Elderly Services Programme Plan

Report on Scoping Stage

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TABLE OF CONTENT

BACKGROUND

1. In the 2014 Policy Address, the Chief Executive has announced the plan to prepare an Elderly Services Programme Plan (ESPP) within two years. The Elderly Commission (EC) was tasked to draw up the ESPP and a dedicated Working Group on Elderly Services Programme Plan (WG) was set up to take the task forward.

2. In July, 2014, the Labour and Welfare Bureau(LWB), on recommendation of the EC, appointed a consultant team from the Department of Social Work and Social Administration, the University of Hong Kong, to provide assistance to the EC and WG to study the issues relating to the provision of elderly services and in engaging various stakeholders, and other interest parties in the process.

3. The objectives of the engagement process are to solicit views of the stakeholders and the general public, in developing the ESPP; to enable dialogues and communications on key issues relating to elderly services, and to build consensus on a ESPP that can meet the needs of the elderly.

4. There are three stages in developing the ESPP; namely, Scoping Stage, Formulation Stage and Consensus Building Stage. Public engagement sessions are arranged under each of the three stages. The engagement sessions of the Scoping Stage started in October 2014 and finished in November 2014. The purpose of this first stage was to open up the discussion on the subject and solicit as many views as possible for setting the scope of ESPP.

5. This Report covers the methods used and the data collected in the Scoping Stage. The scope of ESPP to be taken forward and the plan for the Formulation Stage are also proposed for the consideration of the WG.

Current policy directions and objectives

6. In the current policy context, the mission behind the provision of various elderly services is 'to enable our elderly citizens to live in dignity and to provide necessary support for them to promote their sense of belonging, sense of security and sense of worthiness'.[1] The policy directions are to promote active ageing and, for elderly persons who became frail and are in need of long-term-care services due to old age, to promote 'ageing in place as the core, institutional care as back-up' through the provision of suitable services. In the process of

[1] Long-term care policy for the elderly and persons with disability (2013). LWB paper for the Panel on Welfare Services cum Panel on Health Services, Joint Subcommittee on Long-term Care Policy, Legislative Council on 26 February 2013.

developing the ESPP, the mission and vision, values, principles and objectives of the services may be revisited by the stakeholders and they would be addressed towards the Consensus Building Stage of the engagement process.

The Scoping Stage

7. Views were collected using the following formats during the Scoping Stage:

Engagement events

8. Five engagement events were conducted during the Scoping Stage from 22 October to 22 November 2014. Stakeholders from the following categories were invited to participate in the engaging events and in soliciting their views on the scope of the ESPP. They included:
   i) Elderly service operators: including operators providing subsidized and / or non-subsidized community care services (CCS) and residential care services (RCS).
   ii) Elderly service users: including service user groups and participants of active ageing projects.
   iii) Industry and professional associations related to elderly services; and
   iv) Interest groups / individuals, carer groups and community representatives (including representatives from political parties, members of District Councils).

Table 1: Scoping events by participants

Date	Category	Groups	Participating units	Number of participants
22nd Oct., 2014	Interest groups[2], carer groups, individuals and community representatives	4	17 organizations 3 individuals	53
1st Nov., 2014	Elderly service operators (subsidized)	4	37 organizations	72
5th Nov., 2014	Elderly service users	2	15 organizations	43
15th Nov., 2014	Elderly service operators (non-subsidized)	2	24 organizations	44
22nd Nov., 2014	Industry and professional associations	1	11 organizations	14

[2] A separate meeting with an interest group was also arranged on 4 December 2014 as the group was unable to attend the engagement events.

9. A total of 223 participants[3] representing 87 organizations[4]; as well as three individuals, have participated in the events (Table 1).

10. In each of the scoping events, participants were briefed on background information pertinent to the development of ESPP, including the demographics, projections of the elderly population, challenges facing the ageing society; as well as existing services for the elderly. This was to familiarize them with the context within which the ESPP would be formulated. Participants were then divided into focus groups according to the nature of the core elderly-related services they provide and/or their area of concerns. The purpose of the focus groups was to identify a range of topics / issues participants would like to cover in the development of ESPP.

11. To facilitate the discussion in the focus groups, a framework depicting the various dimensions of the topics to be discussed during the focus groups were provided for participants for reference:

Type of Service	**Service areas**	**Needs and issues**				
		Service provisions	**Staffing**	**Premises**	**Financing**	**Service gaps / service interface & others**
Community support	DECC/NEC/SE					
	Active Ageing					
LTC services	CCS / Carer					
	RCS					

Legend:

CCS: community care services for the elderly

DECC/NEC/SE: District Elderly Community Centre/Neighbourhood Elderly Centre/Social Centre for the Elderly

LTC services: long-term care services for the elderly

RCS: residential care services for the elderly

12. A total of 13 focus groups were conducted. Data were collected through audio taping, note taking and transcripts.

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[3] Including two participants representing the interest group mentioned in Footnote 2.

[4] Organizations that participated in multiple engagement sessions are only counted once.

Written submissions

13. Stakeholders were also invited to submit their views in writing by email, post or through a designated ESPP website[5]. A total of 17 written submissions[6] were received during the Scoping Stage (Appendix I).

Meetings at Panel on Welfare Services (Welfare Panel) of the Legislative Council (LegCo)

14. The methodology in the engagement process of ESPP was presented in a meeting of the Welfare Panel on 8th December, 2014 and views from Panel Members were collected.

15. A deputation session was arranged by the Panel on 20 January, 2015 and views from 46 deputations were collected.

Interviews with other relevant parties:

16. Interviews were conducted with representatives from the following government departments / bureaus, statutory bodies and non-Governmental organizations (NGOs):
    i) Food and Health Bureau (FHB) and Department of Health
    ii) Housing Department
    iii) Hospital Authority (HA)
    iv) LWB and Social Welfare Department (SWD)
    v) NGOs that provide funding /donations for non-subsidised elderly services

Documentary review

17. Documents reviewed to supplement the engagement events and stakeholder interviews included, but not limited to, the following:

    i) Services for the Elderly (November 1977), The Secretary for Social Services, Government Secretariat, Hong Kong Government
    ii) Report of the Working Group on Care for the Elderly (August 1994), Working group on Care for the Elderly, Hong Kong Government
    iii) Consultancy Study on Residential Care Services for the Elderly (December 2009), EC
    iv) Consultancy Study on Community Care Services for the Elderly (June 2011), EC
    v) A Study on Silver Hair Market Development in Selected Economics (2012), Central Policy

[5] espp.socialwork.hku.hk

[6] Two of the written submissions were received in 2015, after the end of the engagement period of the Scoping Stage.

Unit

vi) Consultancy Study on Review of Day Care Centres, Multi-service Centres and Social Centres for the Elderly and Development of Integrated Care Services for the Elderly (2000), Health and Welfare Bureau

vii) Report of Joint Subcommittee on Long-term Care Policy (July 2014), Welfare Panel, LegCo

viii) Report on the Provision of long-term care services for the elderly by the Audit Commission on 30 October 2014

ix) Minutes of the public hearings on 'Provision of long-term care services for the elderly' at the Public Accounts Committee (PAC) at 8 December 2014

x) Submissions by representatives at the deputation session of the Welfare Panel of the LegCo on 20 January 2015

xi) Other relevant papers and minutes of meeting of the Welfare Panel in relation to elderly services.

18. The following reports and ongoing initiatives/reviews were noted as background information and will be taken into account in discussion and deliberations at subsequent stages:

i) Hong Kong Population Projections 2012-2041

ii) Strategic Review on Healthcare Manpower Planning and Professional Development, FHB[7]

iii) Discussions of the Review Committee on Mental Health, Food and Health Bureau

iv) Project on Enhancement of the Infrastructure of Long-term Care in Hong Kong (including an review of Standardized Care Need Assessment Mechanism (SCNAMES)), SWD[8]

v) Pilot Scheme on Community Care Service Voucher for the Elderly, LWB[9]

vi) Special Sites Scheme on Privately Owned Sites for Welfare Uses, LWB

vii) Feasibility Study on Introducing a Voucher Scheme on Residential Care Services for the Elderly, LWB

viii) A Case Mix Study on the Community Care Services for the Elderly, SWD[10]

ix) Pilot Scheme on Living Allowance for Carers of Elderly Persons from Low Income Families, The Community Care Fund Task Force[11]

x) Pilot Scheme on Visiting Pharmacist Services for Residential Care Homes for the Elderly, SWD

xi) Pilot Residential Care Services Scheme in GuangDong, SWD

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7 This review commenced in January 2012 and a healthcare manpower projection model was developed by November, 2013. Ref: http://www.hpdo.gov.hk/doc/legcopaper_en.pdf; http://www.legco.gov.hk/yr13-14/english/panels/hs/hs_hps/papers/hs_hps0415cb2-1283-1-e.pdf

8 This project is expected to be completed in October 2016.

9 The interim review report is expected to be ready in mid-2015.

10 This study is part of the evaluation study on the Pilot Scheme on Community Care Service Voucher for the Elderly and is expected to complete by September, 2014

11 The Pilot Scheme was commenced in June 2014 and an evaluation will be conducted during the two-year pilot period.

xii) 'First-hire-then-train' Pilot Scheme and Navigation Scheme for Young Persons in Care Services, SWD[12]

xiii) Hong Kong 2030+, Towards a Planning Vision and Strategy Transcending 2030, Planning Department

xiv) Manpower Projection to 2022, LWB

[12] The Pilot scheme was launched in 2013 and the Navigation Scheme will be launched with an expended scope to cover rehabilitation services and provide an additional 1000 places in 2015. Source: http://www.swd.gov.hk/en/index/site_pubsvc/page_elderly/sub_highlighto/

ANALYSIS OF VIEWS EXPRESSED

19. In this section, themes from views expressed in the engagement events, written submissions, and meetings at the Welfare Panel and stakeholder interviews (a detailed summary of views is presented in Appendix II) are identified. Priority would be given to addressing issues covered under these themes given that they are most directly related to care services for the elderly and were most concerned by stakeholders. For other views, they will be passed to relevant bureaux and departments for consideration via the LWB. Those views were reported and discussed in Appendix III.

20. The themes can be categorized under six major headings:
    A. Definition of 'elderly' people and target service users of elderly services
    B. Existing Services
        B.1 Active ageing
        B.2 Community support services
        B.3 Community care services
        B.4 Carer support
        B.5 Residential care services
        B.6 Interfacing between active ageing, community support, CCS and RCS
        B.7 Monitoring and quality control mechanism
    C. Manpower and training issues
    D. Premises and space
    E. Sustainable financing of elderly services
    F. Interface and other issues
        F.1 Interfacing between various disciplines, policy bureaux and departments
        F.2 Mode of service planning
        F.3 Technology and information
        F.4 Services for older people with dementia
        F.5 Other issues

21. The major concerns expressed by stakeholders under each heading and the issues proposed for further discussion and deliberation at the Formulation Stage are described in the following section[13].

[13] As mentioned in paragraph 17, the comments and suggestion included in the Chapter on provision of long-term care (LTC) services in the Audit Commission's Report No. 63, as well as the associated discussions of the PAC of LegCo have been considered when preparing this report. Those comments and suggestions related to planning issues were found to be in line with the ones gathered from the public engagement sessions of the Scoping Stage. For the other comments and suggestions, which were considered technical and operational in nature, it is recommended that they should be followed-up by the SWD separately and as appropriate.

