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FINAL REPORT (Volume 2 of 3, Part 1)

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For Hebei Provincial Government

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Asian Development Bank

Asian Development Bank

TA No. 8996-PRC

**Preparation
of
The Hebei Elderly Care Development Project**

Final Report

Volume 2 of 3

**Due Diligence and Technical Reports
Prepared by Individual Consultants**

September 2017

INTRODUCTION

This volume of the report contains the detailed assessment and due diligence reports prepared by the individual PPTA consultants who were appointed directly by ADB and undertook project preparatory work as briefly described in Chapter 3, Section 2 of Volume 1 of this report.

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Document 2-A	Detailed Sector Analysis (Elderly Care)
Document 2-B	Technical Report on the Development of Home- and community-based Care
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Document 2 –D	Procurement Risk Assessment
Document 2- E	Project Administration Manual (full version with appendices)

Hebei Elderly Care Development Project

Final Report

Volume Two

Document 2-A

Detailed Sector Analysis (Elderly Care)

HEBEI, PRC

PPTA

HEBEI EC DEVELOPMENT PROJECT:
EC (EC) SECTOR ANALYSIS

September, 2016

ABBREVIATIONS

ADB	—	Asian Development Bank
ADL	—	activities of daily living
DMF	—	design and monitoring framework
CAB	—	Civil Affairs Bureau
CNY	—	Chinese yuan
EC	—	elderly care
FSR	—	feasibility study report
HC	—	home care
HCBC	—	home- and community-based care
HPG	—	Hebei Provincial Government
HPMO	—	Hebei project management office
HRD	—	human resources development
IA	—	implementing agent
IADL	—	instrumental activities of daily living
ICT	—	information and communication technology
IT	—	information technology
KM	—	kilometer
LTC	—	long-term care
NGO	—	nongovernment organization
NRC	—	neighborhood resident committee
OR	—	occupancy rate
PPTA	—	project preparatory technical assistance
RC	—	residential care (institutional care)
SA	—	sector assessment
SSA	—	summary sector assessment
TA	—	technical assistance
TR	—	technical report
USD (\$)	—	US Dollars
12FYP	—	12th Five-Year Plan (2011–2015)
13FYP	—	13th Five-Year Plan (2016–2020)

NOTE

In this report, 1USD = 6.1CNY (Yuan)

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1. INTRODUCTION

1.1 Background

1. The most significant demographic challenge facing the People's Republic of China (PRC) today is population aging. The proportion of people aged 60+ across the PRC is expected to grow from roughly 12% in 2010 to 34% by 2050. Combined with fast urbanization, internal migration with youth moving away from rural areas, and the one child policy, traditional family support system is stressed out and increasingly unable to meet the EC (EC) needs. These demographic, social and economic challenges will require increased involvement from Government, the private sector and voluntary sector efforts and other social organizations in order to build a socially inclusive EC system that is able to meet the care needs of China's huge aging population.
2. China's growing elderly population and the need to provide EC to them is such a complex social issue. So much so that President Xi Jinping in a recent learning session of the Political Bureau of the CPC Central Committee, used three superlatives to describe China's elderly population: (1) largest, (2) fastest growing, and (3) toughest to cope with¹. Population ageing in Hebei is no exception. The elderly population is increasing in size and rapidly so. Government EC policies are many but resources are limited. The government hopes to cope with the toughest EC issue by placing increased reliance on private capital/providers.
3. The government of the PRC requested loan from the Asian Development Bank (ADB) to support seven private public partnership (PPP) projects on EC in Hebei. Upon completion of all these projects, the quality and coverage of EC in Hebei is expected to significantly enhance. The project sites are as follows:
 - a) Li County –Baoding Municipality
 - b) Julu County – Xingtai City
 - c) She County –Handan Municipality
 - d) Shuanglan District –Chengde Municipality
 - e) Xinji County – Shijiazhuang
 - f) Yanshan University - Qinhuangdao
4. This sector analysis is part of the project preparation technical support (PPTA), which will include a review of reports, studies, and policy papers prepared by the People's Republic of China (PRC) - both provincial and municipal governments, and international organizations – ADB, United Nations, World Bank, WHO, etc. It will also include national and international and national good EC practice. It assessed government policies, plans,

¹ http://news.xinhuanet.com/politics/2016-05/28/c_1118948763.htm

key sector strengths and challenges and, where possible, issues relating to sector performance, including anything specific to Hebei and/or smaller cities². Based on these reviews and assessment, and in accordance with ADB guidelines and templates, the consultants prepared the necessary report and recommendations for the consideration of the President (RRP).

1.2 Objectives

5. Specifically, this sector analysis report is to:

- a. Analyze the EC situation in Hebei Province to get a comprehensive understanding of EC issues (demographic, socioeconomic, financing, policy and regulatory aspects, human resources situation, gender issues, available services in the public and private for profit and not-for-profit sectors, new development trends, etc.).
- b. Meet all key stakeholders (public, private sector firms, not-for-profit organizations) to discuss and collect information, understand their expectations, and get their views on current situation, proposed policies, appetite for investment and constraints to address the current and future local situation, and develop an EC industry banking on the proximity of major cities (Beijing and Tianjin).
- c. Review current government policies on EC—identify strengths and weakness (social protection, incentives to private sector, accreditation and regulation and make recommendations.
- d. Analyze the affordability of current and future EC services in Hebei Province for different socioeconomic groups (3 "Nos", 5 guarantees, *dibao* recipients, marginal poor, middle-class, and better-offs).
- e. Analyze appropriateness of EC services modalities given needs, affordability, cost-effectiveness, and implementation considerations, including ICT support.
- f. Study the constraints and potential for human resources production for EC services and management in the provinces.
- g. Analyze quality of EC provided to the elderly and current quality and safety monitoring and assurance systems.
- h. Study the arrangements (services, financial, proximity, and quality) for health care provided to the elderly.
- i. Collect qualitative data through focus group discussions with officials, private sector, community leaders, volunteers, and older people.
- j. Prepare a sector analysis based on the quantitative and qualitative information collected, which will serve as a basis for provincial wide planning and include clear recommendations for future development of the EC sector in Hebei Province.

1.3 Methodology

6. This study collected quantitative and qualitative data of elder care by reviewing and assessing (1) relevant literatures, both locally, nationally and internationally, whenever

² As per Peter Jaques' email on July 17, 2014.

available; (2) two survey reports prepared by the consultants of this PPTA; (3) notes of focus group meetings with elderly including current EC service users, in-depth interview of community dwelling elderly, children of elderly, RC users, RC employees and private for profit EC operators; and (4) use materials presented by various stakeholders: government, IAs etc.

7. This PPTA contracted with two local consultants, who are both university professors in China to conduct two separated surveys on the EC needs of the older population in three counties: Xinji, Chengde and Zunhua. These counties were selected as they are the potential EC sites of this PPTA. The Xinji's survey involved 952 community dwelling elderly aged 65+ in early 2016. 18% of the elderly had and 82% had no LTC impairment.³ The Chengde (187) and Zunhua (167) study involved 354 community dwelling elderly aged 60+ in June 2016. 85% of the people surveyed were considered independent, 9.3% lightly, 4.2% moderately and 1.7% severely dependent.⁴
8. Focus group meetings were also conducted in Xinji⁵ and Shijiazhuang⁶. In Xinji, two focus groups were conducted in January 2016, each had six elderly as participants. One group was held in Yijie, one of the 10 oldest communities in the downtown area, and another was in Xinleitou, a rural community around 2km away from the urban area. The participants were selected partly based on prior survey interview. The selection took into account the age, gender, and disabilities of the elderly. The purpose of focus group meeting was to discuss and understand participants' current conditions, their expectations of the government, community and family, and their attitude towards EC in general and RC/HCBC including call center in specific. In Shijiazhuang, two focus group meetings with six elderly each were conducted in August 2016. Four of the participants were current RC users. The objectives of the meeting were all about their attitude towards EC including RC and HCBC.
9. 15 community dwelling elderly, 5 RC users, 3 RC workers and 10 children in Chengde; 5 community dwelling elderly and 9 children in Zunhua⁷, 3 operators in Shijiazhuang were selected for in-depth interview In July and August, 2016. Focus of the elderly interview again was about their views and expectations on EC in general and RC and HCBC in specific. Focus of the EC operator interviews was to get their views on current situation, proposed policies, appetite for investment and constraints to address the current and future local situation, and develop an EC industry banking on the proximity of major cities.

³ Xu Yuebin, Chen Lin and Wang Xiaobo. (2016). *Assessing Care needs of Urban Community Dwelling Elderly People in Xinji*. Asian Development Bank: SC 106398 PRC: Preliminary Survey Work to Support Development of the Hebei EC Development Project.

⁴ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126).

⁵ Xu Yuebin and team - focus group report

⁶ Wang Hsiaopo – focus group and interview reports

⁷ Yu Qingnian and team - interview note 1 & 2

10. Zunhua dropped out later. However, the findings of Zunhua did not. To an extent as much as possible, the findings of Zunhua were reported along with Chengde in this report. It is believed that the findings of Zunhua from survey, focus group meetings and interviews would help to gain a better understanding of EC in Hebei in general.

2. EC SITUATION IN HEBEI

2.1 Demographics

11. Hebei has a population of 75M people with 13M (17%) aged 60+ and 1.3M (2%) aged 80+. By 2050, people aged 60+ and 80+ will be about 31% and 7% of the Hebei total population. More notably, it is the increase in number of people aged 80+. It was 10.7% of the elderly population in 2015, and will be increased to 11.1% in 2020 and 22.1% in 2050. As shown in Diagram 1⁸, the proportion of people aged 80+ is the only group of the elderly increasing incrementally, whereas other elderly groups: people aged 60-69 and aged 70-79 will be either dropping or stable.

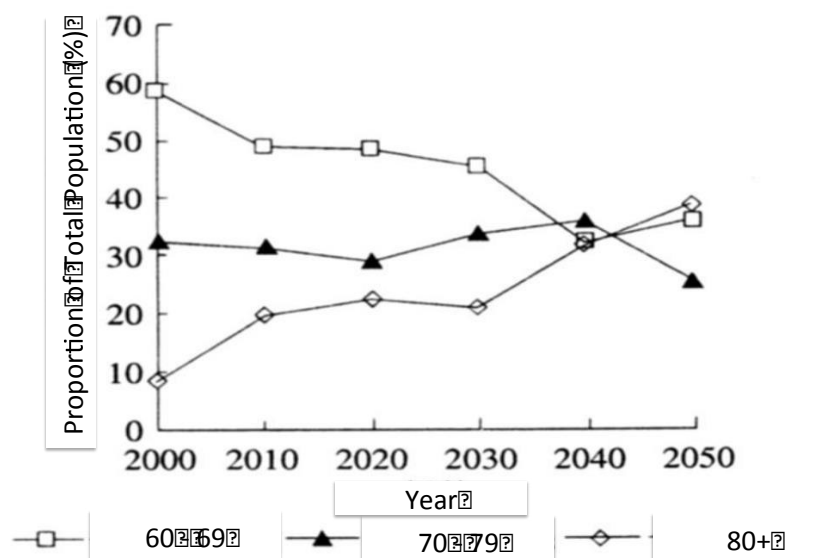
TABLE 1: Population by Aged Group 2015, 2030 and 2050 in Hebei⁹

	2015	2020	2050
Total populaton	74,667,614	77,074,078	82,225,814
Population aged 60+	12,792,856	15,618,160	257,86,796
Population aged 80+	1,372,870	1,738,326	5,710,837

⁸ Yan Lu Na, et al. (2010). Analysis of current ageing and prediction of ageing development trend in Hebei. *Hebei Journal of Industrial Science and Technology*. China Academic Journal Electronic Publishing House. Vol 27, No. 4. P. 279. Available at: <http://www.cnki.net>

⁹ Based on the Census 2010, these predictions are calculated by using the population, mortalities and birth rates of each 5 years-age-group, considering different genders and different municipalities. Per Wang Hsiaopo's email on Aug, 27, 2016.

DIAGRAM 1: Proportion of Elderly Age Group in Hebei, 2000 – 2050



In Hebei, 52% of Hebei people lived in rural and 48% in urban areas in 2013. There were more male (51%) than female (49%) population.¹⁰

TABLE 2: Gender and Geographical Distribution by Districts in Hebei, 2013

District	Total Pop (10,000)	Gender (%)		Urban/Rural Distribution (%)	
		M	F	Urban	Rural
Hebei	7,332.61	50.78	49.22	48.12	51.88
Boarding (Lixian)	1,141.63	50.67	49.33	44.20	55.80
Chengde (Shuangluan)	351.51	51.45	48.55	42.00	58.00
Julu	41.29	50.60	49.40	N/a	N/a
Handan (Shexian)	932.51	50.86	49.14	42.80	57.20
Xinji	62.69	50.57	49.43	52.02	47.98

12. Among the 5 municipalities where the EC projects of this PPTA are located, the proportion of people age 60+ will increase from 17% in 2015 to 21% in 2020 in Chengde (Shuangluan); 16% to 20% in Shijiazhuang (Xinji); 17% to 19% in Baoding (Lixian), 14% to 17% in Handan (Shexian) and 15% to 20% in Julu¹¹.
13. Population ageing comes with a number of opportunities and challenges. Key opportunities include (1) increased enjoyment of old age, and (2) new and strengthened silver market. Key challenges are: (1) Increased healthcare, social care needs and costs, and (2) reduced government' capacity to respond to other competing social needs. The findings of the two surveys conducted by this PPTA showed that 15% of the elderly

¹⁰ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126).

