**153**	**100**

*missing data = 1; **missing data =2

Table XXXVI: Respondents by CSSA status

CSSA status	Type of questionnaire						Total	
	A		B		C			
	f	%	*f*	%	*f*	%	*f*	%
Non-CSSA recipient	259	75.0	242	84.6	166	41.7	667	64.8
CSSA recipient	87	25.0	44	15.4	232	58.3	363	35.2
Total	**346**	**100**	**286**	**100**	**398**	**100**	**1030**[#]	**100**
CSSA case nature								
Individual	46	53.5	21	47.7	195	89.4	262	75.3
family	40	46.5	23	52.3	23	10.6	86	24.7
Sub-total	86*	100.0	44	100.0	218**&#	100.0	348	100.0

[#] the sum may not add up to the actual number of respondents due to rounding.
*missing data = 1; **missing data = 13

Table XXXVII: CSSA Respondents interested in RCSV by willingness to give up CSSA for RCSV

Willingness to give up CSSA for RCSV if the amount of RCSV is higher	***Type of questionnaire***						***Total****	
	A		***B***		***C***			
	f	%	*f*	%	*f*	%	*f*	%
Willing	25	29.4	19.0	47.5	114.0	52.5	158.0	46.2
Not willing	55	64.7	18.0	45.0	102.0	47.0	175.0	51.2
Depends on RCSV value	5	5.9	3.0	7.5	1.0	0.5	9.0	2.6
Total	**85**	**100.0**	**40.0**	**100.0**	**217.0**	**100.0**	**342.0**	**100.0**

*missing data=19

Table XXXVIII: Respondents interested in RCSV by factors affecting their decision on service providers of RCSV

Factors affecting decision on service provider	***Type of questionnaire***						***Total***	
	A		***B***		***C***			
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*
Service quality of the RCHE	162	90.0	110	91.7	85	38.5	357	68.5
Care skills of staff better	*153*	*85.0*	*107*	*89.2*	*82*	*37.1*	*342*	*65.6*
Activities more frequent	*124*	*68.9*	*60*	*50.0*	*54*	*24.4*	*238*	*45.7*
Suitable diet	*127*	*70.6*	*72*	*60.0*	*59*	*26.7*	*258*	*49.5*
With medical consultation	*134*	*74.4*	*79*	*65.8*	*71*	*32.1*	*284*	*54.5*
Staffing ration of nurses and rehab staff	*146*	*81.1*	*86*	*71.7*	*70*	*31.7*	*302*	*58.0*
With specialised service for dementia	*99*	*55.0*	*55*	*45.8*	*49*	*22.2*	*203*	*39.0*
Near my family	160	88.9	103	85.8	83	37.6	346	66.4
Environment of RCHE	164	91.1	102	85.0	80	36.2	346	66.4
Better living environment	*154*	*85.6*	*86*	*71.7*	*65*	*29.4*	*305*	*58.5*
Better facilities	*149*	*82.8*	*91*	*75.8*	*74*	*33.5*	*314*	*60.3*
Reputation of the RCHE or recommendation by friends	87	48.3	43	35.8	43	19.5	173	33.2
Flexibility to change to another RCHE using	124	68.9	75	62.5	64	29.0	263	50.5
No special consideration	3	1.7	6	5.0	0	0.0	9	1.7
Others	3	1.7	0	0.0	4	1.8	7	1.3

[#]respondents may choose more than one option

List of tables: Survey on RCHEs providing non-subsidised places[106]

[106] In some of the tables, sum of the breakdown might not be the same as the total or sub-total figure due to roundup numbers after weighting.

Table I: Responses by type of RCHEs

	No. of homes*	No. of responses	Response rate (%)	Weight	Weighted frequencies appeared in this report
Type 1: EA1 private RCHE	60	25	41.7	1.335	33
Type 2: EA2 private RCHE	82	38	46.3	1.200	46
Type 3: non-EBPS private RCHE	411	225	54.7	1.016	229
Type 4: Self-financing homes	36	34	94.4	0.589	20
Type 5: Subvented/ contract homes	33	24	72.7	0.765	18
Total	**622**	**346**	**55.6**	**---------**	**346**

*As at 30 September 2014

Table II: Respondents by reason(s) for not interested in becoming a service provider for RCSV

Reason(s) for not interested#	Type of RCHE*			
	EA2	Non-EBPS private	Self-financing	Subvented / contract
	f	*f*	*f*	*f*
Do not want to change/No need to change	-------	38	2	-------
Not able to reach EA1				
Limited space/hardware of the RCHE	-------	23	1	-------
Service standard of EA1 is high	-------	2	-------	-------
Both hardware and software requirements are high	2	1	-------	-------
Manpower issue (manpower shortage and diff. to recruit professional staff such as PTs and nurses)	3	21	1	1
Not able to manage additional admin tasks/ Too many restrictions	2	13	-------	-------
Have not heard/no clear idea about the RCSV scheme	2	13	2	-------
May not be beneficial financially	1	5	1	-------
Religion issue	-------	-------	1	-------
no reason provided	-------	4	3	1
Total	**10**	**120**	**11**	**2**

* all EA1 EBPS have indicated 'interested' or 'not decided'

respondents may give more than one reason

Table III: Respondents by reason(s) for not decided in becoming a service provider for RCSV

Reason(s) for not decided	Type of RCHE				
	EA1	EA2	Non-EBPS private	Self-financing	Subvented / contract
	f	*f*	*f*	*f*	*f*
Have not heard/not clear idea about the RCSV scheme	2	1	16	2	1
Manpower issue (manpower shortage and diff. to recruit professional staff such as PTs, OTs and nurses)	-------	3	3	-------	-------
May not be beneficial financially	-------	-------	4	-------	-------
Not able to reach EA1					
Limited space/hardware of the RCHE	-------	-------	1	-------	-------
Service standard of EA1 is high	-------	-------	-------	-------	-------
Both hardware and software requirements are high	-------	1	2	-------	-------
Not able to manage additional admin tasks/ Too many restrictions	-------	-------	-------	-------	1
Do not want to change	-------	-------	1	-------	-------
no reason provided	2	2	5	1	3
Total	**3**	**7**	**32**	**3**	**5**