A. Definition of 'elderly' people and service targets

i. There were views that currently there were different age eligibilities for different types of services and/or welfare provision[14], which may pose inconsistency and difficulty in planning. Some expressed the view that there may be a need to designate uniform age eligibility for elderly services.

ii. Some participants pointed out that the government has recently responded to the global trend by deferring the retirement age of new recruits of civilian civil servants to 65 starting from 2015, and this was considered in accord with the regard to the improving health conditions and addressing the issue of enhancing overall labour force productivity.

iii. Some also raised the point that the service needs of different elderly cohorts (e.g. the 'young-olds', 'middle-olds' and 'old-olds')[15] should be better addressed with due regard to the improving health conditions, literacy, financial affordability and preferences.

iv. There were views that chronological age should not be the only criterion in defining the service users under the ESPP, and that the degree of impairment and level of care needs should be taken into account. Specifically, some raised the point that people with physical and/or intellectual disabilities would show signs of ageing earlier than people in the same age cohort; but their care needs cannot be catered for in other service sectors. Examples of these conditions are people with Down's Syndrome and stroke patients[16].

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[14] For DECC/NEC/SE membership, age 60 is the age eligibility, but for some of the centres, people aged 55 to 59 can also join as 'affiliate members'. For most subsidized LTC services, age 65 is the eligibility and people aged 60 could be provided on case by case basis, while for the Integrated Home and Care Services (Frail Cases), age 60 is the eligibility. Old Age Allowance (non-means tested part) sets 70 as the age eligibility.
For residential care services is 65 (eligibility for those aged 60-64 will be considered if there is a proven need.
In many developed countries, the definition of 'elderly' is often associated with the age at which a person retires / can receive pension benefits, i.e. mostly 60 or 65. It is generally accepted that the definition is arbitrary and its significance lies in its implications for ageing policies. Ref.:
http://www.who.int/healthinfo/survey/ageingdefnolder/en/

[15] The elderly population are often classified into different age subgroups such as 'soon-to-be old', 'young-old', 'middle-old' and 'old-old'. There is no standard age range for these subgroup, but a common classification among academia regarded 60-64 as 'soon-to-be old'; 65-74 as 'young-old; 75-84 as 'middle-old'; and above 85 as 'old-old'. Ref. http://www.hkis.org.hk/ufiles/Elderly-FinalReport.pdf. The Census and Statistics Department classified those aged 45-59 as 'soon-to-be-old', and those 60 and above as 'elderly people'. Ref. http://www.statistics.gov.hk/pub/B11301272001XXXXB0100.pdf

[16] The issue of ageing of persons with intellectual disabilities is being followed up by the Working Group on Ageing of Persons with Intellectual Disabilities under the Rehabilitation Advisory Committee.

Proposed issues for further discussion on definition of 'elderly' and target service recipients

a) Should chronological age be a pre-requisite to level of impairment in setting the eligibility for different elderly services?
b) Whether there should be a unified definition of 'older people' with respect to chronological age as the age eligibility for various types of welfare services? If yes, what should it be? If no, what should be different age eligibility for various types of services?

B. Existing Services

i. Existing services for the elderly can be broadly categorized as (a) services related to promoting active ageing, (b) community support services[17], (c) CCS, and (d) RCS. Views on issues related to these four types of services will be deliberated as a whole as they are interrelated.

ii. Service users, service providers and interest groups alike unanimously demanded for increase in volume of service provided in CCS and RCS, as well as further improvement in the service delivery mode to make them more accessible. There were other groups which were concerned about the long-term financial sustainability of the present service delivery model against an ageing population and they would wish the government to explore a sustainable financial model.

B.1 Active Ageing

i. Some participants were of the view that more efforts should be put in promoting active ageing, in particular in areas such as illness prevention and maintaining a healthy lifestyle for people who are relatively young. Attention should be paid to the changing demographic profile of the younger olds who were likely to be better educated and have better financial means as their needs and expectations would probably be very different. Examples cited by participants included their desire for a sense of autonomy and active participation in making life decisions; preference for a non-centre-based service delivery model; and wish for maintaining / building their social capital for a productive, independent and fulfilling life.

[17] Support services for carers are often provided as part of community support and community care services.

ii. There were views that active ageing should include such aspects as elderly lifelong learning, volunteerism, post-retirement employment and participation in community affairs, and that elderly services should cater for such a wide range of active ageing activities.

iii. Some suggested that the productivity of the young-old who had just retired from full-time employment but preferred part-time jobs or flexible working hours could be mobilized to join the elder care industry in such jobs as home care or residential care service assistants.

iv. Community education to promote an age-friendly attitude in the society was considered important by some participants.

v. There were views that active ageing programmes should not only be focusing on those who were healthy, but should also cover and benefit the frail elderly persons.

vi. The Public Transport Fare Concession was considered by some participants as a good measure to encourage the mobility of elderly persons in good health. The Elderly Healthcare Voucher is also welcomed.

B.2. Community support services

i. Currently, centre-based services, including services provided by District Elderly Community Centres (DECCs), Neighbourhood Elderly Centres (NECs) and Social Centres for the Elderly (SEs); and team-based services such as Support Teams for the Elderly (STEs) and Integrated Home Care Services (Ordinary) (IHCS (Ordinary)) are providing 'community support services' to the community-dwelling older people. Support services for carers, the views on which are summarised in section B.4, are also commonly provided through DECCs, NECs and SEs.

Participants generally viewed existing services as fragmented, with unclear service boundaries in between. As a result, coordination among services were not smooth enough; and there was a potential 'time gap' during service transition.

ii. Some alleged that the roles of DECC and NEC had changed over time and the scope of their services had expanded, requiring more specialized knowledge (e.g. on cognitive impairment) and professional input (e.g. physiotherapists (PT) and occupational therapists (OT)). However, some participants felt that both the workload and the services required were beyond the capacity of their staff training

and/or manpower provision. In particular, some suggested that additional resources should be allocated for services targeting older people with cognitive impairment.

iii. There were views expressed in making community support services (i.e. delivered by the current centre-based services like DECC) serve as the node for education, prevention, and early identification and intervention, which should be linked effectively with CCS and even RCS in performing referral, case management, and other interfacing functions.

iv. Some participants expressed that there were heavy demands for meal and housecleaning services under IHCS (ordinary). Part of the demand was caused by the scheme's low fee rather than actual care needs of the elderly. It was opined that the pull for resources from meal and housecleaning services has affected the quality of other IHCS services.

v. A number of participants alleged that the location of some service centres was not easily accessible; and in some neighbourhood there were no centres for the elderly in the neighbourhood.

vi. The STE was considered helpful by some participants but there were difficulties in finding community partners to provide affordable services for the elderly.

vii. Some participants stated that the transformation from SE to NEC[18] was not smooth, the catchment area of many districts has not been defined, and some of the frontline staffs were not well-equipped to handle the upgraded service requirements.

B.3 Community care services

i. CCS include Day Care Centre / Unit for the Elderly (DE/DCU), Integrated Home Care Services (Frail) (IHCS (Frail)), Enhanced Home and Community Care Services (EHCCS), Respite Services for Elders and Home Help Service (HHS). These services aim at providing long-term care services to enable frail elderly to live independently or with assistance in the familiar home and community environment.

Some participants were of the views that the boundary of various services were unclear, functions of some services seemed to be overlapping (e.g. IHCS (Frail) and

[18] The transformation from SE to NEC is part of the re-engineering exercise conducted by SWD in 2003. SEs provide social and recreational activities, provision of information on community resources and referral services while NECs provide counselling service, educational and developmental activities, volunteer development reaching out and networking, carer support and meal service, etc. Ref: http://www.swd.gov.hk/en/index/site_pubsvc/page_elderly/

EHCCS), and there was severe shortage in service provision (e.g. IHCS, EHCCS, respite services, day-care services, etc.). Reviewing and streamlining the services was suggested and the use of a case management model was generally deemed desirable.

ii. Some suggested that the staffing structure of IHCS was not adequate to provide quality and professional service to the clients because of the heavy caseload and the complexity of some of the frail cases (e.g. cases involving elderly persons with severe cognitive impairment).

iii. Some participants suggested that the competitive bidding policy for services would affect the long-term planning and manpower stability and should therefore be reviewed[19].

iv. Some participants expressed that the 'bundled' service delivery model[20] of EHCSS and IHCS (Frail) was not flexible enough as some frail elderly might just want to receive basic personal care services.

v. The possibility of public-private partnership between CCS and private residential care homes for the elderly (RCHEs) were raised by some participants. Some suggested that to ease the issue of long-waiting time for some CCS services such as meal service or occupational therapy service, facilities in private RCHEs could be further utilized, e.g. using their free space in provision of meals for community-living elderly, kitchens to provide meals-on-wheels to nearby home-bound (but not yet in need of RCS) elderly, laundry or OT services. However, there were also concerns that the private sector might take up the more profitable services for people with means only.

vi. Some participants emphasised the importance of life and death education and the needs for bereavement counselling for elderly surviving spouses.

B.4 Carer support

i. Participants were of the views that both emotional and tangible supports (such as training courses, help groups, counselling services, etc.) for carers were inadequate. Some participants considered alleged that existing services (such as training courses) for carers who have to work during the day and respite services were insufficient; 24-hour emergency respite service should be introduced; and the coverage of the

[19] There are 24 service contracts for EHCCS involving 5579 places which are due to expire in late February 2015 and the concerned contracts have been extended to two years till 28 February 2017. Reference: http://www.info.gov.hk/gia/general/201406/18/P201406180840_print.htm

[20] Participants used this term to refer to the provision of service package.

living allowance for carer should be expanded.

ii. However, there were different views regarding the extent of the support to carers. Some participants were of the view that the service hours of D/E and DCU could not match their working hours; but some providers of day care services opined that there should be a balance between supporting the carers and encouraging them to take up responsibilities of caring for their elderly family members.

iii. Some participants stated that in view of the ageing population, it was expected that more and more older persons would be cared for by domestic helpers. It was suggested that training and support should be extended to domestic helpers as well.

iv. Some suggested that each elderly service user and his/her carer should be treated together as a single 'service unit' in service provision; and services should also cover the carer if a case management approach is used.

v. Some also suggested that the society should give more recognition to the contribution and efforts made by family caregivers. Many family caregivers were juggling a career, their own family responsibilities, and the care of an older person. To ease the caregiving burden, employers could be encouraged to provide special leave arrangement and/or special work arrangement with carers. Some suggested that measures could be taken to enable 'full-time carers' to provide support for other elderly in the neighbourhood in addition to their own. It was suggested that in the long run, the rights of the carer should be protected by law.

B.5 Residential care services

i. The role of the private sector in the provision of RCS was an important issue raised by many participants, and the possibility of public-private partnership (e.g. the provision of day care cum residential service, cooperative model, etc.) and setting up of elderly facilities in the Mainland to cater for the needs of elderly from Hong Kong were suggested (cross reference with the topic on 'Sustainable financing of elderly services').

ii. Some private operators expressed that private RCHEs could play the role of taking care of elderly persons with special needs (e.g. those who were HIV positive)but do not yet require long-term care services (and hence not on the Central Waiting List (CWL)).

iii. Some participants expressed that older people generally have to wait for a long time for subsidized service, and there was imbalanced proportion of care-and-attention (C&A) homes and nursing homes[21]. Some noted that a number of older persons on the CWL might not require immediate RCS as they declined offer when one was given. They queried if such practice was an effective use of public resources.

iv. Case management was also considered by some as necessary in residential care services to provide continuous services for the elderly and keep track of their changing needs.

v. Some alleged that for elderly staying in C&A homes, the transition to RCHEs of higher care levels was inflexible as they have to be put on the CWL again.

vi. The quality of service of private RCHEs was a concern for many participants. Some participants alleged that the EA1 standard for the Enhanced Bought Place Scheme (EBPS) could no longer meet the expectations of the society and urged for a review of the existing standards for EBPS. However, for private operators, they expressed that it was difficult to improve the service quality without support from the government. More specifically, there were suggestions about increasing the maximum percentage of places that could be bought in EBPS homes, providing support in getting suitable sites, and allowing more flexibility in provision of escort service.

vii. Some suggested that end-of-life care should be included in RCS.