¹¹ Wang Xiaobo (2015). Hebei EC System Development. A report prepared for ADB (SC 104708). Section 3.1 & Julu FSR, August, 2016,p.38

surveyed in Xinji were moderately and 3.5% severely impaired. In terms of LTC service need, 2.9% are in need of RC and 27% HCBC. In Chengde, 9.3% of the people surveyed were lightly, 4.2% moderately and 1.7% severely dependent. The 5 most reported chronic conditions in Xinji were: high blood pressure (62%), heart diseases (47%), rheumatoid arthritis (39%) back and neck pain (34%), stroke or cerebral vascular diseases (30%).¹² The 5 most reported chronic conditions in Chengde were: high blood pressure (42%), heart diseases (29%), stroke or cerebral vascular diseases (25%), diabetes (11%) and back and neck pain (10%).¹³

14. The findings of Xinji and Chengde (including Zunhua) may not be sufficient to generalize to Hebei as a whole. They did provide a snapshot of functional impairment in old age and EC need in Hebei. First of all, the majority of elderly are fairly independent in spite of the fact that many elderly complained about difficulties in performing housework.¹⁴ Secondly, the proportion of elderly people who are moderately to severely impaired were about 18.5% in Xinji and 5.9% in Chengde. These are likely the people who require LTC services. Thus to cope with the rising health and social care needs of the elderly will be a challenge but is not entirely impossible.

2.2 Socioeconomic

15. In Xinji, 87% of elderly with LTC impairments lived with spouse and/or children, only 10% lived alone. The majority of respondents (74.4%) had at least one child living in the same community, and 20% in the same city. Less than 3% had no children or children living in another city in the same province.¹⁵ In Chengde and Zunhua, 47% of community dwelling elderly lived with children including living with different children by turn (9%), 45% did not live with children but their children lived within the same city or community, 7% did not live with children and/or their children lived in other city or province.¹⁶
16. In Xinji, 97% of the respondents with LTC impairments had informal caregivers, and 7% also had formal helpers. About two thirds had 1 informal caregiver, and 28% had 2 informal caregivers¹⁷. In Chengde and Zunhua, 36 children of the elderly surveyed were interviewed by phone. 62% of those children interviewed, visited their parents 7 times a

¹² Xu Yuebin, Chen Lin and Wang Xiaobo. (2016). *Assessing Care needs of Urban Community Dwelling Elderly People in Xinji*. Asian Development Bank: SC 106398 PRC: Preliminary Survey Work to Support Development of the Hebei EC Development Project.

¹³ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126).

¹⁴ Xu Yuebin. (2016). Summary of focus group discussion. As per email March 11, 2016.

¹⁵ Xu Yuebin, Chen Lin and Wang Xiaobo. (2016). *Assessing Care needs of Urban Community Dwelling Elderly People in Xinji*. Asian Development Bank: SC 106398 PRC: Preliminary Survey Work to Support Development of the Hebei EC Development Project. Table 4.4.1 & p.22

¹⁶ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126). Table A01.1,10

¹⁷ Xu Yuebin, Chen Lin and Wang Xiaobo. (2016). *Assessing Care needs of Urban Community Dwelling Elderly People in Xinji*. Asian Development Bank: SC 106398 PRC: Preliminary Survey Work to Support Development of the Hebei EC Development Project. Table 4.5.1

week, 30% 2 – 3 times per week and 8% less than 1 time per week. 62% of them experienced some difficulties and 38% had no difficulties in the care of their parents¹⁸.

17. Findings from the focus group tell a slightly different story¹⁹. Many participants of the focus group expressed a strong sense of loneliness and helplessness especially when they were sick and had to rely on their children to help. However, their children had not been always available and they were reluctant to seek help from their children as their children were working also and had a family to support. Even if their children were available, the Chinese elderly tended not to over rely on them as “no child would continue to have ‘filial piety’ when their parents become chronically ill or disabled” – a common Chinese saying frequently quoted and agreed up by the participants in other focus group meetings.²⁰ For the rural elderly, their sense of loneliness and helplessness was even more intense if their children were migrant workers in other place. Many old people felt that they helped their children to do housework, work on farmlands, and take care of their frail or older spouse but they didn’t have other people to turn to when they needed help.
18. In terms of home ownership, 40% and 68% of the elderly surveyed owned their own house in Xinji, and Chengde (including Zunhua) respectively. 53% and 29% of the elderly in Xinji, and Changde (including Zunhua) lived in houses owned by their children²¹.

TABLE 3: Home Ownership

Home Ownership	Xinji (N=390)		Chengde & Zunhua (N=354)	
	Freq.	%	Freq	%
Own housing	155	40.0	241	68.1
Child’s housing	207	53.4	101	28.5
Rented housing	13	3.4	10	2.8
Other	13	3.4	2	0.6

19. Home ownership helps to improve financial status of the elderly. Finding of another focus group meetings suggested that 5 out of 12 focus group participants depended on rental income. 6 lived with family, 3 lived alone and 3 lived in a RC facility. The rental income helped those living alone and in RC.²²
20. In 2013, the annual disposable income per capita in Hebei was 22,200 and 9,200 Yuan for urban and rural residents. Annual disposable income for project districts can be found in the table below. Basically, residents in urban districts have far more disposable

¹⁸ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126). Table F1.1, F1.3 and F2.

¹⁹ Xu Yuebin. (2016). Summary of focus group discussion. As per email March 11, 2016.

²⁰ Wang Hsiaopo. Notes of focus group meeting as per email on Aug 25, 2016.

²¹ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126). Table A1

²² Wang Hsiaopo’s focus group meeting notes as per email Aug 25, 2016.

income than their counterpart in rural areas. Overall, Xinji, Zunhua, and Handan have more income than other project districts, both in urban and rural areas.²³

TABLE 4: Annual Disposable Income Per Capita (2015)

District	Total Pop (10,000)	Annual Disposal Income (Yuan)	
		Urban	Rural
Hebei	7,332.61	22,226	9,188
Julu*	41.29	16,454	5,220
Lixian (Boarding)	1,141.63	19,757	8,649
Shexian (Handan)	932.51	20,662	9,307
Shuangluan (Chengde)	351.51	18,896	6,031
Xinji	62.69	22,651	11,115

*Based on 2010 data

21. In Xinji, 56% of respondents lived on financial support of their children, and about 25% on pension. Average pension was about 600 Yuan per month. The average income and expenditure of elderly per month with LTC needs was about 760 and 590 Yuan respectively. 1/3 of respondents reported that their income had been very difficult to difficult to meet their daily needs²⁴. It is a different story in Chengde and Zunhua, 74% lived on pension including spousal pension, only 14% on financial support from children. The average pension was about 1,837 Yuan and the financial support from children was 253 Yuan per month²⁵. This is further substantiated by the telephone follow-up, 62% of the 36 children interviewed provided no financial support. 23% provided 1-500 Yuan, 10% 501- 1,000 Yuan per month.

TABLE 5: Sources of Income

	Xinji (N=388)		Chengde & Zunhua (N=354)	
	Freq.	%	Freq.	%
Support from child	218	56.2	49	13.8
Pension	94	24.2	260*	73.5
Spouse's income	30	7.7	8	2.3
Employment	20	5.2	16	4.5
Personal savings	10	2.6	13	3.7
Government benefits	10	2.6	6	1.7
Support from other relatives	3	0.8	0	0
Renting of housing or other	3	0.8	2	0.6

*Including spousal pension

²³ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126). Slide 5

²⁴ Xu Yuebin, Chen Lin and Wang Xiaobo. (2016). *Assessing Care needs of Urban Community Dwelling Elderly People in Xinji*. Asian Development Bank: SC 106398 PRC: Preliminary Survey Work to Support Development of the Hebei EC Development Project. Table 4.3.3.

²⁵ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126). Table A3

22. In Xinji, 58.7% of elderly with mild to severe LTC impairment rated their economic situation as “fair”, over 15% “good” or “very good”, and 24.6% “poor”²⁶. It was 43% “fair”, 45% “good” or “very good”, and 11% “poor” in Chengde and Zunhua.²⁷
23. In terms of social support, a great majority of the elderly in the three districts of Hebei live with their children and/or live in the same community/city as their children, and maintain close contact with them. Only 3 - 7% of the elderly live alone. In spite of this, many elderly in the focus group meetings reported a strong sense of loneliness and helplessness especially when they were sick.
24. In terms of economic wellbeing, most of the income of the elderly comes from either pension and/or children. The per capita income e.g., annual disposable income remains modest, it was <1,000 Yuan in Xinji and <2,000 Yuan in Chengde and Zunhua. Despite half of the elderly surveyed own their own homes, which may be the largest asset they have, many of the elderly perceived their economic well-being as fair and about 20% as poor. Many elderly interviewed are generally conscious about their money. Limited income plus cautious money spending attitude may affect people’s willingness to purchase LTC service. For instance, many elderly people in the focus group meeting reported failure to perform housework but only a few old people were willing to purchase private home service such as paid maid or handyman. There reasons for this are many. One of the key factors is because old people usually don’t like to spend money and want to reserve some money for the children regardless if their children are in financial need or not. Chinese culture tends to see money first spent on children and second on education. Spending on the elderly comes after these priorities.²⁸

2.3 Financing

25. The value of China EC market is huge. It ranges from 0.15 to 4 trillion. According to the China Aged Care Industry Report, 2014-2017, the Chinese aged market is estimated worth about 4 trillion Yuan and is expected to surge to 13 trillion Yuan by 2030.²⁹ Yet another Japanese company Nichiigakkan, estimated that China’s market for nursing care services is worth at least 0.15 Trillion Yuan (2.4 trillion yen or US\$22.9 billion) in 2016.³⁰ This is mainly propelled by the huge potential of the EC industry and multiple preferential EC policies. Many local real estate developers, insurance companies, and diversified companies have expanded into endowment real estate, medical care, pension finance and EC investors and providers.

²⁶ Xu Yuebin, Chen Lin and Wang Xiaobo. (2016). *Assessing Care needs of Urban Community Dwelling Elderly People in Xinji*. Asian Development Bank: SC 106398 PRC: Preliminary Survey Work to Support Development of the Hebei EC Development Project. Table 4.3.7

²⁷ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126). Table 5A

²⁸ China’s Senior Care Market. p.12 www.HealthIntelAsia.com

²⁹ <http://www.reportlinker.com/p01162198-summary/China-Aged-Care-Industry-Report.html>

³⁰ <http://asia.nikkei.com/magazine/20160825-ASIA-S-SILVER-LINING/On-the-Cover/Failure-to-prepare-for-an-aging-population-could-cost-China>

26. Despite private sector's involvement, the central government is still a major EC payer. In 2012, nationally a total amount of 3.1 billion Yuan was used for piloting RC facilities. In addition, the Ministry of Civil Affairs allocated 50 million Yuan from the welfare lottery funds for building rural EC facilities. Between 2010 and 2012, investments from local government increased from 15.6 billion to 27.7 billion Yuan, while private funding in 2012 reached 14.5 billion Yuan³¹.

TABLE 6: Sources of EC Funding in 2012

Sources of funding	Amount (billion Yuan)	%
Local government	27.7	29.0
Welfare lottery	54.0	56.0
Private	14.5	15.0
Total	96.2	100.0

27. Before 2013, welfare lottery funds was the major source for both central and local governments to fund EC service, which was also the major source of revenues for social assistance programs such as Medical Financial Assistance. In 2013, State Council's "Opinions on Speeding Up the Development of the EC Service Industry" allowed the provision of subsidies out of general revenues or free loans for building or operating RC facilities, in addition to welfare lottery funds. Since 2013, there have been liberation of public resources that can be deployed to support EC: (1) General revenues were allowed to fund EC services; (2) insurance funds can be invested in the industry; and (3) piloting reverse housing mortgage for old people to buy care services. The permission to use general revenues and insurance funds to fund EC services has opened up new sources of funding for local government. In October 16, 2013, the Ministry of Finance stated that it had allocated 2.22 billion Yuan for use in health, EC, and other public services, and pledged to increase government funding in the subsequent years. In an earlier policy document issued by State Council, the central government pledged to increase funding of the health and service industry to over 8,000 billion Yuan by 2020, covering services such as hospitals, rehabilitation and nursing for the elderly³².
28. Despite central government financial commitment in EC, local governments continue to be a major EC provider and payer. Facing the financial challenge, local governments have sought to diversify its EC funding sources - government allocations, public donations, and fee-paying service to finance publicly run services, while also give subsidies for privately-run facilities and allow them to provide services by charging market rates.
29. The exact amount of public EC spending in Hebei is unclear. Based on a report Hebei Civil Affairs, the government's share of the EC market including subsidy to EC providers and users in 2015 was about 3%. Government subsidies are targeted at the elderly and

³¹ Xu Yuebin (2014). The EC System in China. ADB contract # SC102836

³² Xu Yuebin (2014). The EC System in China. ADB contract # SC102836

EC providers. Subsidy may vary from county to county, village to village due to varied economic development.³³:

TABLE 7: Types of government EC Benefits in Hebei

Target	Subsidy	Per month
Individual (Cash)	Advanced age (80 – 84)*	150 Yuan per person
	Advanced age (85 - 90)*	200 Yuan per person
	Advanced age (90+)*	400 Yuan per person
	Advanced age (100+)*	300 Yuan per person
	Wubao (5 Guarantees)	300 Yuan per person*
		354 Yuan per person (in RC)**
		317 Yuan person (in community)**
	Dibao	100 Yuan per person*
		382 Yuan per person (urban)**
		191 Yuan per person (rural)**
Operator (Cash) ³⁴	Severely disabled	500 Yuan person
	Construction subsidy	4,000 Yuan per bed
	Operation award subsidy	100 Yuan per bed
Preferential policy ³⁵	<ul style="list-style-type: none"> • Tax relief – sale, capital gain, corporate income, property • Land use at no/low cost • Fee remission on public utility Liability insurance 	

* Zunhua FSR, p.16 (Aug, 16, 2016).