Table IV: Type of RCHE by readiness to accept RCSV[#]

Readiness to accept RCSV	Type of RCHE#							
	EA1*		EA2		Self-financing**		Subvented/ contract***	
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*
Yes	32	100	34	94.4	5	71.4	9	69.2
No	0	0	2	5.6	2	28.6	4	30.8
Total	**32**	**100**	**36**	**100**	**7**	**100**	**13**	**100**

[#] only RCHEs indicating 'interested' or 'not decided' need to answer this question; non-EBPS licensed homes are likely to need more time in upgrading and therefore, not included in this question.

* missing data=1; **missing data=2; ***missing data=3

Table V: Responding RCHEs by vacancy rate

Interest in becoming a service provider	Type of RCHE				
	EA1	EA2	Non-EBPS private	Self-financing	Subvented /contract
	Average vacancy rate of non-subsidised places (%)				
Interested	17.2	14.8	17.3	28.6	5.8
Not interested	NA	12.5	11.9	13.3	6.7
Not decided	12.6	8.6	11.0	41.9	6.1

Table VI: Responding RCHE by turnover rate of non-subsidised places

	Type of RCHE					Total
	EA1 n=31*	EA2 n=43**	Non-EBPS private n=214***	Self-financing n=19****	Subvented/ contract n=18	
Non-subsidised places	2 220	2 262	14 534	1 627	821	21 464
Turnover rate/yr (%)	23.5	19.6	13.6	21.7	6.8	15.6

*missing data=2; **missing data=3; ***missing data=15; ****missing data=1

Table VII: Responding RCHE not reaching EA1 and intended to upgrade#

Intention to upgrade	Type of RCHE					
	EA2 n=36		Non-EBPS private n=109		Self-financing n=8*	
	f	*%*	*f*	*%*	*f*	*%*
Yes	13	36.1	22	20.2	2	25.0
Time needed						
< 6 months	*0*	*0.0*	*9*	*40.9*	*1*	*50.0*
6 -- < 12 months	*10*	*76.9*	*6*	*27.3*	*0*	*0.0*
12-- 18 months	*2*	*15.4*	*0*	*0.0*	*1*	*50.0*
Missing date	*1*	*7.7*	*7*	*31.8*	*0*	*0.0*
No	11	30.6	49	45.0	5	62.5
Not decided	12	33.3	38	34.9	1	12.5

only RCHEs indicating 'interested' or 'not decided' need to answer this question

* missing data=1

Table VIII: Responding RCHE by participation in local accreditation scheme(s)[#]

Participation in local accreditation scheme	Type of RCHE									
	EA1 n=32[*]		EA2 n=35[**]		Non-EBPS private n=109		Self-financing n=9		Subvented/ contract n=15[***]	
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*
Yes	24	75.0	16	45.7	17	15.6	1	11.1	2	13.3
No	8	25.0	19	54.3	92	84.4	8	88.9	13	86.7
planned to join	*0*	*0.0*	*0*	*0.0*	*2*	*2.2*	*1*	*12.5*	*2*	*15.4*
No plan to join	*8*	*100*	*14*	*73.7*	*80*	*87.0*	*7*	*87.5*	*10*	*76.9*
Missing data	*0*	*0.0*	*5*	*26.3*	*10*	*10.9*	*11*	*0.0*	*1*	*7.7*

[#] only RCHEs indicating 'interested' or 'not decided' need to answer this question

* missing data=1; **missing data=1; ***missing data=1

Table IX: Responding RCHE by local accreditation scheme participated in^

Accreditation scheme*	Type of RCHE									
	EA1 n=24		EA2 n=14[#]		Non-EBPS private n=13[##]		Self-financing n=1		Subvented/ contract n=2	
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*
Hong Kong Association of Gerontology Accreditation Scheme	18	75.0	6	42.9	7	53.8	1	100	1	50.0
Hong Kong Health Care Federation Quality Elderly Service Scheme	4	16.7	6	42.9	4	30.8	1	100	1	50.0
Hong Kong Quality Assurance Agency Service Quality Management – Elderly Services	4	16.7	0	0.0	2	15.4	0	0.0	0	0.0
SGS ISO:9001 2008	5	20.8	4	28.6	0	0.0	0	0.0	0	0.0

^ only RCHEs indicating 'interested' or 'not decided' need to answer this question