B.6 Interfacing between active ageing, community support, community care services, and residential care services

i. There were concerns about the possible gap between the various types of services, resulting in considerable workload when making referrals, inadequate provision for seamless services, delay in service provision, possible delay in early identification and intervention, and the long waiting time for both subsidized CCS and RCS.

ii. A number of participants were mindful of the fact that a lack of knowledge and access to available service is a continuous challenge faced by many older persons and their family members. Thus, they further suggested the use of care management as an approach to address this challenge. Within the care management system, care

[21] As at 30 October 2014, there were 15,014 subsidized C&A places and 3,284 subsidized NH places. In contract homes, the majority of places are for NH cases and the remaining places are C&A with continuum of care. The average waiting time was 36 months and 33 months respectively.

manager would play a critical role. They are expected to be involved in assessing needs, connecting prospective service users with appropriate services, coordinating care resources, monitoring service delivery, and providing support to the older persons and family through service transitions.

iii. Some participants alleged that there was imbalanced provision of services across elderly groups with different health status and level of care needs. It was suggested that the relative weight in allocation of resources for older groups with diverse attributes and care needs should be reviewed. It was also suggested that the SCNAMES[22] be reviewed so that those with mild impairment would be provided with suitable services. They further commented that the MDS-HC dataset is not fully utilized in analysing the service needs of the elderly. In particular, with its focus in detecting physical impairment, MDS-HC is not sensitive enough to cognitive impairment.

B.7 Monitoring and quality control mechanism

i. Some participants expressed that in view of the changing profile of the elderly, the existing standards and requirements for RCS might need to be reviewed to better meet the needs / expectations of the elderly. In this connection, the Residential Care Homes (Elderly Persons) Ordinance and its subsidiary legislations might also need to be updated when reviewing the service standards and requirements.

ii. Some participants raised concerns about the adequacy and the need to standardize the quality assurance measures of private RHCEs; and that the process quality (e.g. quality of life and life satisfaction) should also be considered in evaluating the performance of the private homes.

iii. Empowering the users to participate in assessing the performance of the service was also considered important by some participants.

iv. It was suggested that service pledge on waiting time for subsidized service provision should be introduced as one of the performance indicators.

[22] The review on SCNAMES is under the project entitled: 'Project on Enhancement of the Infrastructure of Long-term Care in Hong Kong'. One of the objectives is to update the assessment tool under SCNAMES from MDS-HC version 2.0 to interRAI HC version 9.1, which is supposed to be more sensitive in assessing the care needs of the elderly persons. The project is expected to be completed by the end of October 2016. Source: http://www.legco.gov.hk/yr13-14/english/panels/ws/papers/ws0725cb2-2077-3-e.pdf

Proposed issues for further discussion on improving existing services

a) How can active ageing be improved to achieve the objective of improving the quality of life of the elderly?

b) Whether the existing services can adequately cater for the need for lifelong learning, volunteering and employment (full or part time) for older people? What improvements can be made?

c) What is the suitable model of interfacing between these various aspects of elderly services? for early identification, diagnosis, intervention, prevention, and seamless care?

d) How DECCs/NECs/SEs should be positioned in the interface between services provided to community-dwelling and institutional living older people?

e) In the provision of long term care (LTC, including CCS and RCS), how the SCNAMES can be improved in better serving the function of allocating various services according to levels of needs?

f) Whether there should be a review of the functions and staffing structure of the IHCS (ordinary and frail cases) and EHCCS? Should the two services be integrated? If yes, how?

g) Is there room for private-public collaboration in the provision of CCS and RCS? If yes, how?

h) In what ways can the carer support services be improved to enable or prolong 'ageing in place'? Should carer support be extended to home-based paid carers (e.g. domestic helpers)?

i) What should be the appropriate model of 'case management'? Should the role of case manager be taken up by NGOs or the government?

j) How can the existing respite and emergency placement services be improved? Should respite services be provided only as a support measure for carers, or should it aim to target elderly persons with temporary care needs in general?

k) Whether the existing mechanisms of quality control are able to ensure quality of service provided by various providers, including NGO (in providing subsidized and self-financed services) and private operators?

l) Whether the current service standards are sufficient and responsive to meet the current and future (changing) needs of older people?

m) How can accreditation mechanisms be further promoted?

n) Is the existing service adequate for the elderly, carer and elderly service workers to handle end-of-life issues? What improvements can be made?

C. Manpower and training issues

i. On the issue of manpower and training, it is noted that the FHB has set up a high-level Steering Committee on Strategic Review on Healthcare Manpower Planning and Professional Development in 2012. The steering committee is tasked to, amongst others, formulate recommendations on how to cope with anticipated demand for healthcare manpower. A consultant has been engaged to conduct a comprehensive manpower projection for 13 healthcare professions which are subject to statutory regulation, including nurses, PT and OT. Findings of the steering committee would be taken into account together with the views gathered from the Formulation Stage before proceeding to the Consensus Building Stage.

ii. It was generally agreed by participants that manpower shortage was a major issue that would need to be addressed, this included paramedical such as PT, OT and to a lesser degree, nurses; as well as frontline care and health workers. Operators of smaller scale service found it particularly difficult to recruit staff (e.g. PT).

iii. One of the issues identified as contributing to the manpower shortage was, apart from inadequate supply of professionals, the comparative lack of career prospect in working in the elderly field. Some participants alleged that in the welfare sector, the posts for these professionals and subsequently, the career ladder were limited. Furthermore, it was alleged that for frontline care / health workers, because of the obnoxious nature of the job, it was difficult to attract young people to enter this field.

iv. Some participants from professional bodies and service operators raised various measures to tackle the manpower shortage problems, including a review of the staffing structure to devolve the more technical aspects of the professional tasks into ancillary staff. It was suggested that this could enable people with lower qualification and training to join the workforce, extend the traditional career ladder, and encourage a higher level of commitment to the field. In addition, for frontline care /health workers, promoting the image of the posts, and recognition in the Qualification Framework were measures proposed to attract more young people to take interest in the field. The salary scale of elderly service workers was also suggested to be reviewed to make it more competitive.

v. The ‘first hire, then train’ pilot project was considered by some participants as a good measure but might not be very effective in retaining the workers as trainees were encouraged to move on to the nursing profession.

vi. Labour importation as a means to deal with the manpower shortage problem was suggested as a means to ease the labour shortage problems of the frontline care workers, but there were also concerns on its impact on the labour market for the welfare sector and the quality of services provided.

vii. Other measures suggested to ease the manpower shortage problem included increasing the training quota, encouraging joint training programmes with overseas institutes, encouraging volunteering among the neighbourhood, the use of 'volunteer allowance' as incentive, unleashing the potential workforce of middle-aged women; and encouraging young-olds in assisting the old-olds.

viii. It was also suggested that specialized training programme on elderly services should be strengthened as some social workers felt that they might not be well equipped to work with complicated cases associated with geriatric illnesses such as severe cognitive impairment.

ix. It was suggested that end-of-life care should be part of the elderly service training at all levels.

Proposed issues for further discussion on manpower and training

a) What mechanisms should be put in place to ensure the provision of trained staff at various levels in joining the care industry – in both subsidized and private sectors?
b) What strategies can be used to enhance the capacity and flexibility of service providers in both subsidized and private sectors in recruitment, training, and retention, in the context of compliance with funding and service agreement and/or licensing requirements?
c) Whether labour importation should be considered as an interim measure (with limited duration of a number of years) to ease manpower shortage?
d) How can various types of informal, non-paid carers (including neighbours, volunteers, students, young-olds) be mobilized, trained, and supervised to provide neighbourhood level community support and home care to older people in the vicinity?
e) How can the curriculum of various caring professionals be further enhanced to be more age-sensitive, so as to ensure fresh graduate practitioners can be equipped with relevant professional knowledge, attitude and skills?

D. Premises and space

i. The difficulties in finding premise for provision of new services and/or find space in existing facilities to cater for the increasing service needs were raised by many participants. Some participants alleged that some local communities do not have elderly centres because no specific provisions were made in the planning process[23].

ii. While some participants stated that they were aware of the provision of additional facilities for the elderly under the Special Scheme on Privately Owned Sites for Welfare Uses, they doubted if just such a scheme was adequate in meeting the increasing demand. It was suggested that elderly services should be better planned in developing new towns and housing estates. There should be designated sites for elderly services in different districts with reference to projections in their elderly population. Furthermore, it was suggested that vacated welfare premises in housing estates could be used as sites for elderly services.

Proposed issues for further discussion on premise and space

a) How to project future demand for different elderly services, and, taking into account the existing and planned provision of the premises for such services, how to plan for the filling in the gap (to meet demand with supply)?
b) How can the planning process for elderly facilities be improved to ensure continued and stable provision of premises for various types of elderly services catering for different subgroups of older people (with different socio-economic status, needs, affordability, etc.) to meet demand?
c) How to ensure having sufficient space/premises for setting up service units? Is there a need to review the current 'schedule of accommodation' (SoA)? Is it necessary to review the relevant sections of the existing Hong Kong Planning Standards and Guidelines (HKPSG) with a view to reinstating the requirement of provision of premises for elderly service?
d) How best to utilize the existing wide network of private RCHE in the provision of CCS and RCS?

[23] According to the HKPSG (Dec 2014), there is no requirement for a pre-determined standard of provision of elderly services in a community. However, as a general reference, standards on the net operational floor areas of DECCs, NECs, DEs/DCUs and RCHEs are provided. Source: http://www.pland.gov.hk/pland_en/tech_doc/hkpsg/full/ch3/ch3_text.htm#10

E. Sustainable financing of elderly services

i. Issues regarding the role of the private sector in the provision of elderly services, particularly in RCS, were raised. There were views suggesting that the target groups between the private and non-profit sector should be differentiated. The private sector should cater for people with means while subsidized services should be mainly for those with limited financial resources.

ii. However, service quality and service monitoring of the private sector were also raised as a major concern. Some private RCHE operators were of the view that it was difficult for operators in the private sector to improve the quality of service due to high rental cost and the difficulties in recruiting staff. Some suggested that the government should provide more support for operators in the private sector to improve service quality, in particular, finding appropriate sites and providing rental support. Nonetheless, reservations on this were also raised by other participants as to whether the government should subsidize private sector operators.

iii. The mode of financing elderly services was considered a key issue that would need to be addressed and there were different views on the various options available. For instance, on the introduction of the 'money-following-the-user' approach, some participants agreed that this mode could allow more choices for the older people, and the introduction of the means test together with the implementation of 'money-following-the-user' should be able to ensure proper use of public funds in LTC. On the other hand, some participants were sceptical about such a financing mode, fearing that this would lead to 'privatization' of social services and government shifting its responsibility of service provision to the private sector.

iv. There were some other modes of financing suggested, which included expanding the tax base, setting up an 'elderly service fund', LTC insurance or encouraging a co-operative model in provision of services.

v. Views were diverse on whether subsidized elderly services should be provided for all as a right; or priority be given to those with both care and financial needs. There were divided views on whether means-test should be used in the provision of subsidized services. Some suggested that to ensure financial sustainability of the elderly services, public funds should be channelled to people with limited financial means and pay-for-service should be considered for those with means. There were also views that allocation of resources should be based on the needs of the elderly persons and no means test should be in place for core services.

Proposed issues for further discussion on sustainable financing of elderly services

a) How can the private sector be involved, and what is its relative proportion in the overall provision? What is the target? Which specific 'market segment'? or 'market share'?
b) How would the Government control / monitor /improve quality of services provided by profit-making operators?
c) Is there a need to review the existing practice of provision of purpose-built welfare premises for service providers in providing contracted services (e.g. contract RCHE)?
d) How would the government monitor non-profit making NGOs in providing self-financed services? (also cross-reference with 'quality control' issues below)
e) In view of the ageing population, is there a need to consider further the financing model for elderly services? For instance, in the provision of government subsidized) services, should there be different levels of subsidy (thus fee charging, co-payment) with reference to users' affordability (i.e. means test)?
f) Should there means-test in subsidized services so that resources could be channelled to those most in need? Whether level of government subsidy should be matched with users' affordability? Whether older people with financial means should be entitled to subsidized services? What would be the implications on co-payment mechanism, fee charging mechanism?
g) Whether the fees for subsidized service should be increased, to reflect the 'user-pay' principle? or as 'cost-recovery'?