** Shuangluan FSR p.39

30. *Wubao* provides income support and services to old people without family caregivers and sources of income. Those eligible for *Wubao* benefits include orphans aged below sixteen and old people who are unable to provide for themselves through labor and cannot avail themselves of the support of legitimate caregivers. Benefits are grouped into five categories, including food and fuel; clothing, bedding articles, and pocket money; housing with the basic necessities; medical care and a person to be arranged to provide nursing care for those elderly unable to perform daily activities; and an adequate burial funeral. Under this program, *Wubao* households can be cared for either separately in the villages or collectively in the “homes for the aged,” depending on the physical conditions of the elderly or the availability of beds in the homes. *Dibao* is a means-tested program for the rural population. The incomes of adult children are always counted in determining the eligibility of their aged parents, regardless of household registration status or living arrangements. It provides cash assistance for households with per capita incomes below the locally determined poverty or assistance threshold.

³³ As per email from Wendy Walker to Peter J. on July 26, 2016

³⁴ 根据《河北省民政厅 河北省财政厅关于对养老服务机构实行奖补的意见》（冀民〔2015〕21号）

³⁵ 根据《河北省关于落实国家支持老年服务机构发展税费减免政策的通知》（冀民〔2011〕55号）and《承德市人民政府关于加快推进社会养老服务体系建设的意见》（承市政〔2012〕141号）

31. In addition to cash subsidy, Hebei government also provided various no cash subsidy for the elderly: free public transportation, reduced accident insurance, subsidy for purchasing HCBC services and free admission to parks and museums. In Baoding (Lixian), people aged 70+ get free bus ride 60 times per month. Elderly pay 10 Yuan premium to purchased insurance to cover accidents – 5,000 Yuan benefit for death and disability and 20,000 Yuan for medical care. In Zhangjizkau, HCBC subsidy was as follow: 50 Yuan for 3 Nos. who are aged 60+ and 30 Yuan for people aged 85+. ³⁶
32. Many elderly and EC providers depend on government subsidy. Thus, the financial capacity of local governments affects their spending in EC. Almost all the municipal governments in which the EC projects are located, ran a deficit budget, their expenses were more than their income. The reported deficits for 2013 were: Lixian (41%); Chengde³⁷ (25%); Zhuhua (24%); Shexian (9%) and Xinji (6%). The higher fiscal deficit does not necessarily prevent local government from EC spending, but does make the policymakers take a wait-and-see attitude or more cautious approach towards implementing new EC policies and increased expenditure commitments.
33. Without doubt, the EC market in China is huge but development of the EC system suffers from public and private underfunding, including the financial ability of old people to purchase services and a limited market of service providers. The government including HPG has taken robust action to provide social protection to the elderly. It has significantly expanded the coverage of public pension and health insurance programs, strengthened social safety net programs, expanded programs and services for the elderly, and raised social awareness about the need to assist the elderly. Today, government funding only covers 1.6% of seniors in need of care, who cannot otherwise pay for their own care. The World Bank's standard for developed nations is 8% coverage. ³⁸ When compared with other developed countries, EC share of GDP investment in EC is relatively small. In US and Japan, EC is 1.0% and 1.6% of GDP in 2011. It was 0.1% China GDP in 2010 (Colombo, F., et al. (2011)). Unless government improve (1) the viability of its public pension system so that people will be able to allocate a significant part of their monthly pension towards the fees of EC and/or (2) subsidy to EC providers; financial challenge in EC will continue to be a problem in China.
34. One pressing question the PRC government must answer is how to expand its reimbursement for EC. HCBC is more cost effective than RC. Currently, much of the government funding and policy supports rest with RC. The current method of providing financial support to the providers may not be wise in promoting EC quality and coverage. If the cash subsidy to the providers is shifted to the users, EC users can then use their purchase power to leverage care quality and coverage of EC in China.

³⁶ http://hebei.hebnews.cn/2014-11/19/content_4326874.htm This is based on 2014 data.

³⁷ Shuangluan's information was unavailable, based on Chengde which consists of Shuangluan and Luanping

³⁸ Christian J. (2015). China's Senior Care Market. Rubicon Strategy Group. www.HealthIntelAsia.com p.5

2.4 Policy and regulation

35. EC in China can largely be divided into two types: informal and formal care, which are governed by different policies and regulations. These policies and regulations apply to all over China including Hebei.

Informal care - family responsibility

36. China is one of the few countries has a legal framework on informal care. Since 1970, a number of legislative acts were passed with a strong emphasis on family obligations to take care of its dependent members, including the elderly. The laws have assigned the duty of care for the aged almost exclusively to the family, which includes financial, practical and emotional support. They include, in chronological order of first release, the Criminal Code of 1979, the Marriage Law of 1980, the Constitution of 1982, the Inheritance Law of 1985, and Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly of 1996. All these laws contained articles stipulating family responsibilities for the aged members.
37. The Constitution³⁹ stated that adult children have the duty to support their parents. The Criminal Code⁴⁰ makes it a crime if one refuses to take care of a dependent member he/she is legally obliged to support. Such a crime is punishable for up to five years of sentence if it results in serious consequences. The Marriage Law⁴¹ reiterated the legal responsibilities of children towards their parents, but placed emphasis on family support as mutual obligations between parents and children. It also extended the duty of family care to grandparents and grandchildren if supports from the immediate legal caregivers are not available. The Inheritance Law linked the share of the assets to be inherited to the performance of successors in providing care to the decedent. A legal successor may get a larger share if he has carried out his duty of care to, or lived with, the decedent, while a smaller or no share shall be given to a legal successor if he has failed to carry out his duties while he has the ability to do so.
38. The Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly⁴² has also provided comprehensive regulations on how family caregivers should take care of their aged members. It stated that care for old people should be provided mainly based on the home, and required their children or others with legal obligations of care to provide the elderly with financial, practical, and spiritual support. It also required children to take care of the medical, practical and housing needs of the elderly. Caregivers are expected to ensure that the elderly receive timely medical service or nursing care and bear the costs if the elderly is unable to cover them on his own. Caregivers should provide practical care to old people if they are unable to perform the daily activities; in case a caregiver is unable to personally provide the care, he should

³⁹ Under #17 of the constitution, most recently revised in 2004.

⁴⁰ Most recently revised in 2011.

⁴¹ Most recently revised in 2013.

⁴² Most recently revised in 2012.

make arrangement by entrusting the care of the elderly to either other people or a care agency in accordance with the wishes of the elderly. In terms of housing, it is also the duty of the caregivers to ensure that the elderly has adequate housing. In 2013, a new article was added, which required that children living away from the elderly should frequently contact or visit them. This was raised in response to the estimated 70% of old people in the cities living in empty-nested households and over 50 million rural old people being left behind to live in the villages by themselves.

Formal care

39. China has adopted a three-tier system: “home-care as the foundation, community services as backbones, and residential care facilities as supplements,” which is the blueprint and guiding principles in the development and planning of EC system in China and Hebei. Both the central and Hebei governments have issued number of government EC policy⁴³ and construction guidelines⁴⁴ – both for HCBC, e.g., adult day care center and RC.
40. The Residential Care Facility Management Act (2013)⁴⁵ stipulated the service, management and monitoring of RC operation. It includes clinical (e.g., ADL) and non-clinical (social recreational activities) services, quality management, manpower requirements and government responsibility in monitoring. Operators of RC facilities failing to comply with the act can face a fine of 30,000 Yuan and other criminal charges if serious. However, the Act does not go in details about what constitute clinical services and quality of care.
41. The government policy also promotes better collaboration between medical/health care and EC. According to an directive issued by the State Department regarding expedite the development of elder care⁴⁶, the local government should accomplish this through optimization of investment environment in elder care, taxation benefits, government subsidy, human resources development and involvement of NGOs. Local governments have to take the lead and enhancing the monitoring EC industry including quality management. The Prime Minister of PRC echoed this on Aug 19, 2013.⁴⁷

⁴³ 国务院关于加快发展养老服务业的若干意见（国发〔2013〕35号）
中国老龄事业发展“十二五”规划

⁴⁴ 中华人民共和国城乡规划法》
城镇老年人设施规划规范（GB 50437-2007）
老年人居住建筑设计标准（GB/T 50340）
老年养护院建设标准（建标 144-2010）
社区老年人日间照料中心建设标准》（建标 143-2010）

⁴⁵ 养老机构管理办法.民政部门户网站
<http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201306/20130600480076.shtml>

⁴⁶ 国务院关于加快发展养老服务业的若干意见.国发〔2013〕35号.民政部职业技能鉴定指导中心，中民民政职业能力
建设中心（2013-10-23）.

<http://injd.mca.gov.cn/article/zyjd/zcwj/201310/20131000534003.shtml>

⁴⁷ 李克强主持召开国务院常务会议 - 确定深化改革加快发展养老服务业的任务措施. 中国社会报（2013-08-19）
<http://cbzs.mca.gov.cn/article/shxw/yw/201308/20130800507801.shtml>

42. The need to promote quality of EC is the focus of a directive issued by a cross-department committee on Feb 10, 2014.⁴⁸ By 2020, there will be standards developed covering home, community and residential care, management and service supports in elder care, and elder care products. EC rating (star rating system), certification and accreditation are to be developed as well. This includes the training of surveyors and pilot projects. As a matter of fact, quality standards for RC was ready in 2012 and standards for home care and adult day care are in the pipeline. They should be out soon.⁴⁹
43. There are plentiful government guidelines pertaining to the construction of stand-alone, leasing, or integrated EC facilities including average gross area required per residential care bed (25 – 32M²) and per community care center (100 – 300M²). Standard facility requirements for residential care include designated areas for food and lodging, medical care, rehabilitation, leisure and recreation. Standard facility requirements for elderly community care center, include 4 rooms (resting, recreating, reading, health care/rehabilitation) and one dining area. For adult day care, there is also designated room for medical care. In home service, there will be facilities, though unspecified, to support service delivery of meal, cleaning, shopping, bathing, medical escorting and ambulating, etc.
44. Family has been and will be the major sources of EC. However, all know the functions of family support in EC is declining due to many factors mentioned above. It is fine to rely on policy and regulation to enforce family support of EC. It is more important to support the family so that they can continue EC support. From a long range perspective, it is equally important to develop EC model creatively that removes the hard work of EC and allows family to provide the needed psychosocial support that most elderly want. Most of the policies, regulations, guidelines and standards of EC are hardware focused but less on software. It has been long known that China government favors bricks and mortar than quality of care. There is no lack of officials who are familiar with EC construction but only a few know care and service for the frail elderly. Thus, it is common to see the EC facility not properly designed to support EC and in some situation, even hinder EC delivery. For instance, adult day care center locating on the upper floor of a building with no elevator is a good example. In addition, most policies and standards were set centrally, which allowed local government more flexibility to adjust the policy and regulation to fit local reality. However, this may be accomplished at the expenses of consistency of care quality across counties, not to mention provinces.

⁴⁸ 民政部,国家标准化管理委员会,商务部,国家质量监督检验检疫总局,全国老龄工作委员会办公室: 关于加强养老服务标准化工作的指导意见. 社会福利和慈善事业促进司 (2014-02-10)

<http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201402/20140200585735>

⁴⁹ As per email from Xu Yuebin to Wendy Walker on Sept 10, 2016.

2.5 Human Resources

45. According to the State Council's "Opinions on speeding up the development of EC industry (2013)", there should be 10M LTC positions covering HCBC and RC, including positions such as physicians, nurses, rehabilitation specialists, social workers and other elder care technicians. The practice of certification and registration of elder care personnel will be available both in medical/health care and EC settings. Meanwhile, there are only less than 300,000 people working in China's RC. Among the existing workforce for the EC in the PRC, more than half of them are over 40 years old, and more than 70% of such workforce has received no education or training of no more than high school level⁵⁰.
46. Turnover rate of the EC workforce is also high and it can be as high as 50.9% in Hangzhou City, Zhejiang Province ⁵¹.