* responding RCHE may provide more than one answer

[#] missing data=2; [##]missing data=4

Appendix V

Staffing and space requirements of various types of RCHEs

<table>
<tr><th></th><th>Subvented/contract[107] RCHE</th><th colspan="2">EBPS[108]</th><th>Statutory minimum requirements</th><th colspan="3">Bought Place Scheme[109]</th></tr>
<tr><th></th><th></th><th>EA1</th><th>EA2</th><th></th><th colspan="2">A1</th><th>A2</th><th>B</th></tr>
<tr><td>Spacing</td><td>According to prevailing Schedule of Accommodation</td><td>9.5 m^2</td><td>8 m^2</td><td>6.5 m^2</td><td colspan="2">9.5 m^2</td><td>8 m^2</td><td>7 m^2</td></tr>
<tr><td>Staffing level</td><td rowspan="6">Should comply with the staffing provision under the ‘essential service requirements’ of the Funding and Service Agreements or the service contracts signed between the RCHE operators and SWD.</td><td colspan="2">Staffing requirement with reference to a 40-place C&A home on the basis of 8 working hours per staff member per day</td><td>A minimum of two shifts of workers. No. of working hrs of each staff member subject to employer-employee agreement</td><td colspan="3">Staffing requirement with reference to a 40-place C&A home on the basis of 8 working hours per staff member per day</td></tr>
<tr><td>Home manager</td><td>1</td><td>1</td><td>1</td><td colspan="2">1</td><td>1</td><td>1</td></tr>
<tr><td>Physiotherapist</td><td>0.5</td><td>-</td><td>-</td><td></td><td></td><td></td><td></td></tr>
<tr><td>R/EN</td><td>2</td><td>Not required</td><td>(unless a health worker is present) 1 for every 60 residents of part thereof (7am to 6 pm)</td><td>1[110]</td><td rowspan="3">8 (based on ratio of 1:5 residents)</td><td>0</td><td>0</td></tr>
<tr><td>Health worker</td><td>2</td><td>4</td><td>(Unless a nurse is present) 1 for every 30 residents or part thereof (7am to 6 pm)</td><td rowspan="2">7</td><td rowspan="2">6 (based on ratio of 1:7 residents)</td><td rowspan="2">6 (based on ratio of 1:7 residents)</td></tr>
<tr><td>Care worker</td><td>8</td><td>8</td><td>-1 for every 20</td></tr>
</table>

[107] Provision of contract homes started in 2001.

[108] The Enhanced Bought Place Scheme (EBPS) was introduced in 1998 to replace the Bought Place Scheme (BPS).

[109] The Bought Place Scheme was the first attempt by the Government to provide incentive to private RCHE operators to upgrade the service quality and to complement the supply of subsidised RCHE places. The scheme was introduced in 1989 and was phased out in 2003.

[110] The home can employ a nurse or two health workers.

	Subvented/contract[107] RCHE	EBPS[108]		Statutory minimum requirements	Bought Place Scheme[109]		
		EA1	EA2		A1	A2	B
				residents or part thereof (7am to 3 pm) -1 for every 40 residents or art thereof (3pm to 10 pm) - 1 for every 60 residents or part thereof (10 pm to 7 am)			
Ancillary worker		8	6	1 for every 40 residents or part thereof (7 am to 6 pm)	4	4	4
Total		**21**	**19**		13	11	11

Appendix VI

Detailed Calculations for Analysing the Number of Available EA1 Equivalent Places for RCSV

Table 1: Capacity and vacancies of non-subsidised places in various types of RCHEs

Non-subsidised places as at 31.12.2014[111]	Capacity	Vacancies	%
Self-financing homes	3 097	733	23.7
Subvented homes	358	37	10.3
Contract homes	1 262	95	7.5
Sub-total	***4 717***	***865***	***18.3***
EA1 homes	4 148	738	17.8
EA2 homes	3 944	601	15.2
Sub-total	***8 092***	***1 339***	***16.5***
Non-EBPS private homes	33 878	9 469	28.0
All private homes (i.e. EBPS and non-EBPS homes)	41 970	10 808	25.8

Estimating the number of vacancies in RCHEs interested and able to upgrade and receive RCSV

i. Not all RCHEs with non-subsidised places would be interested to join the RCSV scheme. In the questionnaire survey for service providers, we have asked respondents to indicate their interest in receiving RCSV and the findings were illustrated in Table 2 below:

Table 2: RCHE type by interest in receiving RCSV

	Type of RCHE									
	EA1 n=33		EA2 n=46		Non-EBPS private n=229		Self-financing n=20		Subvented / contract n=18	
	f	*%*	*f*	*%*	*f*	*%*	*f*	*%*	*f*	*%*
Interested	30	90.9	29	63.0	77	33.6	6	30.0	11	61.1
Not interested	0	0.0	10	21.7	120	52.4	11	55.0	2	11.1
Not decided	3	9.1	7	15.2	32	14.0	3	15.0	5	27.8

[111] Information provided by SWD.

ii. In addition to findings from the questionnaire survey, the following assumptions were made to estimate the percentage of RCHEs joining the scheme

(a) The final decision of those 'not decided' will be distributed according to the same ratio as those currently saying 'interested' and 'not interested'.

(b) For those interested, it is estimated that 75% would finally decide to join the scheme as RSP. However, for EA1 RCHEs, since they have already met the requirements of becoming an RSP, it is assumed that all of them will join the voucher scheme.

(c) For EA2 RCHEs, if converted to EA1, the reduction of places would be 15.8%[112]. As at 31 July 2015, the average vacancy rate of EA2 was 15.2%. We will expect those with vacancy rate of less than 15.8% would not be interested in conversion. Assuming an even distribution of vacancy rate from 0% to 30.4% (i.e. the maximum vacancy rate is 30.4% for EA2 homes and that 15.8% is the median and mean), and as of 31 July, 2014, the percentage of EA2 that would have an incentive to be converted to EA1 would not exceed 48.0%[113]. The number of vacancies among all EA2 is 601. The total vacancies among those having an incentive to be converted from EA2 to EA1 homes will be reduced to 139[114].

(d) All licensed RCHEs have at most reached EA2 standard and the reduction in vacancies would be at least 15.8%.

iii. Based on the assumptions ii(a) and ii(b) above, and using findings from the questionnaire survey on respondents' indication of interest on RCS voucher, the percentage of different types of homes showing interest is adjusted and illustrated in Table 3.

[112] The reduction of places is resulted from the difference in required net floor area per capita in which EA1 is 9.5m^2 and EA2 is 8m^2. Reduction percentage is therefore (9.5 - 8)/9.5*100%, i.e. 15.8%.