F. Interfacing and other issues

F.1 Interfacing between various disciplines, policy bureaux and departments

i. There were general concerns regarding the interfacing between elderly services and healthcare system in providing seamless services for the elderly. Issues raised included a lack of coordination between Elderly Health Centres and the welfare sector, overlap in healthcare services between the Elderly Health Centres and some CCS, and insufficient collaboration between health and welfare sectors for elderly discharged from the hospital, and inadequate sharing of information to facilitate transition from one service to another[24].

[24] Existing collaborative work between the Hospital Authority and welfare sector include:
a) Community Geriatric Assessment Service (CGAS) / Visiting Medical Officer (VMO) collaboration scheme launched in 2004;

ii. Some good practices in inter-disciplinary / inter-sectorial collaboration were mentioned by the participants, including multi-disciplinary case conference to formulate healthcare plans for the elderly, use of Information and Communications Technology (ICT) in providing support and communication as an alternative to on-site medical consultation, visiting geriatricians to community facilities for the elderly, and community pharmacies. It was also suggested that a district-based platform for multi-disciplinary collaboration should be established.

iii. Other interfacing issues expressed by some participants included physical barriers to 'ageing in place' in housing estates, in particular, wheelchair accessibility of bathrooms in public housing estates; institutions for people with cognitive impairments not being able to cater for those who are old and frail; public housing units for the ageing couples, double-generation older people with care needs, and ageing couples with disabled child(ren)[25].

iv. An age-friendly environment was also considered important by participants. Examples of strategies included installation of more lifts to footbridges, building more leisure facilities for the elderly and creating more open space for social and recreational activities for older people living in the community.

v. Some participants considered that transportation means for those who are frail or using wheelchairs was inadequate, e.g. public vehicles with wheelchair seats, Rehabus, or taxis.

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b) Remote Clinical Management System (CMS) access in old age homes in 2004;
c) Elderly Care at Home (ED@Home) service in 2006;
d) Integrated Discharge Support Programme (IDSP) in 2008;
e) Community Health Call Centre (CHCC) in 2009

The Department of Health runs 18 elderly health centres which provide health assessment, physical check-ups and health education for elderly people.

[25] At the moment, the Housing Authority has a number of special schemes for senior citizens, including the harmonious Families Priority Scheme, Single Elderly Persons Priority Scheme, Elderly Persons Priority Scheme and Senior Housing. Special arrangements are also possible for people with disabilities to allocate to a more accessible flat and undergo conversion to allow wheelchair accessibility.

Proposed issues for further discussion on inter-disciplinary, inter-departmental, cross-sector interfacing

a) How could inter-disciplinary, cross-disciplinary, inter-departmental, inter-sectorial collaboration and coordination be promoted? In particular, which is the best approach to interface between welfare and health sector services (under different policy bureaus and between government departments and statutory bodies like Housing Authority, HA, etc.)? Specifically,
    i. How can seamless CCS/RCS services be better provided to elderly patients discharged from hospitals?
    ii. What improvements can be made to the interface between various community support services and primary healthcare services for the elderly (such as EHC, Visiting Health Teams, general out-patient clinic and community outreach services of the HA, private practitioners, etc.)?
b) How can manpower, space, facilities, equipment, information be better shared between different service providers in various sectors/departments/ units?
c) How can client information be best interfaced to facilitate streamlining of administrative procedures like referral, user information retrieval, etc.?

F.2 Planning mechanism and review of ESPP

i. Some participants expressed their expectation of seeing a programme plan that would be based on careful projections of supply, demand and shortfall of services. The programme plan is also expected to set short-term, medium-term and long-term objectives.

ii. District-based planning with the involvement of the District Council was suggested to address the difference in demographic profile of the ageing population in different districts. The District Council was also proposed as one of the possible platforms for multi-disciplinary / inter-sectorial coordination.

iii. It was suggested that older people should be empowered to participate in policy planning and their wish be respected in formulating their own care plan. There were also concerns that views from minority groups, including those from ethnic minority background, people with physical disability and people with different sexual orientations were not fully represented.

iv. There were views expressed that currently there is no designated proportion or number of seats for older people in various statutory and/or advisory bodies to adequately reflect the views of senior citizens.

v. Some referred to practices in other countries that designate specific targets of level of provision of specific services (e.g. as a proportion of elderly population) in planning for services for senior citizens. For instance, some made reference to some Mainland cities designating the ratio of 90:6:4 for the 3 types of services (i.e. family care, CCS, RCS) for different types of older people.

Proposed issues for further discussion for planning and review of ESPP

a) How could older people be engaged in the planning and review of elderly services? at district and territory-wide levels? At which specific platform or committees?
b) Whether the existing planning mechanism of elderly services[, with the involvement of a multitude of stakeholders, including the statutory bodies, advisory committees, bureaus, departments, NGOs, trade associations, training institutes, professional bodies, labour unions, users, etc.,] need to be reviewed / improved?
c) Whether the existing planning mechanism can provide a longer term planning, in addition to meeting short-term (e.g. annual) service demands? Or whether there should be any specific time frame (e.g. 5-year) for planning or 'plan'?
d) How would this ESPP be reviewed to keep up with the changes and developments of the society?

F.3 Technology and information

i. There were views suggesting that currently there were a multiplicity of various client information systems maintained by different government departments and service sectors. There might be possible overlap or gap between these various systems in data collection, retrieval and compilation, that may render delay in service provision, duplication of resources (manpower, time and monetary), and hinder comprehensive planning for service development and monitoring

ii. There were views that concerned about possible incidence of limited information technology (I.T.) literacy amongst the current cohort of older people, though it was anticipated that such situation could be improved in the future cohorts. It was reckoned that I.T. could become an indispensable platform and source of information for older people in their daily living. In connection, there were concerns about how best to improve I.T. literacy and accessibility amongst older people. It was suggested that there could be a better proliferation and development of ICT provision and information dissemination by the multiple channels ranging from government departments and NGOs.

iii. Views were expressed as to how technologies could be better harnessed to improve quality of life of older people (for both community-living and institutionalized) in various ways. Some raised such examples as assistive device, IT-aided assisted living, telematics-based care technologies[26], and others suggested that better utilization of 'high-tech' devices in the care industry may attract youngsters to join the workforce.

[26] In Germany, there can be 6 areas of application in IT-aided assisted living (Enste, Naegele & Leve, 2008), including a) technology for promoting independent living in old age; b) mechanical household and mobility aids, i.e. user friendly domestic appliances; c) the utilization of technology in connection with housing adaptation, such as self-adjusting blinds and blackout installations and electrical equipment that automatically switches off in case of malfunction; d) technology assisting health promotion and health control, e.g. e-health or health monitoring; e) technology assisting communication, such as home emergency call system; and f) tele-care, i.e. new forms of telematics-based care possibilities in the case of long illness and the need for care.

Proposed issues for further discussion on technology and information

a) Whether there is in place any mechanism that can tap on evolving technological advancement in improving service delivery modes, monitoring, and system maintenance?
b) How strategies can be developed to improve I.T. literacy and accessibility amongst older people?
c) How technologies can be better developed, incorporated and utilized in the four aspects of elderly services, ranging from active ageing, community support, CCS and RCS?

F.4 Services for older people with dementia[27]

i. Family carer concern groups had expressed concerns about the increasing prevalence of dementia amongst older people with increasing age, and that there was currently no comprehensive planning and service provision. This has resulted in the inadequate service provision in aspects such as early identification, early intervention, and support for family caregivers.

ii. Professional groups and practitioners also noted the inadequate pre- and in-service training for practitioners of various professions in engaging effectively in diagnosis early identification, intervention, and making referrals.

iii. Whether specialized or integrated services could best served this target group was controversial among the participants. Some suggested specialized services because the needs were different while some alleged that integrated service could provide better and more stimulation for elderly with severe cognitive impairment.

[27] Services for older people with dementia were considered one of the issues that should be addressed under ESPP. On this issue, it is noted that the Food and Health Bureau has set up a Review Committee on Mental Health, under which an Expert Group on Dementia was formed to examine the existing service delivery model for dementia, with a view to identifying service gaps and suggesting ways to strengthen long-term care for people with dementia. The study report of the Review Committee would be taken into account together with the views gathered from the Formulation Stage before proceeding to the Consensus Building Stage.

Proposed issues for further discussion on services for older people with dementia

a) Whether existing elderly services can adequately cater for the needs of older people with different levels of dementia? What could be done to further strengthen the support to demented elderly? E.g. can elderly centres serve as early identification and education nodes for older people with dementia and their family caregivers on top of the existing channels under the healthcare stream?
b) Whether elderly services for older people with dementia should be integrated with other elderly services or be separated as a specialized service?
c) How can welfare and health sectors achieve better collaboration in the early identification, diagnosis and treatment of older people with dementia? How can the delivery of welfare and healthcare services for the elderly be better coordinated at the district level (e.g. District Coordinating Committee for Elderly Services)?
d) How can professional training programmes be further enhanced in their curriculum and training for practitioners serving older people with dementia?

F.5 Other issues

i. Some participants expressed that special needs of the underprivileged and minority groups should be addressed; and the rights of elderly persons with mental health problems should be protected.

ii. The role played by private charitable foundations in encouraging new initiatives and innovative projects was pointed out by some but these were often short-lived. There were views suggesting more communication between private charitable foundations and the government to enable a better linkage with mainstream services.

Proposed issues for further discussion on other issues

a) What are the special needs of the older persons from the underprivileged and minority groups? If their special needs cannot be met by existing elderly services, what further support could be provided for them?
b) What role can private charitable foundations play in supporting projects for the elderly and how can the experience of such projects help better the mainstream services?

PROPOSED WORK PLAN FOR FORMULATION STAGE

Purpose

To discuss and deliberate on the overall directions and specific strategies under the various themes/ issues identified at the Scoping Stage which will form the basis for the development of a draft ESPP for consensus building

Format

1. Half-day or whole day sessions and public forums will be organized based on the six major headings:
   (A) Definition of 'elderly' people and target service users of elderly services,
   (B) Existing services,
   (C) Manpower and training issues,
   (D) Premise and space,
   (E) Sustainable financing of elderly services; and
   (F) Interfacing and other issues.

2. Stakeholders familiar with the topic will be invited to participate. Other interest parties can also register subject to availability of places. Participants will be briefed on the background, views/concerns expressed at the Scoping Stage and the issues to be deliberated at the beginning of the session. Depending on the topic, seminars with presentations from relevant parties will also be arranged to familiarize participants with the subject and prompt later discussion. Participants will then be divided into theme-based workshops focusing on concrete suggestions to formulate strategic directions. Written discussion guide would be provided for the participants during the session.