TABLE 8: Turnover Rate of EC Personnel in selected Cities in China, 2015

	Turnover Intention ^{52,53,54,55,56}	Sample Size
Ningbo, Zhejiang Province	14.59% ±4.45	246
Hangzhou, Zhejiang Province	50. 90%	220
Shaoyang, Hunan Province	13.54% ± 2.63	300
Sichuan Province	2.17% ±0.61 with 23.5% variation	1046
Chongqing, Sichuan Province	15.22±4.62	154

47. Hebei is no exception. Shortage of EC workforce in Hebei was cited by various studies and sources. There were about 20K+ care workers in Hebei by 2014. According to the 12FYP, there should be about 500K RC beds by 2015. Based on 5 RC beds per care worker, total EC care workers required by the end of 12FYP (2015) should be about 100K. 70K+ more PCW are therefore needed. Based on the strategic plan on EC human resources development of the Hebei Department of Civil Affairs, Hebei needs 200K+ care workers in EC by 2020⁵⁷. RC only will need 150K+ care workers based on 5 RC

⁵⁰ Human Resources Development for the EC Sector in the PRC, ADB. Available at: Dropbox\Hebei\HR\HR dev in EC_Wendy_ADB

⁵¹ LiQingKun (2015). Intention of leaving elder care industry

⁵² 苏吉儿, 方仕婷, 夏雅雄, 等. 宁波市养老机构护理员离职意愿与社会支持的相关性研究《护理学报》, 2015(19):72-74. Accessed April 4, 2016 from <http://www.cnki.com.cn/Article/CJFDTotat-NFHL201519025.htm>

⁵³ 马婷, 张银华, 陈燕, 等. 养老护理员离职意愿与社会支持的相关性研究.《护理研究》, 2016(7). Accessed April 4, 2016 from <http://www.cnki.com.cn/Article/CJFDTotat-SXHZ201607022.htm>

⁵⁴ 李雨昕, 杨茜, 陈丽, 等.四川省养老机构护理人员心理契约与离职意愿的关系研究.《护理学杂志》, 2016(3). Accessed April 4, 2016 from <http://www.cnki.com.cn/Article/CJFDTotat-HLXZ201603025.htm>

⁵⁵ Anonymity. 某市养老院养老护理员离职意愿调查分析. Master's Thesis, 2013. Accessed April 4, 2016 from <http://www.51lunwen.com/hllwfb/2013/0731/lw201307311904101660.html>).

⁵⁶ 田义华, 赵庆华, 肖明朝. 重庆市养老机构护理员工作认知与离职意愿的相关性研究.《中华护理杂志》, 2013, 48(7). Accessed April 8, 2016 from <http://d.wanfangdata.com.cn/Periodical/zhhzz201307012>

⁵⁷ A study report on "the state of personal care workers in Hebei, its problems and solutions". A study supported by Provincial and Municipal Elderly Committees of Hebei, conducted in Zhangjiakou, Hengshui, Cangzhou, Tangshan, Qinhuangdao and Shijiazhuang. Section 2.1 Available at - http://wenku.baidu.com/link?url=TFledsv0urMCazcopig2K6M-mArye3KLU2IsEkvgPiiXA6CGWqwxDcoaMviFoR9bbYgY0iBsgUVVg_jwXokvXnB1Dlf1Cbw9ynE_etwmGTm

beds per PCW, according to an estimation of Hebei Medical University⁵⁸. A great majority of care workers are between aged 40 and 50, according to a study report on “The state of personal care workers in Hebei, its problems and solutions.” Most of them have low education level. Based on the education levels of graduates from a Hebei care workers’ training program, >50% of the graduates have an education level lower than junior secondary,⁵⁹ which has also been supported by in-depth interviews of RC care workers in Chengde.⁶⁰

48. Zhongqiao Nursing Home in Shijiazhuang, which was established in 2013, has 260 beds and specializes in caring for the elderly who suffer from cerebrovascular diseases. Most of the elderly are not able to take care of themselves. The facility has only 20 care workers and most of them have retired from their jobs in manual labor and are too old to find jobs as nannies. It is common to see managers join care workers helping elderly residents move and bathe. According to the chairman of the nursing home, they need young workers badly but could not find any during recruitment because most young people consider the nature in EC work as menial with low pay and poor social image⁶¹.
49. Not only shortage of EC workers affected RC, it also leads to the quality of HCBC including adult day care centers and happiness gardens in rural area. These services have been understaffed, often with no full or part time dedicated staff. This means the services provided can only reach those people with no care needs i.e. those who can self-care. For example day care centers, in other developed countries are mainly utilized by people classified as ‘semi disabled’, and therefore need some trained staff to ensure quality care. In most of the cases, day care centers are suitable for people with dementia if dementia trained staff are also available.⁶²
50. Shortage of human resources in EC, both in China and Hebei, is largely due to (1) low income, (2) hard work, and (3) poor social image as EC care workers that have traditionally been considered as menial work in the Chinese society. Compared to the income of about 10,000 Yuan per month for live-in family caregivers such as nannies, care workers in many RC facilities are doing no less tough work taking care of the elderly with a much lower income of only about 1000 to 2000 Yuan. In addition, some of the elder residents, especially those with chronic illness, can be really demanding just to maintain and hard to deal with. This makes the already hard EC work even much harder and more stressful. As a result, it is very common that due to serious EC manpower

⁵⁸ HMU FSR, 2015. p.10

⁵⁹ A study report on “the state of personal care workers in Hebei, its problems and solutions”. A study supported by Provincial and Municipal Elderly Committees of Hebei, conducted in Zhangjiakou, Hengshui, Cangzhou, Tangshan, Qinhuangdao and Shijiazhuang. Section 2.2 Available at - http://wenku.baidu.com/link?url=TFledsv0urMCazcopig2K6M-mArye3KLU2IsEkvgPiiXA6CGWqwxDcoaMviFoR9bbYqY0iBsgUVVg_jwXokvXnB1Dlf1Cbw9ynE_etwmGTm

⁶⁰ Yu Qingnian and team - interview note 2 – interview record 7.

⁶¹ http://usa.chinadaily.com.cn/china/2016-08/23/content_26571895.htm

⁶² Meredith Wyse, Xu Yuebin (2016). PPTA – EC development in Hebei Province. Technical report: output 1: Home and Community Based Care. p.27

shortage, instead of the 1 care worker to 3 elderly (3:1) as suggested by the PRC's Ministry of Civil Affairs, the ratio of the elders and PCW can be as high as 1:5, 1:6, and sometimes even 1:10 in some RC of the PRC's major cities such as Beijing, Tianjing, Jangsu, Zhejiang, and Hebei Provinces, etc.

51. Shortage of EC workforce exists in all levels: professional and nonprofessionals. There are few qualification standards for staff training and little consistency between facilities and regions in how staff were prepared for their roles.⁶³ In general, there is no mechanisms in place (i) to accredit health professionals (e.g., physicians, dentists, nurses, midwives and pharmacists), (ii) to regulate health professionals, (iii) to License/Re-License health professionals. According to a report by only 9% of caregivers are certified and qualified, 14% certified but underqualified and 77% are not certified in China in 2013.⁶⁴
52. A number of specific HR issues of EC in Hebei were identified by this PPTA are:
 - i Recruitment difficulty due to low wages, work hard and poor public image as EC workers;
 - ii The replacement of existing an ageing EC workforce;
 - iii Hard to retain existing EC workforce;
 - iv Imbalanced skills-mix -insufficient utilization of health workers, nurses, advanced practitioners such as dietitians, physical therapists, and volunteers.
 - v Lack of long term HR planning in EC including a HR information system
 - vi Incomprehensive HR education and training strategies including pre and on the job training
 - vii Performance assessment and the quality of care are afforded insufficient priority.

2.6 Gender

53. Gender plays a significant role in EC. First of all, there are more women than men aged 60+ as female tends to live longer than male. However, women are more likely than men, to need help with their daily activities of living (M:F 19.8% : 27.5%), have more body pain (M:F 27.5% : 39.1%), have more incidents of hypertension (M:F 49.1% : 58.6%), and report poorer health (M:F 29.2% : 34.3%). (CHARLS, 2013)⁶⁵
54. Findings from the two studies conducted in Xinji, Chengde and Zunhua, Hebei are also in line with the above findings. In Xingji, more women than men were LTC impaired (23% vs. 14%) and with LTC needs (36% vs. 26%). 3.6% of the women vs. 2.7% of men may require RC and 22% of the women and 18% of men may require HCBC services. More

⁶³ Report on "LTC for Elderly in Asean Plus Three: Research and Policy Challenges". Organized by Changing Families in Asia Cluster, Asia Research Institute, National University of Singapore. March 1-2, 2016. p. 24

⁶⁴ <http://www.slideshare.net/smithstreet/opportunities-in-chinas-elderly-care-facilities-market/15> (Slide 13)

⁶⁵ Powerpoint presentation by Sebastian Riimalo (2015). Equitable Ageing: Seizing the Longevity Dividend. Economic Analyst on Population Development, UNFPA.

women than men are in need of (i.e., using or making their need known) social activity, escorting, money management, transportation, climbing steps, home nursing, meal preparation and housekeeping. More women (56%) than men (52%) had one or more unmet need⁶⁶. In Chengde and Zunhua, more women than men have hypertension (44% vs. 40%) and heart disease (31% vs. 27%). More women than men are expecting to be in need of physical examination, health education, rehabilitation/nursing service, physical therapy including occupational therapy and speech therapy, escorting service, family doctor and emergency service in future. More women than men (54% vs. 50%) expect to be in need of ADL service in future but will less likely use it because of shortage of money (36% vs. 13%).⁶⁷

55. Despite the fact that women need more care and that women are also likely be main caregivers to family members, women in general are less economic independence and receive lower benefits through public transfer. According to the studies conducted by this PPTA, women and men differ in income sources. The majority of respondents live on financial support from pension, children, and spousal income. Significant gender difference exists in major income resources ($p < 0.001$). Table 9 provides the major sources of living for respondents.^{68 & 69}

TABLE 9: Sources of living in descending order

	Xinji (N=388)		Changde & Zunhua (N=353)	
	Male (N=153)	Female (N=235)	Male (N=143)	Female (N=211)
	%	%	%	%
<u>Support from child</u>	<u>43.8</u>	<u>64.3</u>	<u>9.8</u>	<u>16.6</u>
<u>Pension</u>	<u>39.2</u>	<u>14.5</u>	<u>74.8</u>	<u>36.0</u>
<u>Spouse's income</u>	<u>2.0</u>	<u>11.5</u>	<u>7.0</u>	<u>35.5</u>
<u>Employment</u>	<u>8.5</u>	<u>3.0</u>	<u>2.8</u>	<u>5.7</u>
<u>Personal savings</u>	<u>3.3</u>	<u>2.1</u>	<u>4.9</u>	<u>2.8</u>
<u>Government benefits</u>	<u>1.3</u>	<u>3.4</u>	<u>0.0</u>	<u>2.8</u>
<u>Support from other relatives</u>	<u>1.3</u>	<u>0.4</u>	<u>0.7</u>	<u>0.0</u>
<u>Renting of housing or land</u>	<u>0.7</u>	<u>0.9</u>	<u>0.0</u>	<u>0.5</u>

56. In terms of economic wellbeing, more women (26%) than men (22%) rated their condition as "poor" in Xinji. It was 14% vs. 8% in Chengde and Zunhua. In Chengde and Zunhua, more men (67%) than women (48%) have employment related medical insurance,

⁶⁶ Xu Yuebin, Chen Lin and Wang Xiaobo. (2016). *Assessing Care needs of Urban Community Dwelling Elderly People in Xinji*. Asian Development Bank: SC 106398 PRC: Preliminary Survey Work to Support Development of the Hebei EC Development Project. Table 5.4.5, 6.1.4, 6.2.2, 7.2.1 & 7.2.5

⁶⁷ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126). Table B1, Bc2.8, C1

⁶⁸ Xu Yuebin, Chen Lin and Wang Xiaobo. (2016). *Assessing Care needs of Urban Community Dwelling Elderly People in Xinji*. Asian Development Bank: SC 106398 PRC: Preliminary Survey Work to Support Development of the Hebei EC Development Project. Table 4.4.3 & p.28

⁶⁹ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126). Table A01.10 (Chi-square)

however, more women (86%) than men (74%) would have to pay after reimbursement of medical insurance⁷⁰. More women than men did not use health (25% vs. 19%), ADL (36% vs. 13%) and community canteen (25% vs. 15%) services due to shortage of money. EC service is likely paid by children/grandchildren in women (38%) than in men (29%).⁷¹

57. Despite women need more care, women are the major caregivers in EC, with women taking most of the role of care provider and men as care recipients. At the family level, the task of looking after the elderly is commonly assigned to daughters or daughters-in-law. Even in cultures where the responsibility of taking care of the elderly parent is traditionally assumed by the son, the actual support provided in terms of ADL, household chores, and emotional support are still provided by the women in the household.⁷² Even at the community level, women tend to be volunteers of EC. Many community care centers for the elderly became a haven for women elderly and unintentionally became a facility that caters exclusively to women, both users, volunteers and staff. This can be substantiated by the findings of focus group discussion held in Xinji, in which women showed no difficulty in identifying recreational facilities in the urban area for dancing, playing cards and chatting. Men however, tend to think there are few such facilities around them⁷³. Gender disparity cannot be left unnoticed if an equitable EC is warranted. How to bridge the gap between men and women require deliberate efforts by all stakeholders concerned and may require breakthrough thinking such as matching companions in old age.