[113] Percentage of homes with incentive to be converted to EA1 = (15.2% x 2 – 15.8%)/(15.2% x 2) = 48.0%

[114] The remaining vacancies after conversion is 601 x[(2 x 15.2% - 15.8%)/(2 x 15.2%)]^2=139

Table 3: Type of RCHE by estimation on percentage joining the scheme

	EA1	EA2	Non-EBPS Private	Self-financing	Subvented /contract
Interested	100.0%	74.4%	39.1%	35.3%	84.6%
Joined the scheme	100.0%[115]	48.0%[116]	29.3%	26.5%[117]	63.5%

iv. RCHEs not reaching EA1 standard have to upgrade to EA1 in order to be eligible as an RSP. For RCHEs that have not reached EA1 standard, but have indicated interest or have not yet decided in receiving RCSV, they were further asked on their intention to upgrade to EA1 and the results were illustrated as follows:

Table 4: RCHE not reaching EA1 and have intention to upgrade

Intention to upgrade to EA1	Type of RCHE					
	EA2		non-EBPS		Self-financing homes	
	f	*%*	*f*	*%*	*f*	*%*
Yes	13	36.1	22	20.2	2	25.0
No	11	30.6	49	45.0	5	62.5
Have not decided	12	33.3	38	34.9	1	12.5

v. It is estimated that only 75% of those who indicated intention and 25% of those who have not decided would finally do upgrading to meet the RSP requirement. The adjusted estimated figures that would upgrade when required are:

[115] Based on assumption ii(b), i.e. all EA1 RCHEs will join the voucher scheme.

[116] Based on assumption ii(b), i.e. 75% of those indicated interest will join the voucher scheme. In the case of EA2 homes, this figure should be 60.7%. However, taking into account the reduction in capacity in converting from EA2 to EA1, based on assumption ii(c), the percentage of EA2 homes that would have an incentive to be converted to EA1 is adjusted to 48.0%.

[117] Survey finding indicated 66.7% of self-financing homes have reached staffing and space standard equivalent to EA1 or above, therefore, at the beginning of the scheme, 17.7% (i.e. 35.3%*0.667*0.75(assumption ii(b))=17.7%) would be ready to join the scheme on day 1.

Table 5: Adjustment on estimated percentage of RCHE not reaching EA1 and able to upgrade when required

Estimated percentage that would do upgrading	Type of RCHE		
	EA2 (%)	Non-EBPS (%)	Self-financing (%)
Intended and would	27.1	15.2	18.8
Not decided and eventually would	7.7	8.8	3.2
Total	34.8	24.0	22.0

vi. The estimated percentage of all types of RCHEs that indicated interest and are ready to do upgrading when required is

Table 6: Estimated percentage of RCHEs that would join the scheme

	Type of RCHE				
	EA1	EA2	Non-EBPS Private	Self-financing	Subvented/ contract
Joined the scheme	100.0%[118]	34.8%	24.0%	22.0%	63.5%

vii. As it will take time for RCHEs not meeting EA1 requirements to upgrade to EA1 standard, interested RCHEs will join the scheme at various points of time during the pilot. To estimate the rates in reaching the required EA1 standard of various types of RCHEs (except EA1). The following assumptions were made:

(a) The RCS voucher scheme will be rolled out in December 2016 and the pilot will last for 36 months (say around 3 years)

(b) SWD will invite subvented/contract homes, self-financing homes, EA1 and EA2 EBPS RCHEs and licensed RCHEs providing non-subsidised places to come forth to apply for the eligibility status as RSPs by demonstrating that they have already reached at least the EA1 standard and have met the other requirements for RSPs[119].

(c) For subvented and contract homes, they have already reached EA1 standard when they join the scheme on day 1.

(a) All RCHEs that will be joining the scheme will join by 2.5 years.

[118] Based on assumption ii(b), i.e. all EA1 RCHEs will join the voucher scheme.

[119] Although RCHEs that have reached the EA1 standard or above is eligible to become an RSP, issuing of RSP status will be in phases. See Recommendation 4 for details.

Adopting a decaying model[120], while the initial rate of joining the scheme is higher, the subsequent rate of joining will slow down in a rate of 50% for every 6 months.

viii. Referring to Table 5, by 2.5 years, the percentage of various types of RCHEs that would join the scheme is estimated to be:

EA1 homes: 100%

EA2 homes: 34.8%

Non-EBPS private homes: 24.0%

Self-financing homes: 22.0 % (17.7% already reached EA1 standard in day 1 and 4.3% intend to upgrade)

Subvented/contract homes: 63.5%

ix. Thus, at different timelines, by adopting a decaying model, the rate of EA2 RCHEs, non-EBPS private RCHEs, and self-financing RCHEs reaching EA1 standard are illustrated in Table 7a to 7c[121]:

Table 7a: Assumed rate[122] of EA2 homes reaching EA1 standard

Point in time	**Percentage**	**No. of vacancies[123]**
within 6 months	18.0%	25
within 1 year	27.0%	38
within18 months	31.5%	44
within 2 years	33.8%	47
within 2.5 years	34.9%	48

[120] Based on the 'decaying model', if the percentage of a particular type of homes joining the voucher scheme in 2.5 years is estimated to be x%, and the participation rate for the first 6 months is y%, then:
$x = y + y/2 + y/4 + y/8 + y/16 = 31y/16$, i.e. $y = 16x/31$
The rates at subsequent periods are: $(y + y/2)$ for the second period (i.e. within one year), $(y+y/2+y/4)$ for the third period (i.e. within 18 months), etc. (Tables 5a to 5c)

[121] Some of the total percentage at 2.5 years is different from the estimation due to roundup figures.

[122] The rates may be further adjusted to take into account the fact that the conversion of EA2, self-financing and other private homes to EA1 standard might bring about a reduction of places in those homes due to differences in space requirements

[123] The number of vacancies after conversion is 154.