3. As some topics have to be deliberated in advance of others, e.g. reviewing service provision prior to discussing premise and space; the sessions and theme-based workshops will have to be carried out in a logical order. Sessions and workshop themes are illustrated in the table below (See Appendix IV on key questions under each workshop / seminar):

THEME A **Definition of 'elderly' people and target service users of elderly services**
Workshop 1 *Definition of 'elderly' people and target service users of elderly services*
THEME B **Existing Services**
Seminar / Workshop 2 *Active ageing and continuous contribution of the elderly*
Workshop 3 *Effective and efficient service delivery and a suitable model of interfacing between various elderly services: Community Support Services, CCS, RCS and SCNAMES*
Workshop 4 *Effective and efficient service delivery and a suitable model of interfacing between various elderly services: Case management*
Workshop 5 *Effective and efficient service delivery and a suitable model of interfacing between various elderly services: Respite and emergency placement*
Seminar / Workshop 6 *Effective and efficient service delivery and a suitable model of interfacing between various elderly services: Supporting carers to enable 'ageing in place'*
Seminar / Workshop 7 *Create synergies in public-private partnership*
Seminar / workshop 8 *Quality assurance and improvement*
Seminar / workshop 9 *End-of-life care*
THEME C **Manpower and training issues**
Seminar /workshop 10 *Tackling manpower issues*
Seminar / workshop 11 *Tackling training issues*
THEME D **Premises and Space**
Seminar / workshop 12 *Planning for provision of premises and space*
Workshop 13 *Public-private partnership to tackle shortage in premises and space*

THEME E **Sustainable financing of elderly services**
Workshop 14 *Financial sustainability and use of public funds in service provision*
Workshop 15 *Public and private marketing mix*
THEME F **Interface and other issues**
Seminar / Workshop 16 *Inter-disciplinary, inter-departmental, cross-sector interfacing*
Workshop 17 *Planning mechanism and stakeholder involvement*
Workshop 18 *Planning and review timeframe*
Workshop 19 *Technology and information*
Seminar / workshop 20 *Services for older people with dementia*
Workshop 21 *Support for ethnic minority groups in provision of services*
Workshop 22 *Role of private charitable funding bodies in supporting new and innovative initiatives*

4. Participants for workshops at this stage will be invited through organizations of key stakeholders, e.g. the Hong Kong Council of Social Services, relevant industry associations and professional associations, the SWD's District Coordinating Committees on Elderly Services, etc. Depending on the number of participants, one or more parallel workshops may be conducted for each theme.

5. The LegCo Welfare Panel will also be consulted as part of the public engagement process.

6. To facilitate discussion and deliberation on concrete strategies, for some of the themes, stakeholders will be invited to submit concrete proposals on strategies for addressing the issues concerned prior to the workshop. They will then be invited to present and deliberate on their proposals in the workshops.

7. At the end of the Formulation Stage, for each major issue to be addressed, more than one possible option may be put forward for consideration at the Consensus Building Stage. The issues covered by the Formulation Stage are not intended to be comprehensive. The consultants and the EC may address in the Consensus Building Stage some of other issues not covered by the Formulation Stage.

Timeframe

8. June to August, 2015

Appendix I

List of written submissions

Name	**Title of the view**
立法會張國柱議員辦事處—長者社區照顧服務關注組	對安老服務計劃方案「訂定範疇」的意見
立法會張國柱議員辦事處	就安老服務計劃方案「訂定範疇階段」第一節公眾參與意見書
曾慶光	NA
香港社會保障學會	就安老服務計劃方案第一階段-訂定範疇意見書
香港基督教服務處--長者評議會、 順利長者鄰舍中心、樂暉長者地區中心、幸福長者鄰舍中心、元州者長者鄰舍中心	ESPP(I)綜合意見
關注家居照顧服務大聯盟	對安老服務計劃方案「訂定範疇」的意見
全港長者及護老者權益聯席	「全民退保」及「家居照顧服務」意見書
羅日光	有助老人健康活動安老院選址方案
羅日光	發掘鄰舍義工作出敬老護老和諧社會服務精神
智障人士老齡關注組	安老服務計劃方案「訂定範疇階段」第一節公眾參與意見書
李輝	「安老服務計劃方案」意見書
香港安老服務協會、中小企國際聯盟安老及殘疾聯會、全港私營安老院同業會	「未來五年香港安老服務前瞻與發展」建議書
黃帆風	NA
The Jade Club	NA
將軍澳長者民生關注會	對安老服務計劃方案「訂定範疇」的意見
香港復康會	就「安老服務計劃方案」提交有關訂定範疇方面的意見書
扶康會	對制訂「 安老服務計劃方案」提交意見

Appendix II

Summary of views collected during the Scoping Stage

	SUMMARY OF VIEWS (within scope)
Definition of 'elderly' people and target service users of ESPP	
	Age should not be the only criterion in eligibility for elderly services. The level of impairment should be taken into consideration.
	In assessing the care need of an individual under SCNAMES, age should not be a criterion in eligibility for service.
	The programme plan should give appropriate attention to the whole spectrum of elderly population, including those who are still healthy and active, those with moderate level of impairment and those who are frail. The needs of the 'young-olds', 'middle-olds' and 'old-olds' should be addressed in planning.
Service provision and interfacing between community support, CCS and RCS	
	Transition of service from CCS to RCS; from young-old to old-old; should be seamless.
	Consideration should be given to keep the family unit intact, including double-ageing couples, two-generation elderly with care needs, double-ageing couples with disabled child(ren) and flexibility in age criterion should be considered.
Community education	
	A culture in accepting and caring for the elderly should be nurtured and strengthened.
	The media should be better utilized to educate the public in how to care for the elderly.
	Intergenerational projects should be encouraged.
	The role of the neighbours as a support for the elderly persons should be strengthened. A small compensation for their services could be an incentive.
Active Ageing	
	Resources input in active ageing projects were not adequate.
	The idea of living in dignity and remain active in the community should be promoted to encourage active ageing. Promotional work should start with the soon-to-be olds, and emphasis should be put in promoting healthy life-style, health management and prevention of illnesses.
	To encourage retired persons to remain active, social support network of the retirees should be strengthened/re-established and

SUMMARY OF VIEWS (within scope)	
	community participation should be encouraged. For example, support could also be given for retirees to learn new skills, and concessions for elderly persons to visit public facilities such as museums, leisure and recreation facilities, etc. could be provided.
	Retired persons could become volunteers to utilize their expert knowledge and they could be a potential workforce to continue contributing to the community. Some of the retirees could help other elderly persons in providing escort service or house cleaning service. This could also help to supplement their retirement income and encourage them to remain active.
	The existing centre-based services could not meet the needs of the soon-to-be olds and young-olds. Their education and economic profiles were different and would probably prefer non-centre based services.
	Efforts should be put to build and sustain the social capital of the elderly and the carers.
	Active ageing programmes should not be only for those who were healthy. Frail elderly persons could also benefit from such programmes.
	Support services should be provided to encourage employment for the elderly persons.
	It was difficult for the elderly and the carers to use public transport since most buses were not wheelchair accessible and there were only a few Diamond Taxis.
	More taxis should be encouraged to participate in taking passengers on wheelchair. References could be made with practice in the Mainland where designated taxis are required by law to take passengers on wheelchair.
	The Public Transport Fare Concession was only suitable for elderly in good health. However, many public vehicles were not wheelchair accessible and those who were frail might not be able to benefit from it.
	The Public Transport Fare Concession Scheme for the Elderly should be extended to green mininbuses and public ferries. This benefit should also be expanded to cover all elderly persons aged 60-65 and free transport should be considered for those 65 or above.
Support for Carers	
	More emotional and tangible support for carers should be provided to encourage ageing in place. This includes increasing the amount of cash allowance for carers, provision of more training courses by paramedical staff (e.g. nurses, OT, PT), developing more mutual help group / mentorship program, provision of counselling services for the carers to build up their positive self-image and allowing the carers to use elderly service facilities. In addition, one-stop services and online training and telephone intervention programmes should be developed for carers. Furthermore, training should also be provided to domestic helpers who need to take of elderly persons.

SUMMARY OF VIEWS (within scope)	
	The carer should be taken as part of the 'service unit' in case management.
	Respite services, including day and residential respite care, should be strengthened to allow 'breaks' for carers in easing their stress. Service needs for respite care should be carefully reviewed. It was proposed to increase the quota for day care and residential care services to 900, 50 each for 18 districts.
	24-hours emergency support service should be developed and home-based services should be strengthened to ease the burden of carers.
	The existing service hours of DECCs and NECs were not able to support caregivers who are 'working adults'.
	The contribution of the carers should be recognized and carer allowances should be for all, not just for those with limited financial means.
	The Living Allowance for Carers of the Elderly persons from Low Income Families should be extended to all districts and eligibility criteria lowered. The amount should not be a flat rate and should correspond to the level of impairment of the elderly person.
	Allowance for employment of home help should be provided to support family with more than one elderly
	Employers should be encouraged to provide special leave for carers of elderly persons.
	There should be more attention and support to carers of elderly persons with terminal illnesses.
	A 'registration scheme' for family members to provide home care for elderly persons should be considered. 'Registered' carers could also provide support for elderly persons in the neighbourhood in meal service, laundry service, and escort for medical consultation etc.
	In the long term, the rights of the carer should be recognized and safeguarded by legislation. The needs of the carers for the elderly and the handicapped should be studied.
Community Support and Care Services	
	The existing services were fragmented, service boundaries confusing and coordination among services not smooth. For example, there could be a time lag in transition from being an 'ordinary' member at DECC to receiving LTC under IHCS (frail). Similar problem was also found in transition from CCS to RCS.
	In meeting the objective of ageing in place, the quality of life of the elderly should also be taken into account. For example, the quality of life of elderly with limited mobility should be considered.
	Case management was necessary to coordinate and plan suitable and timely services for the elderly; and to facilitate seamless transition between various services. However, the current case management system was not able to perform its role since there was no proper training and case managers did not have the power to deploy resources.

SUMMARY OF VIEWS (within scope)	
	Case management service should be provided for elderly aged 60 or over
DECC/NEC/SE	
	The role of NEC and DECC had changed over the years with increasing demand on professional inputs from PT and OT. However, recruitment of these professionals was an issue; and the staffing issue of NEC and DECC had an impact on the workload of IHCS (ordinary cases)
	Some districts did not have provision of NEC and elderly persons in the district had no means to apply for services. There was a long waiting list for home-based services such as meal services and domestic cleaning services. Respite services were not adequate.
	The location of some day care centres were not elderly friendly, creating extra difficulties for both the elderly and agency in terms of transportation.
	The catchment area of many districts had not yet been defined in the transformation from SE to NEC, making it difficult to perform administrative tasks such as calculation of service statistics, making referrals etc.
	DECC should be provided with adequate support such as manpower and suitable physical setting that could enable them to provide the services they are tasked with.
	Respite services could be arranged through SCNAMO instead of having RWs approaching each unit directly.
	When transforming social centres for the elderly to NEC, additional training and support are needed to equip frontline staff with skills and knowledge to provide services for the elderly and their family.
	The Support Teams for the Elderly help to fill the service gaps and save costs for the government and should be encouraged. However, it was sometimes difficult to form partnership with private sector in the community in supporting the service. For example, some elderly still found household repairing services expensive because they still had to pay for the expenses of the material.
CCS	
	The service quota IHCS and day-care services were inadequate. In particular, the number of IHCS teams remained at 60 for many years.
	IHCS (Ordinary) should also be part of LTC as it serves the function of early detection and prevention of health problems and its increasing service demand should be addressed.
	Some of the ordinary cases under IHCS had mild cognitive impairment but the staffing structure did not provide appropriate professional services such as OT. The Dementia Supplement should be extended to IHCS.
	The preventative function of CCS should be enhanced. 70% of the elderly receiving IHCS are ordinary cases or elderly people having mild

SUMMARY OF VIEWS (within scope)	
	care needs (e.g. those suffering from diabetes and high blood pressure). Community support services should be provided to prevent further deterioration in health. In addition, measures to prevent the elderly from home injuries should also be strengthened.
	The 'bundled-up' model in service provision of IHCS was too rigid without taking into account the priority of the elderly placed on different services (e.g. meal service might have higher priority than doing exercise). Some elderly persons, although assessed to be of moderate to severe level of impairment, still chose to just use IHCS services for ordinary cases because they were not used to using rehabilitation services. This resulted in thinning out the resources for ordinary cases
	There was heavy demand for meal service and housecleaning service, with over 5000 persons on the waiting list. The service quota of IHCS should be increased and more community canteens for the elderly should be set up. Furthermore, the meal service provided under IHCS (Ordinary) was prone to abuse due to its low fee. This has also affected the resources put in housecleaning service and the quality of service of both is affected.
	Due to the heavy workload and inadequate staff support, IHCS had difficulties in taking care of the frail elderly, and these cases were just receiving minimal service; and when the case could no longer be managed, the only alternative would be institutionalization at private home.
	Continuity in service provision for IHCS should be improved. It was reported that one case with physical impairment had to wait for 3 years to obtain just 6-month period of service; and had to reapply to continue receiving the service.
	Funding for IHCS was not able to catch up with inflation.
	Services provided by IHCS (Frail) and EHCCS were very similar, their role and functions should be reviewed. The possibility of integrating these two services should be studied.
	The EHCCS team had to undergo regular review for competitive bidding. This would create a lot of pressure of staff, affected long-term planning and job security for staff.
	The EHCCS had difficulties in managing meal service because day care centres did not have kitchen. They were now relying on the IHCS kitchen but the capacity of which was limited.
	The bundled-up service model in EHCCS might not be appropriate for all. For elderly persons assessed to have moderate to severe level of impairment, they could not choose only the services they needed. A 'basic' care package with just basic personal care should be provided to them.