2.7 EC Services in public sector

58. The China National Committee on Aging (CNCA) is responsible for planning, developing policies, conducting activities and coordinating across 32 ministries and institutions pertaining to EC at national and local levels. The major stakeholders in provision of EC include Ministry of Civil Affairs which was the lead agency for responding and coordinating EC, and the Ministry of Health and Family Planning. Funding of EC services is generated mainly by local governments from diverse sources including government allocations, public donations, etc. Since 2013 general revenues are allowed to fund EC services and insurance funds can be invested in the industry. As Li Jianguo, vice chairman and general secretary of the Standing Committee of the National People's Congress stated last year, if China followed the World Bank's standard of coverage of 8% of elderly in need of care, this would translate to a need for an additional 3.4 million

⁷⁰ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126). Table AC2.1 & C3 (Chi-square)

⁷¹ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126). Table Bb2.8.1, Bc2.8.2, B3.a.2 & Cd.5.10.1 (Chi-square)

⁷² Report on "LTC for Elderly in Asean Plus Three: Research and Policy Challenges". Organized by Changing Families in Asia Cluster, Asia Research Institute, National University of Singapore. March 1-2, 2016. p. 28

⁷³ Results of two focus group meetings in Xinji in January 2016 conducted by this PPTA.

hospital and nursing home beds dedicated to senior care over the next five years alone.⁷⁴ The power of public sector commitment will mean a lot in driving EC in China.

59. Public EC services are owned by the government and are accessible at lower price. They are financing from government general revenue, fee collections and donations. Public EC services mainly include RC, HCBC and ICT. Operations of these services are managed by government. According to the government policy, these publicly operated EC facilities will gradually sub-contracted to private operators, profit or not-for-profit.
60. In 2016, there are about 164 public county-level EC/RC facilities operating in Hebei. Due to staff shortage, most of these public EC facilities are vacant. Other than those with full and/or high occupancy, there will be no further expansion of these facilities.⁷⁵ Most of these facilities will also be contracted out to private operators, profit and non-profit.
61. Community EC center which is a key element of HCBC, mainly funded by the government both in terms of construction and operation. Under the “opinions on advancing the construction of community EC centers (2012)”, all sub-districts of Hebei should establish a demonstrative community EC center, and by 2015, 80% of urban communities should have such a facility in place. The above policy directive was updated in the 2014 by Hebei government to have all urban communities, 90% of townships and all rural villages through the “happiness gardens” covered by community EC center. Local government (city and county) should provide subsidies for construction and operation of EC center based on local economic conditions, and provincial government will provide financial support in the form of award for best practices. The EC center can be operated in four different modes: 1) direct operation by residents’ committees; 2) contracting out services to nonprofit EC agencies; 3) contracting out services with residential care providers; 4) contracting out services to other social organizations.
62. Not only are there construction specifications, each EC community center should include a minimum number of four types of services: 1) care supports, including supervision and rest for those who have no caregivers in the day time but can go outdoors, and home visit service for those unable to go out; 2) meal services including both aggregate and home delivered meals; 3) health service, including exercises, rehabilitation, and emergency relief, including 1-2 doctors available to provide health guidance; and 4) social support such as learning, entertainment and other social interactions.
63. There were 1,390 RC facilities in 2014 in Hebei of which 730 (53%) were public and 660 (47%) were private. Total beds were 250,000, of which 175,000 (70%) public, 75,000

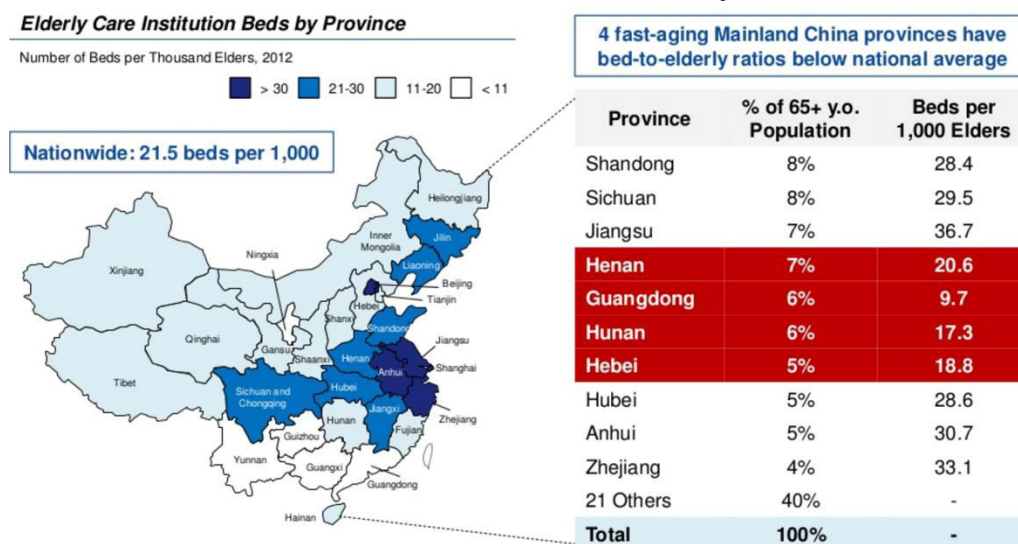
⁷⁴ China-US Exchange Foundation. (2013). UN-China Economic Relations in the next ten years: Towards deeper engagement and mutual benefit. September 2, 2013. Chapter 8.

Available at: http://cusef.org.hk/wp-content/uploads/2014/05/03_eng.pdf

⁷⁵ Wang Hsiaopo's reply to Wendy Walker re double check of subsidy on Sept 20, 2016.

(30%) private⁷⁶. According to Smith Street Healthcare, there were 18.8 beds per 1,000 elderly in 2012. By 2014, the ratio increased to 24.3 per 1,000 elderly with a net increase of 5.5 beds in 2 years.

DIAGRAM 2 : Residential Care beds of EC by Province⁷⁷



64. Government subsidy enables public RC facility to offer complete package of service at less expensive price. Thus, most of the well run public RC facilities have a long waitlist. In places, such as Yichang, Hubei, there is a 6-12 months waiting time for Yichang 1st Welfare Home and in Beijing, there are 10,000 elders in the waitlist for the Beijing #1 Welfare Home at all time⁷⁸. Having said that, 50% to 75% of the public RC beds, especially in rural areas, are unoccupied due to the fact these public EC beds in rural areas are mostly low-end public RC facilities for the *Wubao* (5 guarantees), *Dibao*, disabled and street sleepers. Their quality is normally poor and the price is low. In Hebei, the occupancy rate of public RC facilities depends on its quality. Here are two examples of public operated RC facilities with different occupancy rate. Lixian Veteran Home was built in 2010 and is resource rich as it is built for war veterans, even though it also takes *Dibao*. It has a 100% occupancy rate. Veteran and *Dibao* elderly reside in different zones within the home. Veterans have bigger room size than *Dibao*. Henan Old Age Home, on the other hand, is a very basic type RC facility, incomplete package of service and manned by unprofessional staff. Its occupation rate is less than 20%.

Lixian Veteran Home (蠡县光荣院)⁷⁹:

⁷⁶ Hebei Government (2014) ADB loan Hebei pension service system construction project profiles. Available at: Dropbox\Hebei\Background\Hebei pension service.docx

⁷⁷ <http://www.slideshare.net/smithstreet/opportunities-in-chinas-elderly-care-facilities-market/15>

⁷⁸ <http://www.slideshare.net/smithstreet/opportunities-in-chinas-elderly-care-facilities-market/15> (slide 12)

⁷⁹ Lixian's FSR, (Aug 8, 2016), Section 2.1.3.

- 110 beds – 77% are occupied by people who are independent and 74% are aged 70 and below
- 100% occupied – for veterans, *dibao* and *wubao*
- # of staff: 20
- Typical Charges

Item	Fees/Month
Rent	Free
Meals	Free
Personal care	Free
Medical care	Free

Henan Old Age Home, Shexian (涉县河南店中心敬老院)⁸⁰

- 200 beds
- 19% occupied – all *wubao* (5 guarantees)
- # of staff: 11
- Typical Charges

Item	Fees/Month
Rent	Free
Meals	Free
Personal care	Free
Medical care	Free

65. Finally, let not forget, there are a number of government subsidy in cash (high age allowance) and in kind (free bus ride) to support EC which are highlighted under Section 2.3.

2.8 EC Services in private not-for-profit

66. Private “not-for-profit” and private “for profit” can be a very convoluted concept in China. Presumably, not-for-profit implies (1) the EC operation is not organized to make and distribute profits and (2) no profits, earnings, or assets can be distributed, directly or indirectly, other than for its not-for-profit purposes.⁸¹ In practice, it is very difficult to differentiate the “for profit” and the “not-for-profit”. Firstly, every private EC operator has to generate sufficient revenue to cover their expenses. Secondly, the Chinese law does not require profit operators to disclose their financial reports. It is difficult to check if there is profit made, let’s alone checking where the profit goes. Finally, many EC operators, profit or not-for-profit, try to register as not-for-profit organization or operate as nonprofit organization, to enable them to acquire land free or at low cost, government subsidy, and other bonuses under various preferential policies e.g., tax, utility subsidy, etc.
67. Chinese government policy has been supportive in engaging the private profit and nonprofit sectors in EC. It has

⁸⁰ Shexian FSR (Aug, 2016), p. 33.

⁸¹ Irish, L.E. et al. (2004). China’s tax rules for not-for-profit organizations – a study prepared for the World Bank. The World Bank., p. II

- i. opened EC market to foreign investors,
 - ii. encouraged cooperation between local and foreign investors.
 - iii. improved its policy and regulations for land acquisition and
 - iv. outsourced public EC services to private operators.⁸²
68. Most private EC operators operate as nonprofit organizations, have low utilization rates and are more appropriate for people with no care needs. The involvement of private not-for-profit operators in HCBC services is minimal and fragmented. Most are focus on the mid-low to mid-range RC market with a few on high end market. Its RC service is driven by a mix of clienteles - (1) independent and active older persons, (2) semi-independent and (3) total dependent.
69. The private not-for-profit EC operators were driven by other motives and in general quite contented with their current operation with no major developing and/or expanding plan. This PPTA interviewed three operators:

Dongyun Elderly Apartment (2006)

- 128 beds operating under a 4-story rental building
- 78% occupied
- # of staff: 16 with a monthly average salary of 3,000 Yuan (including no social insurance)
- Average Charges: 1,500 to 2,700 Yuan depending of level of care.
- Background of operator: a former coal merchant

Changan Community Elderly Apartment (2001)

- 120 beds operating under a 4-story building owned by the district government
- 100% occupied
- # of staff: 30 with a monthly average salary of 4,000 Yuan (including social insurance)
- Average Charges: 1,900 to 3,500 Yuan depending of level of care.
- Background of operator: a former staff of community

Xisanjiao Elderly Apartment (2007)

- 628 beds operating under a 7-story self-built building on collective land
- 32% occupied with the rest of beds leased to a private hospital
- # of staff: 40 with a monthly average salary of 3,000 Yuan (including social insurance)
- Average Charges: 1,200 to 2,300 Yuan depending of level of care.
- Background of operator: city residents

70. Their entrance to the EC market was mainly driven by (1) personal adverse experience and (2) opportunity available, but not by profitability at least at the very beginning. For instance, one of the operators' mother in law became disabled and was placed in a local nursing home. The environment and service of the nursing home were unbearable that he and his wife decided to open one themselves so as to benefit the community at large. Another one was handpicked by the governor to run an outsourced government built RC facility because of his track record in community services. The government offered free rent and covered his staffing cost for six months. Yet another one was due to the availability of a vacant land resulting from relocation due to urban expansion. None of the operators interviewed were over concerned about financial sustainability. For instance, the owner of Dongyun Elderly Apartment has been quite well off and profitability has never been the focus of his business model. He does not mind losing money and in fact he lost money for the first few years of operation. Only in recent years that he saw some profits. Since the building of Xisanjiao Elderly Apartment is owned by the operator, who also has other sources of revenue generating from leasing beds to a private hospital. This helps to reduce his financial risk. Finally, the operators generally consider a balance budget possible as long as they can achieve a 50% occupancy rate, which has been considered as no challenge at all. In addition, EC fees rose higher than cost of living, this also may help to balance their books.
71. All operators had no or very limited experience in EC market, let alone EC operation. None of them started their business with thorough market research. This was not an issue at all as there were not too many RC operators to compete or to learn from in the first place. Having said that, some existing RC operators did try to dissuade them from entering the market. None of the operator is keen to expand their EC business as they are quite contented with what they have and they are exhausted by their current issues of operation. If given the opportunities, some may consider moving into HCBC.
72. There are two types of operating issues. Firstly, it is about dispute with residents and family. Secondly, it is the transaction with the government. In addition to public image damage, dispute with residents/family is both time and energy consuming. To avoid dispute, proper staff reimbursement and training, allowing staff enough time for good rest and quality improvement are important. Resident and family will be more forgiving for wrongdoing by staff only if they have been treated well on a regular basis. Operators have learned to become selective in only taking those elderly who are not "mentally challenged" and "selfish." This is done through "free trial for a month". During the month of free trail, the elderly will see if they are adaptable to communal life. It also provides an opportunity for the operators to evaluate the suitability of the prospective users. Government policies are good on paper and not so good in practice. Dealing with many government departments which have jurisdictions over RC operation has been a source of headaches for EC operators. Since EC is a risky business and many government officials are reluctant to make decision which they may have to be accountable for life. This is the reasons why obtaining a permit from the Fire Department is so difficult now

and it was estimated that almost 60% of the RC operators do not have permits issued by the Fire Department in Shijiazhuang.