Table 7b: Assumed rate of self-financing homes reaching EA1 standard

Point in time	Percentage	No. of vacancies[124]
Day 1	17.7%	130
within 6 months	3.7%	27
within 1 year	5.5%	40
within18 months	6.4%	47
within 2 years	6.9%	50
within 2.5 years	7.1%	52

Table 7c: Assumed rate of non-EBPS private homes reaching EA1 standard

Point in time	Percentage	No. of vacancies[125]
within 6 months	12.4%	512
within 1 year	18.6%	767
within18 months	21.7%	895
within 2 years	23.3%	959
within 2.5 years	24.0%	991

x. Thus, taking into account the estimated number of vacancies and the assumed rate in reaching EA1 standard, the number of EA1 places available in receiving RCSV at various point in point is:

	Estimated EA1-equivalent vacancy (cumulative)					
Point in time (months)	**Subvented / contract home**	**Self-financing**	**EA1**	**EA2**	**Non-EBPS licensed homes**	**Total**
1-6	84	130	738	0	0	952
7-12	84	130	738	25	512	1 489
13-18	84	157	738	38	767	1 784
19-24	84	170	738	44	895	1 931
25-30	84	177	738	47	959	2 005
31-36	84	182	738	48	991	2 043

[124] The number of vacancies of self-financing homes is 733.

[125] The number of vacancies of non-EBPS private homes after conversion is estimated based on the assumption that the vacancy rate for all homes under this category is 25.9%, and the number of vacancies after conversion is therefore calculated by: 8760* ((25.9% - 15.8%)/25.9%) = 3408.

xi. Based on this estimation, disregarding the expected 470 non-subsidised places available in the market from 2017-18, the total number of available EA1 vacancies is short of 3 000.

xii. However, there may be a 'discounting factor' on the number of vacancies actually used. For those who are already residing in a non-subsidised place at EA1 level, they may not need to use up a vacancy per se. The estimation is calculated as follows:

- From the survey, the projected number of cases on CWL & waiting for C&A place & living in institution = 10 852
- Percentage of those living in institution who showed interested in RCSV & accept means test & not changing their inclination = 12.3%
- No. of cases in RCHEs who are likely to take RCSV = 1 335
- With reference to Table 1, proportion of various type of RCHEs:

Subvented /contract homes	3.5
Self-financing homes	6.6
EA1	8.9
EA2	8.4
Non-EBPS RCHE	72.6

- No of cases likely to take RCSV in each type of RCHEs would be the total number of cases likely to take RCSV by the corresponding proportion in that category:

Subvented /contract homes	47 (1 335*3.5%)
Self-financing homes	88 (1 335*6.6%)
EA1	119 (1 335*8.9%)
EA2	112 (1 335*8.4%)
Non-EBPS RCHE	969 (1 335*72.6%)

- With reference to the percentage of various RCHEs that would join the scheme as illustrated in point viii, the no of cases likely to take RCSV and residing in an RCHE likely to join the scheme is:

Subvented /contract homes	29 (47*63.5%)
Self-financing homes	19 (88*22%)
EA1	119(119*100%)
EA2	39(112*34.8%)
Non-EBPS RCHE	233 (969*24%)
Total	439

xiii. Therefore the estimated RCSV issued to current RCHE residents who may not require a vacancy per se and the vacancy situations at various timeline, using the decaying model, would be:

Table 8: Estimation on number of vacancies at different timelines and the proposed RCSV issued

Phase	Month	Type of RHCE	Batch	Estimated vacancy	RCSV issued to RCHE residents	RCSVs issued
I	1-6 (prep.)	Subvented/ Contract/ Self-financing homes	NA	NA	NA	NA
	7-12		1	214	42	250
II	13-18	Subvented/ Contract/ Self-financing homes + EBPS EA1	2	979	164	750
	19-24		3	992	167	1250
III	25-30	All homes meeting RSP requirements	4	2005	373	1750
	31-36		5	2043	439	3000

Appendix VII

Non-subsidised places in RCHE[126]										
Non-subsidised places offered by	**No. of Unit**	**No. of places**	**Fee per month**				**Average ($)**		**Median ($)**	
			Min.		**Max.**					
			From	**To**	**From**	**To**	**Min.**	**Max.**	**Min.**	**Maximum**
Self-financing homes[127]	36	3,047	2,000	22,650	4,000	59,560	8,848	20,943	7,260	11,500
Subvented and contract homes[128]	36	1,680	3,165	13,800	3,165	23,700	9,014	15,137	9,000	14,451
Self-financing nursing homes under DH[129]	3	334	14,300	19,980	33,500	66,070	17,927	54,640	19,500	64,350
Licensed private homes[130]	547	56,548	1,500	13,500	4,900	3,5000	5,445	8,792	5,200	8,000
EBPS places in private homes										
Private homes with EBPS[131]	143	23011	1603	13500	5800	25000	5822	9559	5500	9000

[126] SWD website. Retrieved from http://www.swd.gov.hk/en/index/site_pubsvc/page_elderly/sub_residentia/id_listofresi/
[127] Record as at September 30, 2015 from SWD website. Retrieved from http://www.swd.gov.hk/en/index/site_pubsvc/page_elderly/sub_residentia/id_listofresi/
[128] ibid
[129] ibid
[130] Record as at November 30, 2015 from SWD website.
[131] ibid

Appendix VIII

Views of stakeholders expressed in public engagement

	Views of stakeholders	Response
RSPs and scope of services		
	Both private and NGO-operated RCHEs should be allowed to become RSPs	Considerations were made with regard to the need to strike a balance between the diversity in choices and regulating the standards of the providers; as well as putting measures to encourage improvement in service quality in place. Details addressed in discussion pertinent to Recommendation (R) 1.
	Contract and subvented homes were in general more popular among elderly persons, while the service standards of many private homes could not meet the expectations of elderly persons. The attractiveness of RCSV might depend on the number of contract and subvented homes joining.	
	The staffing and space requirements should be set at a level lower than EA1 standards to allow more choice for voucher users.	
	It would be difficult for some private homes (especially ones in urban areas) to increase its floor space to meet the space requirements due to physical limitations and rental considerations.	
	More incentives should be provided to RCHEs to join RCSV.	The voucher values and the provision of supplements were benchmarked with EBPS and incentives were provided to join recognised accreditation scheme. The top-up mechanism also allows voucher users to buy additional services on top of the standard package. Details addressed in discussion pertinent to R3, R14, R15, R18.