SUMMARY OF VIEWS (within scope)	
	Day care centres could only manage to take care of elderly with mild cognitive impairment, but not those with moderate or severe level of cognitive impairment.
	Day care centres handling cases with cognitive impairment should be allowed to admit pay-for-service cases to supplement the cost.
	Extending the service hours of DEs/DCUs and arrangement of transportation services were challenging for the centres. Family members should be encouraged to take up more responsibilities.
	Public-private partnership between CCS and private RCHEs might help to ease the long waiting list for CCS. For example, possibility of developing elderly homes cum day care centres could be explored. This might partly solve the manpower shortage issue as staff such as PT and OT can be shared. In addition, RCHEs already equipped with facilities for meals preparation and laundry services could be utilized fully to provide support for CCS.
	However, public-private partnership in provision of CCS might result in the private sector taking up the more profitable services and NGOs have to deal with difficult cases.
	Life and Death Education should be promoted in DECC for elderly and their carer. More attention should be paid to provide counselling for elderly after the death of their spouse.
	Formal services were not able to reach elderly who were 'socially withdrawn'.
RCS	
	The transition to RCS with different care levels lacked flexibility. If an elderly person wanted to change to a different facility with higher level of care due to change in health condition, they had to be put on CWL again.
	Many elderly applied for subsidized RHCE as a 'security measure' in case their health deteriorated. Some might not need immediate service. They might reject an offer and requested to be matched again after a few months. This could waste resources.
	Some elderly persons were institutionalized because of housing, financial or accessibility problems; and/or there is insufficient CCS.
	There was imbalanced proportion of C&A and nursing home. Elderly with severe impairments had to wait for a long time.
	Elderly homes were taking in elderly people needing various levels of care and this could be very demanding for staff. Subsidy should be in accordance with the care needs level and the government could play a monitoring role in assessing the level of subsidy.
	The use of case managers should also be introduced to residential services. A case manager could help in updating the condition of the elderly; obtaining services for them in a timely manner and speeding up the administrative procedures. In addition, it might help to assess

SUMMARY OF VIEWS (within scope)	
	and provide continuous care for elderly whose health had deteriorated beyond the C&A level.
	Around 70% of RCS was provided by the private sector. There was a need to examine the roles played by the public and private sectors respectively in the provision of RCS. For example, homes in different sectors could focus on providing services for elderly persons with different care needs. Sometimes, private homes might have the advantage of being more flexible in manpower allocation and problem solving.
	For many private homes, a large proportion of their residents were CSSA recipients. However, it was very difficult for operators to provide high quality service at such fee level. In line with the concept of 'money-following-the-user', licensed private homes should be allowed the opportunity to participate in the Voucher Scheme on Residential Care Services for the Elderly that is being studied, so that the elderly persons could have more choices and the homes have opportunities to improve service.
	Increasing the proportion in EBPS places to 60% could be an incentive for EBPS homes to improve service quality.
	With the changing profile of the ageing population, standards such as EA1 / EA2 could no longer meet the expectations of the younger olds.
	The essence of 'money-following-the-user' was to respect the elderly persons' choice. Input control such as requirements in staff structure did not fully reflect the service quality of the home. Quality of life and life satisfaction were also important indicators of performance.
	Public-private partnership should be encouraged to develop innovative projects in providing RCS and to shorten waiting time, e.g. adopting a model where private foundations, service operators and the government work together to increase the number of RCS places by constructing new RCHEs, providing subsidies through purchasing places from the RCHEs, and operating the remaining places as self-financing places respectively.
	Considerations could be given to encourage operators to set up elderly homes in the Mainland and allow Hong Kong residents to use the service. Young people could be encouraged to start business in RCS in the Mainland.
	The possibility of developing day care cum residential care services should be explored.
	Escort service to medical consultation was a strain for RCS staff and the possibility of having visiting doctor should be explored.
	The eligibility in provision of escorting vehicles in private homes should be reviewed.
	Many family members would apply for RCS on behalf of the elderly. Attention should be paid to ensure that the wishes of the elderly persons are respected.

SUMMARY OF VIEWS (within scope)	
	End-of-life care should be part of RCS.
Monitoring and quality control mechanism	
	The Residential Care Homes (Elderly Persons) Ordinance and its subsidiary legislation should be reviewed to improve the service quality of private homes.
	Performance indicator of services should include waiting time pledge in service provision.
	Quality assurance measures of private RCHEs should be unified and strengthened. Accreditation scheme should be standardized in terms of core scope and standards. Subsidy should be provided for application for accreditation.
	In view of the difficulties in staff recruitment, instead of fixing the staffing standard, a mechanism by which homes were assessed and categorized by 'levels' could be a more flexible way to use resources.
	A platform should be developed for customers to comment on the service quality of private RCHEs.
Manpower and training issues	
	There was serious manpower shortage for professionals, including PT, OT and nurses. Training quota for these professionals should be reviewed.
	Manpower shortage problems were also particularly serious among care workers. Many care workers were getting old themselves and a lot of the tasks had to rely on other staff (such as health workers) who received training for other tasks.
	It was very difficult to recruit staff, especially younger people, in RCS because some of the tasks were obnoxious in nature; and the career ladder was very limited. Staffing structure and pay scale should be revised to attract more young people in the elderly service field.
	More opportunities should be created to help younger persons in understanding elderly service. Promotional work could be launched among secondary school students to enhance their understanding on elderly services. In Taiwan, young people could replace their military service time by working in elderly services. In addition, elderly homes could serve as practicum sites for professional training such as for medical doctors and nurses.
	To attract younger persons to enter the field, training quota at VTC should be expanded. The qualification of ranks such as PT assistant should be given more recognition and input of other professionals such as students from the HK Sports Institute should be considered. Elderly homes could also serve as practicum sites for professional training.
	The 'first hire, then train' pilot project on Multi-skills Workers Training might not be very effective in helping to retain health workers as

SUMMARY OF VIEWS (within scope)	
	trainees might move on to the nursing profession. A better career ladder for health care workers could be more appropriate.
	Image building for elderly service workers should also be enhanced.
	Professional tasks could be differentiated into different skills levels, which may ease the manpower shortage problem. For example, OTs could do assessment and OT assistant could execute the plan; blood samples could be drawn by nurses instead of doctors. The New York model of using phlebotomists to draw blood samples, the Japan model of separating the medical profession from the elderly service profession were useful references. In developing the elderly services as a profession in its own right, the status of people working in this field might be raised and a better career ladder could be developed.
	Another factor contributing to the difficulties in recruiting professional staff was that working in elderly service was un-rewarding. The job nature was challenging but the career path was very limited. Furthermore, there was usually one position for the same profession, and the opportunity for upward mobility was low. Incentives and stimulations to professional development were low.
	Physiotherapy services were monopolized by intermediary company and smaller agencies were difficult to compete with larger ones to get high quality PT services.
	To increase the supply of professional staff, possibility of recognizing some overseas professional qualification should be explored, and joint professional training programme between overseas and local universities should be encouraged.
	It would be difficult to improve service quality without solving the manpower shortage problems. Labour importation could be a short-term measure.
	Private homes had to pay a levy to ERB for the Supplementary Labour Scheme (SLS) but they did not seem to receive any benefit from the contribution.
	Labour importation could not resolve the manpower shortage problems for frontline care workers. It would only pull down the pay scale and subsequently, further lower the service quality.
	District-based volunteers should be recruited to provide meals and housecleaning services for elderly persons with severe impairment in the neighbourhood. Some allowances for the volunteer services should also be considered.
	Middle-age women could also be considered as a potential workforce.
	Social workers are not sensitive in assessing the condition of the elderly with cognitive impairment and not well-equipped to handle the relating mental and emotional problems.

SUMMARY OF VIEWS (within scope)	
	End-of-life care training should be provided for care workers.
	Deaths in elderly homes could create stress for frontline staff and should be attended to.
Premises / space	
	Some districts do not have elderly centres because the Housing Department does not have this provision in their planning[28].
	In view of the difficulties in finding suitable sites for elderly services, for new developments, sites for elderly services should be included in the planning.
	In some districts with high proportion of elderly persons, the space in DECC / NEC could not accommodate the number of elderly needing a place to gather during the day, let alone expanding the service to cater for more clients.
	The possibility of reserving space for elderly homes in housing estates should be explored. This could also serve a base to provide support for CCS in the community such as meals service and outreaching services.
Sustainable financing of elderly services	
	Allocation of resources for elderly services should be based on the proportion of the elderly persons in the population.
	Allocation of resources should be based on needs of the elderly, not just proportionate to Gross Domestic Product.
	Allocation of resources for people with different levels of impairment was not balanced (many CCS are only targeted at the frail elderly). Resource input should be increased for those who were still healthy or those with mild impairments to maintain their active lifestyle and prevent deterioration in health.
	Existing elderly services were heavily subsidized by the government and were not financially sustainable. Public funds should be channelled to people with limited financial means. Pay-for-service should be considered for those with means.
	There should not be means test for core elderly services as all those in need should be entitled for these services.
	Subvented RCHEs should not provide non-subsidized places. This could ease the long waiting time for subsidized services.
	Means test should be introduced for subsidized RCS places.
	The role of private sector in the development of private / fee-for-service community services should be encouraged. This could reduce the financial burden of the government, enables synergy in the private sector and encourages the development of innovative ideas.

[28] The Housing Department mainly makes reference to the HKPSG in reserving locations for the provision of community facilities, including premises for elderly services. Currently, the HKPSG does not have any planning requirements on the number of elderly centres to be provided.

SUMMARY OF VIEWS (within scope)	
	Government could provide sites to support development of community services in the private sector.
	Rental concession for subvented homes was unfair for homes in the private sector. Subvented homes should be for those without means or those who need the highest level of care.
	Adopting the 'money-following-the-user' model could ensure proper use of public funds in LTC.
	The 'money-following-the-user' approach would encourage privatization of social services; but social service provision should be the responsibility of the government. Furthermore, privatization of social services could result in a downward mobility for those with limited financial means.
	The model of competitive bidding for services would affect the long-term planning and manpower stability of the services and should be reviewed. This funding model is particularly hard for smaller agencies.
	Dementia supplement should also be provided for private homes as they are taking care of the largest share of elderly persons with dementia.
	Communication between private funding bodies and the government should be strengthened to enable continuation of projects funded by private source.
Other issues and interfacing	
Interfacing between various disciplines, policy bureaus, departments etc.	
	Health sector
	Seamless transition between welfare and health sectors should be strengthened; e.g. ensuring that the care / rehabilitation plan prescribed while hospitalized be followed-up in RCHEs, shorten waiting time and streamlining workflow for RCHE residents attending emergency service.
	Collaboration between health and welfare sector should be strengthened in developing systematic plans to promote healthy lifestyle for the elderly. Large scale health promotion activities and community health education should be launched to reduce future medical costs.