73. Major international organizations are currently working towards the EC development in China especially working with private nonprofit EC operators. For instance, World Bank is contributing to the 13FYP on EC through sector work and identification of best practices. It is also preparing a first investment loan on EC in Anhui province focusing on service provision and EC system development. UNFPA is working on socio-economic data collection on aging issues with a right based approach and healthy aging strategy. WHO is supporting research on aging, prevention activities and age-friendly cities initiatives. ADB is working closely with Hebei and Hubei government to prepare loans for EC development via PPP.
74. One segment of nonprofit EC organizations appears to be missing in China is the social or voluntary sector. In almost all countries with a comprehensive social service system there is an important role for the voluntary/nonprofit/ social sector. This is usually a combination of nonprofit providers providing formal RC and/or HCBC services contracted by government, or long term care insurance, and more informal care services provided by voluntary groups, support groups who can provide a wide range of services such as befriending, companions, home help, meal delivery, organization of social activities, information and education sessions for carers and people needing care. These are activities that are important for an effective EC. There are a number of options to develop the social or voluntary sector:⁸³
 - i Review definition, policies and structure of nonprofits, as in international best practice such organizations are obligated to invest any generated profits back into the organization or contribute towards the organization's objectives.
 - ii Publicize more widely the existing guidelines, and create incentives for social organizations working in EC field, to encourage new entrants or encourage existing organizations who currently do not work in EC field to expand the scope of work. Incentives should include grants, not only for activities but also for operating costs. Other incentives include public recognition of good work.
 - iii Map existing social organizations, and provide access to training on EC if interested in developing activities or services. These could include Older People's Associations, Women's Federation, Village Health Doctors, schools, universities, resident committees, Third Age Colleges and so forth.
 - iv Encourage private providers, including IT call center operators, to develop volunteer networks. This is often effectively used by private providers as marketing mechanism.

⁸³ Meredith Wyse, Xu Yuebin (2016). PPTA – EC development in Hebei Province. Technical report: output 1: Home and Community Based Care. p.29

2.9 EC Services in private for profit

75. According to Smith Street Healthcare, major private EC development especially those for profit, is largely concentrated in the Beijing, Langfang (Hebei) and Shenyang area, Yangtze River Delta and Pearl River Delta.⁸⁴ Insurance, real estate, and service companies, both foreign and local, are involved. Other companies tapping China's silver market include U.S.-based Brookdale Senior Living, France's Orpea, Australia's Aveo, Singapore's Active Global Specialised Caregivers and Japan's Nichiigakkan.⁸⁵

DIAGRAM 3: Distribution of Private for Profit EC Developers



76. In Hebei, the number of private for profit EC organizations has increased by 163% between 2006 -2015 (Table). The number of for profit EC organizations grows steady in the past decade. There are two significant increase in 2008 and 2015 which reflect changes of government policy which favored the involvement of private operators, both profit and nonprofit, local and overseas. In 2007 the provincial government issued an "Opinions about Accelerating to Development the Elderly Services," and the China Development Bank offered low-interest loan to EC organizations recommended by the Ministry/Department of Civil Affairs. In March 2016 four national-level financial administration authorities and MoCA jointly issued "Guiding Opinions about Financially Supporting to Accelerate the Development of Elderly Services", which expanded the scale of loans, and encouraged financial innovations. As a result, between April to August 2016, the number of private for profit EC organization doubled to 62 companies, which claimed to provide elderly services, EC or medical care for elderly, registered with the Hebei Administration of Industry and Commerce.⁸⁶ Major private for profit EC operators always lay eyes on the financial and lands policy, and try to derive benefits under the banner of EC services.

⁸⁴ <http://www.slideshare.net/smithstreet/opportunities-in-chinas-elderly-care-facilities-market/15> (Slide 18)

⁸⁵ <http://asia.nikkei.com/magazine/20160825-ASIA-S-SILVER-LINING/On-the-Cover/Failure-to-prepare-for-an-aging-population-could-cost-China>

⁸⁶ Wang Hsaipo's email on Aug 20, 2016

**TABLE 10: Number of private for profit EC organizations by year in Hebei Province
(2006 – 2015)⁸⁷**

	increase	Exit	Active
2006	4	0	14
2007	2	2	14
2008	10	1	23
2009	1	2	22
2010	1	5	18
2011	1	3	16
2012	2	0	18
2013	2	4	16
2014	0	0	16
2015	21	0	37

77. Private for profit EC services are largely provided in the form of gated communities or resort-style residential complexes with a market- driven mix of (i) independent-living residences for active elderly; (ii) assisted-living units for elderly who require some support; and (iii) access to skilled nursing care for frail or infirm elderly who require frequent assistance or acute medical care.⁸⁸ In Hebei, it is estimated that 20+ EC big projects are currently developing in the regions between Hebei/Beijing and Hebei/Tienjin. Some of the projects are in operation such as the International Health City in San He, Lai Shui Xian, Zuchongzhi ancient city, etc. Some are under construction and some are still at planning stage.⁸⁹
78. Many expertise believe EC market in China is a promising opportunity especially in RC. If scalable and profitable business models emerge, the country could quickly become one of the world's most lucrative markets for EC companies. When comparing with public RC, private RC, especially those in high end providing a full service package including medical and nursing care, has certain advantages.

DIAGRAM 4: Comparison between public and private EC beds⁹⁰

⁸⁷ The data derived from Enterprises MIS, which is published by Administration of Industry and Commerce

⁸⁸ Bromme H. Cole (2013) Enter the Ageing Dragon: Musings on the nascent senior living industry in China, China Senior Living Ltd.

⁸⁹ Xu Zhen Ke (Deputy Director General, Hebei Civil Affairs Bureau) - Minutes of High Level Meeting with Hebei Government held on (Tuesday) May 17, 2016 at Conference Room, 5/F., Yan Sun Hotel, Shijiazhuang.

⁹⁰ <http://www.slideshare.net/smithstreet/opportunities-in-chinas-elderly-care-facilities-market/15> (slide 15)

Government vs. Private Nursing Homes

High  Low

Ownership	No. of Beds	Medical	Nursing	Accept Disabled	Location	Price	Occupancy
Private	300+	✓✓	✓✓	✓	Suburb	Very High	High
Private	300	✓	✓	✓	Urban	High	High
Private	200	✓	✗	✗	Urban	Medium	Medium
Private	50	✗	✗	✗	Urban	Low	Low
Government	500+	✓	✓	✓	Urban	Medium	Very High
Government	300	✓	✗	✗	Urban	Low	High
Government	30	✗	✗	✗	Rural	Very Low	Low

79. The assumption of engaging private for profit sector in EC is that EC is profitable. However, such as assumption is not without risk. The challenge to the investors and operators is how to come up with a care model that the Chinese LTC/EC user want, and is willing to pay for. It is estimated that it may take at least 5 years to get a return on capital. All depend whether or not if the hot real estate market will be cooled off so that some of the real estate assets can be repositioned for EC.⁹¹
80. In reality, use of private EC is still low - only 2% of the elderly are enrolled in RC. This is due to (1) cultural factor such as strong filial piety especially in rural area, (2) shortage of beds in quality and affordable facilities and (3) the old are not wealthy enough and the wealthy are not yet old,⁹² However, there are positive signs that people's mindset about RC begins to change ⁹³:
- the children are burdened, are not skilled in providing care and are not always around to provide care
 - exposure to new premium and luxury RC setting as a social status
 - penetration of western EC concept and RC models
 - Increase in pension benefits
 - increase in media coverage
 - increase in demand for quality and better EC

In addition, Chinese consumers are becoming increasingly sophisticated:

- Changing lifestyle and more receptive to EC concept of the west
- Exposure to luxury and premium type of EC services
- Increasing expectation on service quality
- More financially prepared

⁹¹ Christian J. (2015). China's Senior Care Market. Rubicon Strategy Group. www.HealthIntelAsia.com p.10

⁹² <http://www.slideshare.net/smithstreet/opportunities-in-chinas-elderly-care-facilities-market/15> (slide 9)

⁹³ <http://www.slideshare.net/smithstreet/opportunities-in-chinas-elderly-care-facilities-market/15> (Slide 10)

81. Recent years also see more private for profit EC investors/providers moves into HCBC. Making HCBC profitable is still a long way to go. First of all, HCBC is still in its earliest stage and is not yet profitable. It is not profitable as (1) it is not being able to provide the highest value (nurse led) health care services in the home due to restrictions in licensing, (2) customer acquisition costs that are too high in relation to the number of hours a family is willing to purchase, and (3) inefficient logistics relative to where caregivers and nurses are sent during the course of the work day. Until such time when the issue of payer, referral sources and how to align Chinese consumer's preferences with service plans, making HCBC services in private profitable is easier said than done.⁹⁴
82. Wisnet, a nursing care services company from Japan, is one of the exceptions. The company opened a day facility in Dalian, Liaoning Province, where users can participate in group exercise, have a nutritious lunch and enjoy other services. The building is elderly-friendly, with handrails on the walls, level floors and railings on the beds. The center's high fees made it hard to attract users at first, but word of mouth has helped its popularity grow, according to Wisnet. The company is now considering building a combined nursing home and store for elderly-related goods.⁹⁵ Other big developers such as Golden Care (Singapore), Buurtzorg (Netherlands), etc. are also providing HCBC through either building senior care center in their residential community or establish small-to-medium sized nursing home in surrounding areas, or stretch community care service by spotting nursing stations in the neighborhood. Whereas business models may differentiate in forms—intergeneration housing, Internet platform or virtual nursing home, transformation of CCRC, or academy senior care, etc.—services will not vary too much around RC, day care, respite care, home care, green-channel to hospitals, medical care, rehabilitation, health management, catering and entertainment. At least on paper, government is trying to encourage private capital to participate in the construction or operation of HCBC/RC facilities.⁹⁶ The good news is that the government takes up strong leadership, has a clear EC vision and transparent HCBC/RC model, and is inviting the private sector, profit and nonprofit, to help realize this vision and model. However, this has yet been seen in Hebei.
83. The Chinese government policy has been positive towards supporting EC by engaging the private profit and nonprofit operators. Most EC policy agendas are driven by the central government, however, the local and provincial leadership do have a wide latitude to implement new approaches. Many local governments are open to new ideas: care model, financial models, and facility design. Successful private operators in China are those quick to engage local government, in particular the ministries/departments of Civil

⁹⁴ Christian J. (2015). China's Senior Care Market. Rubicon Strategy Group. www.HealthIntelAsia.com p.16

⁹⁵ <http://asia.nikkei.com/magazine/20160825-ASIA-S-SILVER-LINING/On-the-Cover/Failure-to-prepare-for-aging-population-could-cost-China>

⁹⁶ Qu Michael (2016). Emergence of Community Care Models. *Industry Insights*. Law View Partners. Available at - <https://1gpwwk3iqz9h1fu14n2iq8i4-wpengine.netdna-ssl.com/wp-content/uploads/2016/05/Michael-Qu-regulatory-update-home-care-elderly-homes-senior-living.pdf>

Affairs and Health to establish a relationship and begin working towards reimbursement schemes that align with the central government's EC agenda.

84. If the EC market is to be driven primarily by private pay as many experts believed⁹⁷, China's government will have to profoundly improve the viability of its public pension system so that people can buy EC in private market.⁹⁸ In rural areas, contributing 100 yuan a month to the pension system for 20 years brings a monthly pension of less than 300 yuan, which is a meager amount for private EC even by rural living standards. Even in urban areas, a pension of slightly more than 2,000 yuan a month⁹⁹ is still not sufficient to cover EC fees without personal saving or support from the children. Fixing this imbalance of pension between urban and rural will not be easy. Even providing a monthly subsidy of 70-100 yuan would put a huge strain on government finances, given that there are about 500 million rural workers.

2.10 New development/trends

85. A few new EC development and trends, both at provincial and national levels are worth mentioning as they may have long range impacts on EC development in China. Not only are they revamp the current EC system e.g., merging of EC facilities, they are also change the face of EC system in China e.g., small scale community based EC, LTC insurance. The first two are Hebei specific and the last 3 are national projects.