	Views of stakeholders	Response
	The quality of services provided by private homes was in general not satisfactory. Private homes would reap the profit from voucher without providing improved service to users. Profit control should be introduced.	One of the objectives in introducing the voucher scheme is to induce a higher level of market competitiveness whereby service providers would have to respond to meet users' satisfaction. Profit control typically employs the instrument of price regulation and is a means to regulate monopolies. It is not intended for service quality assurance. Additional regulatory measures were introduced to ensure effective monitoring mechanism. Details addressed in discussion pertinent to R6, R7, R19, R20, R21, R22.
	NHs should also be allowed to become RSPs to provide services to those requiring higher levels of care.	Due to limited supply of NH places, it was deemed more feasible to provide RCSV to C&A applicants for the purpose of the pilot scheme. Details addressed in discussion pertinent to R1.
	There was a general shortage of manpower in the elderly services sector, and it might be difficult for operators to recruit more staff to meet the staffing requirements.	This is noted as a potential challenge for RSPs and has to be reviewed in evaluating the pilot scheme. Long term planning for manpower in the elderly service sector would be addressed in the concurrent study for the development of the Elderly Services Programme Plan (ESPP).
	RCSV could be extended to provide respite services and emergency placement.	Suggestion noted. Respite services are provided to carers whose elderly relative under their care and are being provided as a kind of community support service. It is

	Views of stakeholders	Response
		noted that the scope of Second Phase of CCSV has been extended to respite service.
Assurance of informed choice/case management		
	Many responsible workers were fully occupied with their existing duties and might not have the capacity to take on additional case management duties.	Taking the views of stakeholders into consideration, case management is recommended to be taken up by a designated team set up by SWD. Role and responsibility of the case managers are addressed in discussion pertinent to R6.
	There could be potential conflict of interest if the case management roles were taken up by responsible workers who were employed by NGOs providing RCS.	
	Responsible workers might not have enough knowledge (e.g. care needs of some health conditions) and updated information to advice voucher users on how to select a suitable RSP.	
	SWD should consider setting up a dedicated team to perform the case management duties.	
	Further details on the case management system (e.g. code of practice, training for case managers, operation procedures, etc.) should be drawn up before implementation of RCSV.	
	Consideration should be given on the support provided to voucher users after the trial period, with special attention to those lacking family support.	It is proposed that the case management service would be available to voucher users at any time.
	There should be a longer trial period (e.g. one year).	A voucher user would have a maximum six months for their selection of RSPs. The trial period is counted when a voucher user is accepted into the pilot scheme. However, if they are only able to enter into an RSP at the end of the

Views of stakeholders		Response
		sixth month, the trial period will be further extended by one month. This should allow time for the voucher user in determining if they are satisfied with the voucher model. A longer period may hold up the quota for the voucher, limiting the number of beneficiaries.
Target recipients		
	Elderly persons waitlisting for NHs should also be eligible to join RCSV	For the pilot scheme, it was deemed more desirable to provide RCSV to C&A applicants with provision for their CoC. Details addressed in discussion pertinent to R1.
	Consideration should be given on whether RCSV could also be used to provide assistance to those recently discharged from hospitals.	Taking the views of stakeholders into consideration, open application is recommended for elderly persons on CWL waiting for C&A home. Details addressed in discussion pertinent to R8 and R9.
	Elderly persons assessed to be eligible only for RCS (i.e. not 'dual-option' cases) should be the primary target recipients of RCSV.	
	Those aged below 60 but with dementia should be eligible for RCSV.	
	It is suggested to adjust the criteria of RCSV to benefit these dementia people who are excluded from the existing SCNAMES assessment.	The issue of strengthening SCNAMES in assessment the LTC needs of elderly persons with dementia is currently underway, which would also be addressed in the ESPP.
	Flexibility should also be considered for elderly persons with dementia but have not been assessed as having RCS need by SCNAMES.	

	Views of stakeholders	Response
Status on CWL		
	Voucher users should be allowed to remain on CWL, i.e. as an interim measure while waiting for a 'traditional' subsidised place.	This may defeat the purpose of the voucher in incentivising the RCHEs to upgrade and improve their staffing and space standards. This may also aggravate the long waiting list on CWL. Users' status on CWL would be changed to "inactive" during the trial period and they may resume their status should they decide to leave the scheme.
	After the trial period, flexibility should be allowed for voucher users to return to the CWL under special circumstance, e.g. closing down, relocation of the home.	Should there be unexpected circumstance affecting the residency of a voucher user, the case should be able to be taken care of by the case manager and moving to another RSP should be arranged.
Voucher value		
	A higher voucher value should be set.	The voucher value is set at a level equivalent to that of the same service standard, i.e. EBPS, and it would not be justifiable to pay an additional amount for the same service standard. The adjustment, if any, would be pegged at the costs of bought places in urban areas. Details addressed in discussion pertinent to R12.
	There should be adjustment mechanisms to take into account the impact inflation had on the cost of providing RCS.	
	Different voucher values and subsidy amounts could be set for RSPs meeting different staffing and space standards.	This issue is related to eligibility of RSP and is addressed in discussion pertinent to R1.