SUMMARY OF VIEWS (within scope)	
	Interface of the Elderly Health Centre with the welfare sector should also be reviewed as this service has not been reviewed for over a decade[29].
	Services appeared to be overlapped between welfare and health sector as some CCS also provide healthcare services. Roles of each service should be defined more clearly.
	Existing good practices such as the joint project with Castle Peak Hospital on suicide prevention, multi-disciplinary case conference, outreach psychiatric consultation, DECC-based medical consultation should be encouraged.
	Support services such as the Pilot Scheme on Visiting Pharmacist Services and the pilot project on outreach primary dental care services for the elderly are very useful and should be regularized.
	Community pharmacies are very useful in coordinating dispensing of drugs if the elderly person has consulted more than one doctor. In addition, if the community pharmacies are located in the nearby vicinity, it can reduce wastage due to prescribing drugs for a long period of time.
	The medical services in RCHEs should be strengthened, e.g. in provision of yearly health check.
	The Integrated Discharge Support Programme for Elderly Patients that used social worker as case manager was found to be able to reduce 30-40% of E&A incidences. The government should consider regularizing this scheme.
	A multi-disciplinary team was needed to handle the complex issues of cases with severe cognitive impairment.
	Private homes were more flexible in taking difficult to place cases such as those who are HIV positive, or those with terminal illness. As they did not require hospital treatment and could be taken care of in elderly homes with support from the government. The VMO scheme under HA could also be considered for private RCHEs.
	Transportation
	In view of the inadequacies in Rehabus services, introduction of taxi coupons could be considered.
	Some Rehabuses were idled due to inadequacy of drivers. The installation of wheelchair seats in public vehicle should be encouraged, subsidy for low income persons to use Diamond Taxi, Easy-Access Transport, 紅棉巴 should be considered.
	The Public Transport Fare Concession is only suitable for elderly in good health. However, many public vehicles were not wheelchair

[29] The Food and Health Bureau advised that two reviews on Elderly Health Centres were conducted in 2002 and 2007.

SUMMARY OF VIEWS (within scope)	
	accessible and those who were frail may not be able to benefit from it.
	The Public Transport Fare Concession Scheme for the Elderly should be extended to GMB and public ferries. This benefit should also be expanded to cover all elderly persons aged 60-65 and free transport should be considered for those 65 or above.
	Barrier-free environment for the elderly should be built and mainstreaming wheelchair accessibility should be considered.
	Age friendly facilities in some districts were examples of good practices. For example, Hoi Sham Temple Park at To Kwa Wan is elderly friendly with facilities for the visually impaired, toilets for the elderly, and highly accessible ramps and stairs.
	Lifts should be installed at all footbridges to make it age friendly.
	On the other hand, considerations should also be taken to encourage the elderly to be more mobile and do exercise, and not relying too much on facilities such as lifts and escalators.
	Resources should be provided for District Councils to renovate the old street to make it accessible to the frail elderly.
	Meeting points should be developed for the elderly to socialize in the community.
	More leisure facilities should be provided for the elderly especially when many of the parks are used by foreign domestic helpers during holidays. The inadequacy in open space and leisure facilities would be even more severe with the ageing population and the likelihood of more home-helpers taking up a carer role.
Mode of service planning and review of ESPP	
	Projections in supply, demand and shortfall should be the basis in planning.
	Proportion and profile of elderly population in different districts should be taken into account in planning.
	Practices in other countries that designate specific targets of level of provision of specific services (e.g. as a proportion of elderly population) in planning for services for senior citizens could be a reference. For instance, some made reference to some Mainland cities designating 90:6:4 for the 3 types of services (i.e. family care, CCS, RCS) for different types of older people).
	In planning the ESPP, concrete timeline and short-term, medium-term and long-term objectives should be set.
	Comprehensive planning was needed among various service sectors. For example, in some districts, there was a surplus of youth centres but not enough elderly centres.
	The elderly persons should be encouraged to involve in the development, planning and if appropriate, execution, of services and projects.
	Platform for direct communication between the policy makers and the service users should be established.

	SUMMARY OF VIEWS (within scope)
	There was no designated proportion or number of seats for older people to the various statutory and/or advisory bodies to adequately reflect the views of senior citizens.
	The role of District Councils in soliciting views of local elderly persons on community issues should be strengthened.
	District-based one-stop multi-service building for the elderly should be developed in 18 Districts. Scope of the service should include recreational activities, training, housing, as well as burial and columbarium. The District Council could play a role in deciding the location of this building and the facility could be operated by NGOs by open bidding.
	Planning for RCS should be district-based. At the moment, some districts do not have RHCEs with EBPS places.
	Since elderly services would interface with multiple sectors, a platform for multi-disciplinary coordination should be set up. If a district-based approach is used, the District Council could play this role.
	The elderly should be empowered and given choices in deciding on their care plans.
	Regular consultation with stakeholders should be conducted to review the implementation of the ESPP
	Consultation should be conducted at district levels and more time should be allowed to collect views from stakeholders, including family carers, working population, young people etc.
	Consultation should be district-based and should be held in 18 districts.
	More promotional work should be launched for the consultation, including using mass media, and should be assessable for those with different types of impairment, ethnic minority, different sexual orientations, etc.
	Results of the consultation sessions should be opened to the public.
Technology and information	
	Currently there were a multiplicity of various client information systems maintained by different government departments, bureaus and service sectors. There might be possible overlap or gap between these various systems in data collection, retrieval and compilation, that may render delay in service provision, duplication of resources (manpower, time and monetary), and hinder comprehensive planning for service development and monitoring.
	ICT should be strengthened in the provision of service.
	IT knowledge and accessibility should be strengthened for the elderly so that they can still be connected without going out actively.
	The use of computer games could be used to help people with cognitive impairment both in day centres and residential homes.

SUMMARY OF VIEWS (within scope)	
	An ICT platform should be developed to promote and disseminate information on active ageing.
	There should be a higher level of transparency in the number of places and fees in IHCS, as well as on availability of places in various homes and districts.
	Dissemination of information on private RCHEs should be strengthened.
	Service information was not user friendly and difficult for family members to find appropriate services. A central referral platform by the Social Welfare Department to disseminate information on the quality of RCHEs should be developed.
Services for older people with dementia	
	More public education on early detection of cognitive impairment and skills in helping to slow down its deterioration.
	More resources should be provided for early intervention of those with cognitive impairment.
	More day care centre for people with cognitive impairment should be provided.
	Dementia supplements provided for day care centres and RCHEs should be extended to those at early stage of cognitive impairment.
	The dataset used to assess the need of the elderly, MDS-HC under SCNAMES, is not fully utilized in analyzing the service needs of the elderly, in particular, MDS-HC focused on physical impairment and not sensitive enough to cognitive impairment.
	The care model for those with cognitive impairment should be reviewed. The appropriateness of integrating them with other elderly persons should be looked at.
	Some elderly centres had admitted cases with mild cognitive impairment and provided services for them together with other seniors; and resulted in unhappy incidents.
	Integrating those with cognitive impairment with ordinary cases could provide stimulation and reduce their rate of deterioration.
	Some private RCHEs might not have the skills and/ or resources to manage elderly with severe cognitive impairment.
	Support for carers of people with cognitive impairment should be strengthened. More education should be provided for carers on how to manage elderly with severe cognitive impairment.
Others	
	A people-oriented approach should be used in elderly services planning.
	The legal rights of the elderly should be protected, to ensure that they were free from being abused; their wills were being protected and their best interest was taken into account even when they were under guardianship. The issue of age discrimination, and the rights of

SUMMARY OF VIEWS (within scope)	
	elderly women, elderly women from ethnic minority, different sexual orientation should be addressed.
	Overseas practices such as in Europe and in the US, where elderly services were planned, managed, and delivered by elderly persons should be made reference to.
	The government should take the lead in promoting age friendly initiatives, instead of relying on District Councils and/or NGOs.
	Current policies were not able to support those elderly who have returned from the Mainland; e.g. they have to reapply for subsidized services.
	End-of-life care planning in the community should be strengthened.

Appendix III

Views outside the scope of the ESPP

VIEWS OUTSIDE THE SCOPE OF THE ESPP	REMARKS
People with disabilities	
People with Down's Syndrome may manifest signs of ageing at an earlier age, those with disabling illnesses such as stroke might also experience symptoms similar to that of ageing.	Services for people with physical and/or intellectual disabilities, disregard of their age, have to be carried out by practitioners equipped with specific knowledge and skills. These issues on service provision and planning should primarily fall within the ambit of the rehabilitation services
Issues pertinent to ageing among those with physical and/or intellectual disabilities should be included in the ESPP.	
Carer allowance should also be extended to carer of people who are handicapped.	
Needs of elderly people with other forms of impairments, such as hearing, visual impairment, should be addressed as more specialized services were required.	
Pilot Scheme on Community Care Service Voucher for the Elderly (CCSV)	
The coverage of CCSV should be for all districts and not just for those designated for the pilot scheme. Some of the elderly persons were also concerned about the continuity of the scheme after the pilot.	The CCSV pilot scheme is currently under review and the interim review report is expected to be ready by mid-2015. To align with timeline of the CCSV review, issues expressed on CSSV will be considered further in conjunction with findings of the interim report.
The CCSV packages were complicated and the type of services cannot be differentiated easily. It should also be used to purchase short-term services.	
Some service providers had increased the charge after the launching of the CCSV scheme.	
Manpower and training issues	
A higher level of recognition in the Qualification Framework should be considered to attract younger people to enter elderly service.	It is noted that the Education Bureau has assisted the elderly care service sector to set up an Industry Training Advisory Committee

VIEWS OUTSIDE THE SCOPE OF THE ESPP	REMARKS
	(ITAC) in February 2012 to implement Qualifications Framework in the sector. After consulting stakeholders, the ITAC publicated a set of Specifications of Competency Standards for the sector in December 2014. While the sector's response to the ITAC's work should be taken into account in the ESPP, it is recommended that the ESPP should focus on other aspects of the issue of manpower. However, related issues may come up in Seminar / workshop 10: Tackling manpower issues and/or Seminar / Workshop 16: Inter-disciplinary, inter-departmental, cross-sector interfacing
Medical services	
The functions of Elderly Health Centres should be emphasized as they were the first step in health management for many elderly persons. Capacity and roles of Elderly Health Centres should be reviewed;	For views relating to medical services for the elderly, it is recommended that the ESPP should focus on those concerning the interface between health and welfare sectors, so as to allow for in-depth and thorough discussions on core issues. The proposed Seminar / Workshop 16:
Primary healthcare services / community nursing service should be strengthened to reduce the LTC needs of the elderly.	
Training should be provided in primary care setting in early detection of cognitive impairment.	
Special clinics should be set up in public hospitals for dementia care for purposes of referrals,	

VIEWS OUTSIDE THE SCOPE OF THE ESPP	REMARKS
information and provision of carer support.	Inter-disciplinary, inter-departmental, cross-sector interfacing will consider such interfacing issues. For other medical and health related views, they will be passed to relevant bureaux and departments for consideration.
Family members should be allowed to stay in the hospital round the clock with cognitive impairment as they would have difficulties communicating with others.	
Health care support for those with cognitive impairment should be strengthened, especially for those living with family members.	
Eligibility for the Health Care Voucher should be extended to those aged 65 and above, and recognized providers should include medical doctors, Chinese herbalists, dentist, orthopaedic surgeons and bone-setters. Value of the Health Care Voucher should also increase to 3000 a year.	
Dental care needs of the elderly should be addressed and more affordable services be provided.	
Support services such as the dental care scheme (Community Care Fund Elderly Dental Assistance Programme) are very useful and should be regularized.	
Housing	
There were physical barriers to enable 'ageing in place'; for example, bathroom design is often not suitable for frail elderly, in particular, those who are wheelchair bound.	For views relating to housing issues, it is recommended that the ESPP should focus on those directly related to care services for the elderly, so as to allow for in-depth and thorough discussions on core issues. The proposed Seminar / Workshop 16: Inter-disciplinary, inter-departmental, cross-sector interfacing will consider such interfacing issues. For other general views on barrier-free
Institutions for people with intellectual disabilities were not adequate to provide care for those who are frail because of inadequacy in manpower provision and wheelchair accessibility.	
Special housing unit should be provided for families that comprise of double-ageing parent and disabled child(ren).	
In planning for housing development, nearby units for younger families and elderly persons could be considered to maintain the family support network.	
For those with better financial means, co-operative type of retirement residential project might be an option. The government could play a role in encouraging this type of private enterprise by providing the site.	