2.10.1 “Merging and integrating of EC facilities” in rural Hebei

86. Department of Civil Affairs in rural Hebei were in charge of three types of RC facilities: (1) Beadhouse for the “three-no” elderly, (2) Welfare Home for the “three-no” disabilities and children, and (3) Veteran (Honorary) Home for the “three-no” veterans. These facilities operated independently. They had separate sites and appropriations, served different target groups, and were managed by different teams. Not only were such arrangements wasteful and leading to low utilization of RC beds, they were also not a good use of public resources. In 2009 the Provincial Department of Civil Affairs reported the experience of Fengning County, which integrated all three RC facilities into the “Civil Affairs’ Service Centers”, at the “National Civil Affairs Work Conference.” Hebei experience was again introduced by the Ministry of Civil Affairs at the “National Urban and Rural *Dibao* Work Conference” in Hainan in 2011.
87. According to the document “Implementation Plan for Accelerating to Promote the Construction of Civil Affairs’ Service Center”, issued by the Department of Civil Affairs (2011[69]: 416 Beadhouses will be expanded into services centers, 252 Beadhouses will be closed, 25 Veteran (Honorary) Homes will be integrated into service centers, and 50 new service centers will be built by 2015. There would be 630 service centers and over

⁹⁷ Christian J. (2015). China's Senior Care Market. Rubicon Strategy Group. www.HealthIntelAsia.com p.5

⁹⁸ Christian J. (2015). China's Senior Care Market. Rubicon Strategy Group. www.HealthIntelAsia.com p.5

⁹⁹ <http://asia.nikkei.com/magazine/20160825-ASIA-S-SILVER-LINING/On-the-Cover/Failure-to-prepare-for-an-aging-population-could-cost-China?page=2>

220,000 beds in the Hebei by 2015. Any cost saving as a result of RC facility merging will be redirected to improve the medical and nursing care and to add more beds. In addition, economy of scale resulting from merging, made it is possible to outsource property management and catering services to more professional providers through tendering.

88. The new Civil Affair Service Center serves mainly the “three-nos”, which accounted for 95% of elderly in rural Hebei. In the new center, “three-nos” and veterans will live in different zones. The veterans may enjoy a better living condition than the others, but all will share the same medical facilities and caregivers.
89. The “Merging and integrating EC facilities” project appears to be a right move of EC development in China by combining small scale and underutilized RC facilities. The saving derived from economy of scale, allows the local Civil Affairs to elevate the quality of EC in rural Hebei. However, instead of improving the quality of living for the “three nos”, the new service center chooses to adopt a segregation strategy by allowing the veterans to reside in a better living zone of the center than the rest of the residents. This may create a sense of inequity.

2.10.2 “Care-with-Love Project” in urban Hebei – Pre medical/health care and EC integration

90. Care-with-love Project¹⁰⁰ can be considered as a prototype “medical/health care and EC integration and The was launched by China Aging Development Foundation (CADF) and enlisted in the “Outline of the 11th Five-Years Plan for National Economic and Social Development” in 2006. Hebei Province has taken part in the project since 2008. The national goal is to build a new type of nursing homes for elderly in over 300 large and medium-sized cities, so that its experience can be a basis for other EC projects such as elderly apartment, elderly school, elderly community center etc.
91. Both public and private organization could apply to become a pilot site, only if they could also obtain the a health care license issued by the Departments of Health and Civil Affair and meet construction and service standards. Specifically, the applicant must construct 4 kinds of functional areas and provide 6 kinds of service. The 4 functional areas are: medical areas for observation and urgent care, rehabilitation area, living area and social recreational area. The 6 kinds o service are: medical and nursing, activities of daily living, rehabilitation, social recreation, counselling and hospice. In addition, the medical and nursing care of pilot sites must meet the nursing standards of Level 1 hospital (the basic level) established by the Ministry of Health whereas the personal care should meet the standards on personal care of the national level welfare homes established by Ministry of Civil Affairs.

¹⁰⁰ Wang Xiaobo (2015). Hebei EC System Development. A report prepared for ADB (SC 104708). Section 4.3

92. The pilot institutions do not belong to CADF. CADF helps in the following areas: (1) building and promoting the brand of “care-with-love” by developing logo, value, function and service standards; (2) communicating with related government departments to ensure the government give preferential policies for EC institutions; (3) organizing trainings on management and nursing; (4) organizing conferences to exchange experiences (5) recognizing good practice; (6) fundraising for the pilot institutions.
93. The “Care-with-Love” appeared to be a prototype of medical/health care and EC integration way before the “opinions on health and EC integration” (State Council, 2015 [84])¹⁰¹, was released in 2015. It shed light on the types of medical/health care services that EC sector has to pick up such as skilled nursing, rehabilitation, hospice etc. However, what is unknown though is the outcomes of the project. In other words, did it achieve what the project originally set out to achieve? Did the stakeholders learn from the project experience? From the discussion with respective government officials and potential EC operators in Hebei, the answer appears to be “no”.

2.10.3 Vertical Integrated EC – RC and HCBC

94. Integration of RC and HCBC is also a new development in cities like Beijing and Shanghai. This new type of facility can be considered as a community nursing homes along with adult day care, home care, elderly catering center. They can be understood as the smallest nursing home that 24/7 boarding services and other community services are provided within it. The number of bed in each of this new facility is relatively small, i.e., 50 – 100. These facilities can be built in residential area or even apartment, There are several advantages of running such a facility including a lower and reasonable cost on rent and personnel, appropriate price akin to the market acceptance, and accessibility to the government’s subsidies. The occupancy of the facility are relatively very high.
95. There are Community Senior Houses or Community Senior Service Centers in Beijing and Elderly Homes in Shanghai. In Chengdu, similar development has been reflected in their Three-Year Plan (2016~2018) for Building Up Community Nursing Homes.¹⁰² In Beijing and Shanghai, they are built by government, and then contracted out to private, profit or nonprofit operators, to operate. There are also facilities that are privately owned and operated such as Cuncachunhui in Beijing.
96. Compared with traditional nursing homes and home-based care companies, the operators of these facilities do not regard the facility a nursing home. It is an integrated EC center, which builds itself into a professional and comprehensive platform to realize the seniors’ wish of ageing in place. The core is the establishment of a professional and comprehensive EC system based on HCBC supported by a professional RC. It requires

¹⁰¹ http://www.gov.cn/zhengce/content/2015-11/20/content_10328.htm

¹⁰² Qu Michael (2016). Emergence of Community Care Models. *Industry Insights*. Law View Partners. Available at: <https://1gpwwk3igz9h1fu14n2ig8i4-wpengine.netdna-ssl.com/wp-content/uploads/2016/05/Michael-Qu-regulatory-update-home-care-elderly-homes-senior-living.pdf>

less investment, provides more efficient and effective services, extends its services from a center to the nearby neighborhoods in a radial pattern, and has the ability to integrate scattered senior service resources. It possesses the following features: small in size, community-based, multi-functional, wide in coverage, and professional. However, this trends of EC delivery appears to be novice to most of the stakeholders of this PPTA.

2.10.4 Horizontal Integrated EC - Medical/health Care and Elder Care

97. The Ministry of Health and Family Planning's "opinions on health and social care (EC) integration" (State Council, 2015 [84])¹⁰³, encourages collaborative approach between health and EC including forming formal collaboration agreement. Health care services offered in EC setting will be covered by health insurance. The government will also provide a subsidy for EC organization focusing on nursing care. Skills certification and the monitoring of health care employees in EC will be similar to those in health care setting. A summary of the Opinions on health and social care (EC) integration is in Annex C.
98. Health and social care integration got a boost in the 13FYP. One of the major emphasis of 13FYP on EC is on the promotion of better integration between medical/health and EC. The concept has been subject of multiple interpretations including the creation of elder care continuum to include: medical, nursing, intermediate care and leisure services so that all older people will be able to obtain the needed services within their most familiar community. Under such an arrangement, there will be special nursing care, medical rehabilitation, disease management and periodical physical examination for total and semi-dependent elderly, as well as health consultation and periodical physical examination for those independent elderly. EC will be encouraged to develop medical and rehabilitation center, which will be operated, equipped and staffed just like a Level II hospital.
99. Medical/health and EC integration, at least in most developed countries, is driven by two factors: (1) client care excellence and (2) system efficiency. Users achieve client care excellence through access to an integrated health and social service continuum. System excellence is through system efficiencies and improved service levels. Service users, who do not need medical care should be able to shift from a more expensive, e.g., hospital to a less expensive care setting, e.g., RC facility or medical rehabilitation center. Thus, health and social integration are also about cost saving for service users, EC providers and the government. If, however, the integration of health with EC does not come with resource transferring from health to EC, the health and EC integration may imply an increase in EC cost.

¹⁰³ http://www.gov.cn/zhengce/content/2015-11/20/content_10328.htm

2.10.5 LTC Insurance Scheme

100. Hebei (i.e., Chengde and Julu) is one of the provinces selected by the Ministry of Human Resources and Social Security to pilot LTC insurance¹⁰⁴ (Notice #80, 2016).¹⁰⁵ According to the Human Resources and Social Security, LTC insurance is to cover care for those who require assistance in activities of daily living and/or with disability. It will be closely linked to the current medical/health and social security insurance. It is based on risk pooling, shared responsibility and local affordability. Hebei will have to explore LTC insurance benefits, coverage (target population), fund pooling and payment to service providers and managing organization.
101. According to Julu, one of the county in Hebei for piloting sites for LTC insurance, the LTC premium is set at 50 Yuan per person per year. Employed residents will pay 10 Yuan per person per year whereas non employed residents pay 3 Yuan. The government's contribution to LTC insurance is by matching the premiums of the residents. The rest will be covered by medical insurance reserve, lottery fund etc. People with neuro-degenerative diseases (such as stroke, severe Parkinson's disease, severe dementia, etc.), in coma, end stage cancer, use of various types of catheter, unhealed fracture, etc., will be eligible. Eligibility will be determined by professionals accredited by Department of Human Resources and Social Security. Fee is set at 600 Yuan per assessment. Eligible LTC users will receive nursing care worth 2,700 Yuan per month (or 90 Yuan per day) in a Level 1 hospital, 3,600 Yuan per month in a Level II hospital and 1,500 Yuan per month in a residential care facility¹⁰⁶. When compared with LTC insurance scheme of Haidian, Beijing (see Section 3.1.11), Julu's scheme appears to be extraordinarily generous.
102. The establishment of LTC insurance has far reaching implications. Firstly, the directives require the development of LTC insurance management organization similar to Medicare and Medicaid Office in USA. This new organization will drive the development of a LTC/EC service system: assessment to determine eligibility, care planning, service coordination, quality monitoring through an impartial 3rd body, EC standards, EC information management, human resource development, etc. Secondly, it also provides sources of funding to ensure the sustainability of EC operation, both for profit and nonprofit operators. At the present time, LTC insurance may not be sufficient to cover all EC expenses. However, LTC insurance along with personal saving and family support, this may provide the incentives for more domestic and overseas EC investors to take part in EC. More players will create more competition, which in turn will lead to service users' excellence and EC system optimization.

¹⁰⁴ General Office, Ministry of Human Resources and Social Security (2016) Guidelines on Conducting Long-term Care Insurance (LCI) Scheme Pilot Projects (No 80, 2016). June 27, 2016.

¹⁰⁵ file:///Users/peterchan/Dropbox/ADB_Hebei/EC%20Sector%20Assessment/%E4%B8%AD%E5%8D%8E%E4%BA%BA%E6%B0%91%E5%85%B1%E5%92%8C%E5%9B%BD%E4%BA%BA%E5%8A%9B%E8%B5%84%E6%BA%90%E5%92%8C%E7%A4%BE%E4%BC%9A%E4%BF%9D%E9%9A%9C%E9%83%A8.html

¹⁰⁶ 巨鹿县人民政府关于建立长期护理保险制度的实施意见 (July 12, 2016).

3. CURRENT GOVERNMENT POLICIES ON EC

103. Ageing and EC is a large, fast growing and complex issue that China needs to manage. To contain this issues, government has developed many EC policies, however, its resources have been very limited. Government realizes it can no longer be able to tackle this issue by itself; it has to rely on the support of private capital/providers.

3.1 National policies

104. China has never been short of EC policies. The central government has issued many of EC legal framework and policies in the last 6 years, which can be found in Annex A. These EC policies are by no mean to be inclusive and can be largely grouped under the following themes:
- i. Rights and interests of the elderly
 - ii. Role of the government
 - iii. Target population of EC and types of EC services to be purchased by the government
 - iv. A three-tier EC system
 - v. RC Services
 - vi. HCBC Services
 - vii. Engagement of social organizations (NGOs)/private sector in EC
 - viii. Quality and human resources requirements of EC
 - ix. HR development
 - x. Health and EC integration.
 - xi. Long term care insurance
 - xii. EC facility construction standards and guidance
 - Code for construction of community adult day care for the elderly. (Annex A:50)
 - Code for design of a residential building for the elderly. (Annex A: 26)
 - Code for design of residential care home for the elderly. (Annex A: 15, 51)

3.1.1 Rights and interests of the elderly

105. The Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly¹⁰⁷ provides an overarching legal framework to protect the rights of the elderly in the PRC, including the rights to receive care and supports from their families¹⁰⁸ and from the government. Sections of the law that are particularly pertaining EC are:
- i. Section #30: developing *long term care* to address elderly with nursing care needs and providing a subsidy to those who are semi and totally dependent, and/or in financial destitute.