	Views of stakeholders	Response
	Considerations should be given to extra charge that might incur if a voucher user requires additional rehabilitation services.	For all voucher users, if they are assessed to be in need of a higher level of care, there will be provision of supplements (Dementia/Infirmary Care Supplement). For voucher users with less financial means, extra allowance will also be provided that is comparable to CSSA recipients. These issues are addressed in discussion pertinent to R14, R15, R17, and R18.
	Some expenses (e.g. funeral expenses, travelling expenses, medical expenses for drugs, etc.) were covered by CSSA and other related schemes and would no longer be eligible to a CSSA recipients who chose to withdraw from CSSA in order to join RCSV.	
	Considerations should be given to allowing 'pocket money' for the voucher users with means. The voucher value could be issued as a lump sum. If the RSP chosen by the voucher user charge a lower fee, the difference in amount could be retained by the elderly persons as 'pocket money'.	
Means-test and sliding scale		
	The need for means test and co-payment is acceptable for long-term financial sustainability of LTC.	One key principle in the introduction of the voucher scheme is using it as a mechanism to channel public funds to those who are most in need. Details of these concerns are addressed in discussion pertinent to R13, R14, R15, R16 and R17
	There should not be any means test for elderly services.	
	The proposed means test and co-payment arrangements should be relaxed, e.g. exclusion of asset in the assessment.	
	Medical fee waivers should be granted automatically to both Level 0 and Level 1 users.	
	Requirement for voucher users to withdraw from CSSA useful in allowing co-payment/top-up from family members for better quality service. However, the concern is whether voucher users have sufficient means to pay for	

Views of stakeholders		Response
	supplements/allowances previously covered by CSSA.	
	Voucher users should not be required to withdraw from CSSA.	
	Care supplement should be provided to all voucher users.	
	Mechanism for reassessment in case of change in financial status of voucher users should be considered	
Quality assurance and monitoring		
	RSPs should be required to undergo accreditation and incentives should be provided for RSPs to join the scheme(s).	Joining accreditation scheme(s) is encouraged and it is recommended that financial incentives be provided for RCHEs. With the support of SWD, the Hong Kong Accreditation Service of the Innovation and Technology Commission provide the service for accreditation of certification bodies for certification of management system of Residential Care Home (Elderly Persons) Service Providers. This is addressed in discussion pertinent to R1.
	SWD should play a role in setting up the guidelines for accreditation bodies.	
	User satisfaction should be considered in monitoring the quality of service of RSPs.	User/stakeholder involvement in monitoring the service quality of RSP is reinforced in the proposed pilot scheme. Details are addressed in discussion pertinent to R6, R22 and in user satisfaction survey in evaluation of the pilot scheme.
	An effective monitoring mechanism should be in place to ensure the quality of services provided, including the involvement of servicer users.	
	Family members should be encouraged to give feedback on the service quality of the RCHE.	
	Set up SQGs in each of the SWD district and enhance efficiency and effectiveness of the mechanism.	

	Views of stakeholders	Response
	Names of RCHEs that have received complaints, warnings, and/or being prosecuted should be made public to stakeholders.	Such information would be uploaded to the proposed information and communication technology platform of the RCSV pilot scheme. This is addressed in discussion pertinent to R7. Currently, the SWD website has provided a 'Record of RCHEs Successfully Prosecuted in the recent 24 months'
	If the quality of service of private RCHE is not assured, the choice for the elderly is actually very limited.	This point would be noted and will be addressed in the evaluation of the pilot scheme.
	Enhance training for RCHE staff.	These concerns are well noted and will be addressed in the ESPP.
	Measures should be taken to enhance the service quality of participating RCHEs. Examples: more training for staff and allowing importation of labour to ease the manpower shortage problems faced.	
Scheme design and timing		
	Elderly persons should be allowed to take the initiative to join RCSV. The alternative of sending out invitations to elderly persons through random selection was not suitable.	Open application is proposed for the pilot scheme. Details addressed in discussion pertinent to R8 and R9.
	A hotline should set up to deal with enquiries.	
	The administrative procedures, in particular the vetting procedures for joining the scheme as RSPs should be kept as simple as possible.	
	The duration of the pilot scheme might not necessarily be 3 years to test out its effectiveness. Shortening the duration of the pilot scheme could enable the	The 3-year duration of the pilot scheme has to take into consideration the estimated time needed for potential RSPs

	Views of stakeholders	Response
	possibility of channelling the resources for enhancement of CCS.	to upgrade their staffing and space standards. This would ensure a steady supply of RSPs and allow flexibility in fine tuning the scheme design during the process. Details addressed in discussion pertinent to R4 and R5.
	More information should be given on the arrangements for voucher users after the pilot period.	As with other pilot schemes, voucher users would be able to continue using the voucher with the same terms and condition disregard of whether the scheme could be regularised after the pilot.
	Arrangement of the voucher users after the completion of the pilot scheme should be spelled out.	
	Arrangement of voucher users residing in public housing alone who decided not to use the RCSV within the trial period should be addressed.	This concern is addressed in discussion pertinent to R10.
	Considerations should be given to elderly persons with impaired ability to make decision on their own and without family member.	The provision of guardianship under the Mental Health Ordinance (Cap.136) is aimed at protecting the interests and welfare of adults who are incapacitated. This would apply to all elderly in Hong Kong.
	The introduction or RCSV should be introduced after the evaluation on CCSV.	The target recipients and services of these two forms of voucher are very different, and experience may not be easily transferable. Instead, in view of the huge demand for RCS, ways to explore alternatives should be considered as early as possible. Another concern is the workload for frontline workers, which would be addressed by the setting up of a designated team under SWD as described in R6.

Views of stakeholders		Response
Potential undesirable consequences and effectiveness		
	The introduction might result in increased instances of premature or unnecessary institutionalisation.	Due consideration on potential undesirable effect is given and is discussed in Chapter V.
	RCSV might induce a price raise in the private sector, having an impact on CSSA recipients not interested in RCSV.	
	It is not clear if the introduction of RCSV can shorten the waiting list for subsidised C&A places.	Given the number of voucher to be issued for the pilot scheme is only 3000, the primary purpose is not to shorten the waiting list for subsidised C&A places. Nevertheless, it serves to shorten the waiting time for those who opt for RCSV.
	The RCSV could not help elderly doubletons who are living in the community	If the couple has met the criteria for voucher recipients, by exercising their own choice, the RCSV may allow even more flexibility in finding a suitable RCHE for both.
	The RCSV could not help those who can be taken care of by their family members and who are not on CSSA.	Applicants for C&A Home who are on CWL, disregard of their CSSA status, are eligible to apply for RCSV.
	Some may use the RCSV during the trial period as respite instead of shortening the waiting time.	These points would be noted for evaluation of the pilot scheme.
	The introduction of RCSV might affect the usage rate and popularity of the CCSV Pilot Scheme.	
	Advantage of RCSV over existing EBPS provision not clear.	