VIEWS OUTSIDE THE SCOPE OF THE ESPP	REMARKS
	environment and transportation, they will be passed to relevant bureaux and departments for consideration via the Labour and Welfare Bureau.
Retirement	
There should be universal retirement protection for all.	The Commission on Poverty (CoP) will conduct a public consultation on retirement protection in the latter half of 2015. It is recommended that the ESPP should take note of the progress of the public consultation and the discussion of CoP, in particular issues that may have implications on elderly services. The views will be passed to relevant bureaux and departments for consideration.
The retirement protection plan should also include Old Age Allowance and Old Age Living Allowance without means test.	
The issue of structural elderly poverty should be addressed as the issue affected the retirees most. The issue was not an imbalance between CCS and RCS but an issue of whether they had the means to age in the community.	
More flexibility should be considered in defining the age for retirement.	There is no mandatory retirement age in Hong Kong and it is up to the employer and employee to negotiate a suitable retirement age. Therefore, age of retirement as such would not be an issue under ESPP. However, related issue of active ageing will be covered in Seminar /Workshop 2: Active
In view of the increasing dependency rate, financial independence of the elderly persons should be encouraged. Retirement age of the elderly could be extended and support provided for them to start small business after retirement.	

VIEWS OUTSIDE THE SCOPE OF THE ESPP	REMARKS
	ageing and continuous contribution of the elderly. The views will also be passed to relevant bureaux and departments for consideration via the Labour and Welfare Bureau.
Financial support	
Elderly persons applying for CSSA should be financially assessed as individuals.	It is recommended that priority should be given to discussing with stakeholders on the core issues relating to care services for the elderly. The views will be passed to relevant bureaux and departments for consideration via the Labour and Welfare Bureau. However, related issues may come up in Seminar /Workshop 2: Active ageing and continuous contribution of the elderly.
Attention should be paid to the poverty issue of the elderly. For those with limited means but not eligible for monetary allowance, joining community activities could be a barrier.	
For non-CSSA elderly with terminal illness, financial support should be provided for them to purchase target therapy drugs.	
Others	
The concept of 'elder village' should be considered.	It is recommended that priority should be given to discussing with stakeholders on the core issues relating to care services for the elderly. The view will be passed to relevant bureaux and departments for consideration via the Labour and Welfare Bureau.
To meet with the increasing need for resource input in elderly services, the tax system should be reviewed to expand the tax base and a 'elderly service foundation' should be set up specifically for these expenditures.	
Tangible support such as tax exemption for carers should be considered.	
The right to vote for elderly persons who are frail and had difficulties to go to voting stations should be protected.	

Appendix IV

Workshop / Seminar topics and key questions

Seminar / workshop topics
Theme A: Definition of 'elderly' and target service users of elderly services
Workshop 1 ***Definition of 'elderly' and target service users of elderly services*** Key questions a) Should chronological age be a pre-requisite to level of impairment in setting the eligibility for different elderly services? b) Whether there should be a unified definition of 'older people' with respect to chronological age as the age eligibility for various types of welfare services? If yes, what should it be? If no, what should be different age eligibility for various types of services?
Theme B: Existing Services
Seminar / Workshop 2 ***Active ageing and continuous contribution of the elderly*** Key questions a) How can active ageing be improved to achieve the objective of improving the quality of life of the elderly? b) Whether the existing services can adequately cater for the need for lifelong learning and volunteering and employment (full or part time) for older people? What improvements can be made?
Seminar / Workshop 3-5: ***Effective and efficient service delivery and a suitable model of interfacing between various elderly services*** **Workshop 3** ***Community Support Services, CCS, RCS and SCNAMES*** Key questions a) How DECCs/NECs/SEs should be positioned in the interface between services provided to community-living and institutional living older people? b) Whether there should be a review of the functions and staffing structure of the IHCS (ordinary and frail cases) and EHCCS? Should the two services be integrated? If yes, how? c) In the provision of long term care (LTC, including CCS and RCS) how the SCNAMES can be improved in better serving the function of allocating various services according to levels of needs?

Workshop 4

Case Management

Key question

a) What should be the appropriate model of 'case management'? Should the role of case manager should be taken up by NGOs or the Government?

Workshop 5

Respite and emergency placement

Key question

a) How the existing respite and emergency placement services can be improved? Should respite services be provided only as a support measure for carers, or should it aim to target elderly persons with temporary care needs in general?

Seminar / Workshop 6

Supporting carers to enable 'ageing in place'

Key question

a) In what way can the carer support services be improved to enable 'ageing in place'? Should carer support be extended to home-based paid carers (e.g. domestic helpers)?

Seminar / Workshop 7

Create synergies in public-private partnership

Key question

a) Is there room for private-public collaboration in the provision of CCS and RCS? If yes, how?

Seminar / workshop 8

Quality assurance and improvement

Key question

a) Whether the existing mechanisms of quality control are able to ensure quality of service provided by various providers, including NGO (in providing subsidized and self-financed services) and private operators?

b) Whether the current standards are sufficient and updated to meet the current and future (changing) needs of older people?

c) How accreditation mechanisms can be further promoted?

Seminar / workshop 9

End-of-life care

Key question

a) Is the existing service adequate to prepare the elderly, carer and elderly service workers in dealing with end-of-life issues? What improvements can be made?

Theme C: Manpower and training issues
Seminar /workshop 10 ***Tackling manpower issues*** Key question a) What mechanisms should be put in place to ensure the provision of trained staff at various levels in joining the care industry – in both subsidized and private sectors? b) What strategies can be used to enhance the capacity and flexibility of service providers in both subsidized and private sectors in recruitment, training, and retention, in the context of compliance with funding and service agreement and/or licensing requirements? c) Whether labour importation should be considered as an interim measure (with limited duration of a number of years) to ease manpower shortage? d) How can various types of informal, non-paid carers (including neighbours, volunteers, students, young-olds) be mobilized, trained, and supervised to provide neighbourhood level community support and home care to older people in the vicinity?
Seminar / workshop 11 ***Tackling training issues*** Key question a) How can the curriculum of various caring professionals be further enhanced to be more age-sensitive, so as to ensure fresh graduate practitioners can be equipped with relevant professional knowledge, attitude and skills?
Theme D: Premises and Space
Seminar / workshop 12 ***Planning for provision of premises and space*** Key question a) How to project future demand for different elderly services (demand) and, taking into account the existing and planned provision of the premises for such services, how to plan for the filling in the gap (to meet demand with supply)? b) How to ensure having sufficient space/premises for setting up service units? Is there a need to review the current 'schedule of accommodation' (SoA)? Whether there is the need to review the existing Planning Standard and Guideline (PSG) in reinstating the requirement of provision of premises for elderly service? c) How can the planning process for elderly facilities be improved to ensure continued and stable provision of premises for various types of elderly services catering for different subgroups of older people (with different socio-economic status, needs, affordability, etc.)?

Workshop 13

Public-private partnership to tackle shortage in premises and space

Key question

a) How best to utilize the existing wide network of private RCHE in the provision of CCS and RCS?

Theme E: Sustainable financing of elderly services

Workshop 14

Financial sustainability and use of public funds in service provision

Key question

a) In view of the ageing population, is there a need to consider further the financing model for elderly services? For instance, in the provision of government subsidized) services, should there should be different levels of subsidy (thus fee charging, co-payment) with reference to users' affordability (i.e. means test)?
b) Should there means-test in subsidized services so that resources could be channelled to those most in need? Whether level of government subsidy should be matched with users' affordability? Whether older people with financial means should be entitled to subsidized services? What would be the implications on co-payment mechanism, fee charging mechanism?
c) Whether the fees for subsidized service should be increased, to reflect the 'user-pay' principle? or as 'cost-recovery'?

Workshop 15

Public and private marketing mix

Key question

a) How the private sector can be involved, its relative proportion in the overall provision? What is the target? Which specific 'market segment'? or 'market share'?
b) Is there a need to review the existing practice of provision of purpose-built welfare premises for service providers in providing contracted services (e.g. contract RCHEs)?
c) How would the Government control / monitor / improve quality of services provided by profit-making operators?
d) How would the Government monitor non-profit making NGOs in providing self-financed services?

Theme F: Interface and other issues
Seminar / Workshop 16 ***Inter-disciplinary, inter-departmental, cross-sector interfacing*** Key question a) How could inter-disciplinary, cross-disciplinary, inter-departmental, inter-sectorial collaboration and coordination be promoted? In particular, which is the best approach to interface between welfare and health sector services (under different policy bureaus and between government departments and statutory bodies like Housing Authority, Hospital Authority, etc.)? Specifically, i. How can seamless CCS/RCS services be better provided to elderly patients discharged from hospitals? ii. What improvements can be made to the interface between various community support services and primary healthcare services for the elderly (such as EHC, Visiting Health Teams, general out-patient clinic and community outreach services of the Hospital Authority, private practitioners, etc.)? b) How can manpower, space, facilities, equipment, information be better shared between different service providers in various sectors/departments/ units? c) How client information can be best interfaced to facilitate streamlining of administrative procedures like referral, user information retrieval, etc.?
Workshop 17 ***Planning mechanism and stakeholder involvement*** Key question a) How could older people be engaged in the planning and review of elderly services? at district and territory-wide levels? At which specific platform or committees? b) Whether the existing planning mechanism[, with the involvement of a multitude of stakeholders, including the statutory bodies, advisory committees, bureaus, departments, NGOs, trade associations, training institutes, professional bodies, labour unions, users, etc.], at central and district levels, need to be reviewed / improved?

Workshop 18

Planning and review timeframe

Key question

a) Whether the existing planning mechanism can provide a longer term planning, in addition to meeting short-term (e.g. annual) service demands? Or whether there should be any specific time frame (e.g. 5-year) for planning or 'plan'?
b) How would this ESPP be reviewed to keep up with the changes and developments of the society?

Workshop 19

Technology and information

Key questions

a) Whether there is in place any mechanism that can tap on evolving technological advancement in improving service delivery modes, monitoring, and system maintenance?
b) How strategies can be developed to improve I.T. literacy and accessibility amongst older people?
c) How technologies can be better developed, incorporated and utilized in the four aspects of elderly services, ranging from active ageing, community support, CCS and RCS?

Seminar / workshop 20

Services for older people with dementia

Key questions

a) Whether existing elderly services can cater for the needs of older people with dementia? What could be done to further strengthen the support to demented elderly? E.g. can elderly centres serve as early identification and education nodes for older people with dementia and their family caregivers on top of the existing channels under the healthcare stream?
b) Whether dementia services for should be integrated with other elderly services or be separated as a specialized service?
c) How can the welfare and health sectors achieve better collaboration in the early identification, diagnosis and treatment of older people with dementia? How can the delivery of welfare and healthcare services for the elderly be better coordinated at the district level (e.g. District Coordinating Committee for Elderly Services)?
d) How professional training programs can be further enhanced in their curriculum and training for practitioners serving older people with dementia?

Workshop 21

Support for minority groups in provision of services

Key question

a) What are the special needs of the older persons from the underprivileged and minority groups? If their special needs cannot be met by existing elderly services, what further support could be provided for them?

Workshop 22

Role of private charitable funding bodies in supporting new and innovative initiatives

Key question

a) What role can private chairtable funding bodies play in supporting projects for the elderly and how can the experience of such projects help better the mainstream services?