Views of stakeholders		Response
Public consultation and publicity		
	Publicity programme should be in place so that elderly persons could fully understand the details of the scheme before making a decision on whether to join RCSV.	The questionnaire surveys for both the elderly persons on CWL and RCHEs providing non-subsidised places were very extensive. After formulation of a preliminary scheme there were a number of public engagement exercise and presentation/deputation sessions at the Panel on Welfare Services of the Legislative Council. The SWD will launch publicity to clarify the details of the Scheme when it is officially launched.
	A more extensive public engagement should be carried out over a longer period of time.	
	The introduction of the RCSV pilot scheme was carried out in a hasty manner, stakeholder do not have enough time to consider the proposed recommendations.	
	The period of the RCSV engagement should be longer and transparent. Also, the consultancy team should extend their invitation to the soon-to-be-old.	
Other comments		
	The policy objective of the RCSV was not clear.	This is described in Chapter VI of the report.
	RCSV should be planned with regard to the long-term elderly service programme plan.	These issues would be addressed in the ESPP.
	Long-term planning for elderly services should be enhanced, including measures to shorten the waiting time for services	
	There are concerns regarding the impact of the 'money-following-the-user' approach on subvented services, leading to 'privatisation' in service provision and the decreasing role of the Government in service provision.	Based on the planned provision for RCS described in Chapter II, the number of RCSV issued does not seem to constitute a large percentage. Whether the pilot scheme would reflect the customers' choice for the private sector, or there could be the evolvement of a market segmentation

Views of stakeholders		Response
		has yet to be evaluated after the pilot scheme.
	The $800 million earmarked for RCSV should be used for enhancing CCS, purchasing more bought places from EA1 homes, the provision of more NH places, increase the supply of other forms of RCS places, respite/emergency services or strengthening the support to carers.	The allocation of resources may not be transferable. Extra resources for CCS and other support service would be addressed in ESPP. CCS and RCS cater for different groups of elderly who have different needs.
	The voucher value could be converted to carer allowance so that the family members can take care of them at home.	
	Resources for RCSV should be used to enhance the EBPS instead.	
	Too many different types of vouchers could be confusing for the elderly and it is difficult to differentiate between using vouchers and using the EBPS vacancies.	The implementation of different pilot schemes caters for people with different needs.
	Greater flexibility should be allowed for elderly persons to choose between RCSV and CCSV Pilot Scheme. For instance, a single voucher could be issued for both RCS and CCS. Whether the same amount of subsidy (and hence voucher value) could be provided for RCS and CCS should be explored.	It would be more desirable to address these issues after evaluation the pilot schemes.
	The means test and co-payment arrangements for RCSV and CCSV pilot scheme should be unified as far as possible.	
	There could be other alternatives for improving the quality of services received by CSSA recipients who were living in private non-subsidised places while waiting for subsidised RCS. Examples: adding service requirements under CSSA, increasing the amount of CSSA subsidies provided to elderly persons living in non-subsidised places, etc.	

	Views of stakeholders	Response
	Voucher users should also be eligible to CSSA and those who are CSSA recipients should not be required to withdraw from CSSA.	Since RCSV is a form of subsidy and should be counted as income, therefore, it would not be justified for CSSA recipients to receive double subsidies.
	The principle of 'money-following-the-user' should be based on the LTC assessment on the care plan and its costs. The voucher users should have a role in formulating their own service package.	This would be addressed in the current SCNAMES review.
	Some districts (e.g. Tai Po, Sha Tin) did not have EA1 homes and the choice available to users could be somewhat limited.	This issue relates to planning for space and premises for elderly services and would be addressed in ESPP.
	To allow more supply, flexibility to increase non-subsidised places for subvented/self-financing/contract homes should be considered.	
	The number of recognised assessors of SCNAMES should be increased and waiting time for CCS shortened to prevent premature institutionalisation.	This issue is related to efficiency in service delivery and would be addressed in ESPP.
	The service requirements (including staffing and space requirements) of all types of RCHEs should be standardised.	This relates to a change in service delivery model and could not be addressed in the current study.
	An independent agent should be appointed to review the protocol and the procedure in monitoring RCHEs.	The SWD is vested with the authority and responsibility to enforce the Residential Care Homes (Elderly Persons) Ordinance and such responsibility cannot be taken up by external agents.
	The Residential Care Homes (Elderly Persons) Ordinance (Cap 459) should be reviewed to enhance quality assurance of services.	These issues would be addressed in ESPP.
	There should be RCHEs specialised in providing services to dementia patients.	

	Views of stakeholders	Response
	The manpower requirements of RCHEs should be reviewed and the unit cost should be worked out more carefully. Without which, it would be difficult to justify the voucher value.	
	If the manpower shortage problem is not dealt with, it would be a big challenge to improve service quality.	
	Considerations should be given to relax the labour importation scheme to address the manpower shortage issue.	
	Professionalism in elderly services should be promoted, such as pegging it with the qualification framework.	
	The case management services should be set up prior to launching of RCSV.	This issue is addressed in R6.
	Universal retirement protection system should be considered.	This is a separate policy issue beyond the ambit of the Study.
	The estimated percentage of elderly showing interest in the RCSV might be misleading as the respondents were not informed of the planned RCS provisions in the coming years.	This is noted for evaluation of the pilot scheme.