¹⁰⁷ 中华人民共和国老年人权益保障法 (2013) <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201302/20130200418213.shtml>

¹⁰⁸ It states that children or others with legal obligations of care to provide the elderly with financial, practical, and spiritual support. It also requires children to take care of the medical, practical and housing needs of the elderly.

- ii. Section #37: developing community care to address the care needs of activities of daily living (ADL), emergency assistance, medical and nursing care, mental health and counseling, etc.
- iii. Section #38: incorporating community care in town planning and developing services to meet the needs of elderly in their vicinity including ADL, cultural and recreational activities, day care, disease management and rehabilitation.
- iv. Section #41: priority of Government's EC services – widows, disabled and people in advanced age.
- v. Section #42: developing services standards for EC facility construction, service quality, manpower requirements, classification of EC facilities, service monitoring, and fee charging

3.1.2 Role of the government

106. The "Directives on good practice of government EC services purchasing (2014)" clearly stated the role of the government, which is to lead, plan, provide policy support and funding, and monitor and evaluate. The department of finance will lead the purchase of services. Civil affairs and other concerned parties are required to provide coordination. Local government is required to formulate service standards for EC services and organize regular monitoring and evaluation activities.

3.1.3 Target population of EC and type of EC to be purchased by the government

107. The law and government policies require the provision of EC services, especially those publicly funded to be prioritized and provided to those requiring *long term care: nursing and ADL, and/or with financial difficulties* such as the three-no, etc. This priority has been reiterated in 13FYP and the intended usage of publicly funded EC services is reflected in (1) "The Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly (2013)", and the (2) "Directives on good practice of government EC services purchasing (2014)" and (3) "Directives on the establishment of subsidizing system for impaired and old people with financial difficulties (2014)."
108. The "Directives on good practice of government EC services purchasing (2014)" clearly stated the type of EC services to be purchased by the government: 1) home care services include meal services, personal care, health services, and nursing care for old people eligible for government subsidies; 2) community care include day care, rehabilitation, and social-cultural-recreational activities; 3) residential care include residential care and nursing care for "three no's" and dependent and semi-dependent elderly people with low-income and financial difficulties; 4) training and continuous education for caretakers and nurses; and 5) needs assessment and evaluation of quality of services.

3.1.4 A three-tier EC system

109. The way how EC should be organized has been clearly covered by (1) 12FYP (2011), (2) 13FYP (2016), (3) "A development plan for EC system (2011)." (4) "Plan for the construction of the EC System" (issued by the General Office of State Council in 2011), and (5) "Opinions on speeding up the development of EC industry (2013)." Basically, these

policies require all levels of government to set up a three-tier EC system with “*home-care as the foundation, community services as backbones, and residential care facilities as supplements.*” All levels of government will have to meet the planning ratio of 9073 (or 9064) of the three-tier EC system that assumes 90% of elderly would have their needs been met with in-home services, 7% with community services and the other 3% with residential care service.

3.1.5 RC Services

110. Under the policy on the management of residential care (RC) (2013)¹⁰⁹, all RC operators are required to provide:

- i. clinical and nonclinical services: ADL/IADL, nursing, rehabilitation, mental health and social recreational activities (Section #9); ADL/IADL including eating, dressing, toileting, bathing, in and outdoor activities (Section #12); preventive health care including periodical functional and health assessment (Section #13); emergent health care and infection control (Section #14)
- ii. management support: risk and safety management (Section #17, 21, 22, 23 and 24); professional staffing requirements and qualifications (Section #19); privacy (Section #25) and periodical collection of users’ feedback (Section #26).

111. The law also requires local Civil Affairs Departments to:

- i. conduct a periodical comprehensive evaluation of RC operation: staffing, facilities, service, management and reputation (Section #29);
- ii. receive statistical reports by RC operators (Section # 30);
- iii. conduct on the spot inspection and make the inspection reports public (Section #28); and
- iv. handle service users’ complaints (Section #31).

3.1.6 HCBC Services

112. The Opinions on Advancing a comprehensive HCBC Services (2008) is the first formal policy guidelines regarding HCBC services, which was jointly issued by the National Committee of Aging (NCA), National Development and Reforms, Ministry of Education, Ministry of Civil Affairs, and Ministry of Finance¹¹⁰. The key points of the directive are summarized below:

- i. HCBC services include personal care, nursing care, homemaking services, cultural entertainment, and psychological counselling.
- ii. By the end of the 11FYP (2005-2010), all urban communities would have established HCBC service networks providing a wide range of HCBC services,

¹⁰⁹ 养老机构管理办法 (2013)<http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201306/20130600480076.shtml>

¹¹⁰ ADB. (2016). Technical report: Output 1: Home and Community Based Care. PPTA – EC development in Hebei province. p.4

80% of the townships set up a comprehensive elderly welfare service center providing residential and HCBC services, and one third of village committees and natural villages would establish a service center to provide cultural activities and services for the elderly.

- iii. For those who can come to the centers, the centers will organize social and cultural activities for them; and for those who are unable to take care of their daily activities, the centers or stations will arrange for their workers to make home visits and provide services to them at their own homes. It also encourages the establishment of community-based information platforms, hotlines, and emergency calls as channels for old people to seek support. The center will assess the eligibilities for old people for government subsidies, inspect the qualifications of care takers, monitoring and evaluate the quality of services, and receive complaints from service users.
- iv. Government is to encourage private sector participation in the provision of HCBC. Ultimately, all current HCBC services operated by the government should be outsourced to other NGO, private not-for-profit and private for profit organizations.

113. **The development of HCBC** got a boost when the State Council's "Opinions on speeding up the development of EC industry (2013)" was released. It required all urban communities to establish a day care center and an activity center for old people with defined quality standards; over 90% of townships and 60% of rural communities should have a comprehensive community service center in place, which include the provision of EC services by 2020¹¹¹.

3.1.7 Engagement of social organizations (NGOs)/private sector in EC

114. Government policies strongly encourage the involvement of social organizations such as NGOs and the private sector in the development of EC industry. The documents on (1) "A development plan for EC system (2011)" and (2) "Opinions on government purchasing services from social organizations (2013)" made the outsourcing of EC services to social organizations through service purchasing and contracts easier. The government will retain the role of service monitoring through the establishment of a clear and transparent performance management system. These policies also mandate all levels of government to develop a service purchasing system by 2020. The (1) State Council (Circular No. 35) re "Opinions on promoting the development of EC Industry, 2013", and (2) Civil Affairs (2016) directives on the promotion of active involvement of private capital in the development of EC industry¹¹² encouraged the engagement of private sector in EC industry through a fair market mechanism such as private public partnership (PPP).

¹¹¹ ADB. (2016). Technical report: Output 1: Home and Community Based Care. PPTA – EC development in Hebei province. p.6

¹¹² http://mp.weixin.qq.com/s?__biz=MjM5MjE0OTU5OA==&mid=2666147514&idx=1&sn=0b710c62f42832e3177bb9dfe990beb9&scene=5&srcid=0530H1v2HTqwPtc11TRoxie#rd

115. A number of preferential policies have been in place to attract the involvement of private sector including social organizations (NGO):

Tax reliefs

116. "The opinions on the implementation of private capital involvement in the development of EC industry (2015 [33]¹¹³", include tax exemptions in the following areas:

- i sales tax;
- ii capital gain
- iii corporate income tax
- iv property tax and urban land use tax on the lands or buildings used by the facility;
- v 100% reduction of administration fee for nonprofit and 50% for profit making organizations

Supports on land supply

117. The Ministry of Land and Resources' opinions on land use for EC facility (2014)¹¹⁴, provides the following supports on land use by EC organizations:

- i For nonprofit EC organizations, they could obtain the right of use of land by allocation at no cost and pay a difference in land cost should they decide to become a profit organization with the approval of the county government.
- ii For-profit EC organizations, they could obtain the right of use of land by leasing and/or auction if there are more than one competitor for land use.
- iii Land for RC should not exceed 3 acres whereas land for integrated RC, medical and health, rehabilitation should not exceed 5 acres
- iv There will be no charge for land cost differences for 5 years should an existing land or facility (e.g., school) be converted into an EC use land or facility

3.1.8 Quality and human resources requirements of EC

118. "The Law on elderly rights protection of PRC (2013)" mandates the State Council to establish standards for EC facility construction, services and manpower, including EC facility ranking (e.g., star). EC standardization is further operationalized by a joint directive issued by the Ministry of Civil Affairs, Standardization Committee of China (SAC), Ministry of Commerce, General Administration of Quality Supervision, Inspection and Quarantine of the People's Republic of China (AQSIQ) and The National Working Committee on Ageing: "Opinions on strengthening the standardization of EC (2014)"¹¹⁵ The directive is set to achieve an universal standard for all EC services, management and products covering HCBC and RC (Section #3.1). The opinions suggest the establishment of EC quality management and ranking (e.g., star) systems through accreditation and certification by an independent 3rd party (Section 3.4). Another

¹¹³ <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201502/20150200777798.shtml>

¹¹⁴ http://www.mlr.gov.cn/xwdt/jrxw/201404/t20140424_1313743.htm

¹¹⁵ <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201402/20140200585735>

important aspect of these opinions is the standardization of human resources training in EC especially for professional and managerial staff, as well as standardization of EC information sharing through the use information technology (Section #4.3). All these will first be proven through pilot and/or demonstration projects before a national roll out.

119. “The opinions on the implementation of private capital involvement in the development of EC industry the Ministry of Civil Affairs (2015)[33]” has also made the following suggestions to support the training of EC workers:

- i. To designate vocational training schools and EC organizations to develop EC workforce and to issue subsidy to those who complete the training and attain the license to practice.
- ii. To provide social insurance subsidy to those EC organizations offering employment to those who have difficulties in job finding.
- iii. To allow physicians and social workers to work in EC organizations.
- iv. To provide credentialing, registration and monitoring of professionals working in EC organizations, similar to that of public organizations.

120. “The Ministry of Civil Affairs’ opinions on introducing liability insurance to EC organizations (2014)¹¹⁶ requests better collaboration between insurance and EC sectors so that EC organizations will acquire liability insurance with government subsidy in insurance premium.

3.1.9 HR development

121. In responding to the State Council’s (Circular No. 35) “Opinions on promoting the development of EC Industry (2013), the Ministry of Education and Other Departments (including Ministry of Civil Affairs, National Development and Reform Commission, Ministry of Finance, Ministry of Human Resources and Social Safeguard, The National Health and Family Planning Commission, Central Civilization Office, The Central Committee of the Communist Young League, and National Aging Office) issued “Opinions on Accelerating personnel training for EC Services” on June 2014. These opinion set forth its working targets: by 2020, a vocational education-based, talents training system that linked up with applied undergraduate and graduate education for EC services are to be basically established. A talent team for EC with sufficient staff, sound structure and good quality is to be cultivated to accommodate and meet the needs of EC services. Following measures are considered:

- i. Speed up development of EC service specialized education system
- ii. Comprehensively improve quality of education and teaching quality that are related to EC service specialty.
- iii. Vigorously strengthen continued education EC service related specialists.
- iv. Actively facilitate students to be engaged in EC service

¹¹⁶ <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201403/20140300600030.shtml>

Another policy measure is to strengthen talents team cultivation for combined medical and ECs. Including link up with existing system for professional title appraisal, specialized technical, continued medical education, making no discrimination to medical personnel working in EC or combined medical and ECs institute

3.1.10 Health and EC integration

122. In response to The State Council (Circular No. 35) re “Opinions on promoting the development of EC Industry (2013), the National Health and Family Planning Commission and Other Departments (including The Ministry of Civil Affairs, National Development and Reform Commission, The Ministry of Finance, The Ministry of Human Resources and Social Safeguard, The Ministry of Land Resource, The Ministry of House, Urban & Rural Construction, National Aging Office, China Bureau of Chinese Traditional Medicine) issued the “Opinions on Health and EC Integration” (State Council, 2015 [84])¹¹⁷,” (hereinafter, call “Guiding Opinions). The Guiding Opinions set forth the following development targets:
123. By 2017, policy system, standard and management system on integrating medical & health care and EC are to be preliminarily established. Talent training system for integrating medical & health care and EC are to take its initial shape. A group of institutions with both certification and ability on medical & health care and EC (hereinafter called “integrated medical and ECs”) are in operation. The grass root institutes for medical & public health are to be gradually improved with ability to provide visiting service for elderly people. Over 80% of institutes for medical & public care are to be able to open green channels to facilitate the older people’s registration and seeking medical advice. Over 50% of EC institutes are able to provide medical & health care to the older people. Accessibility of older people to medical & health care and ECs are to be significantly increased.
124. By 2020, a comprehensive institutional mechanism, policy and legislation system conforming to Chinese national conditions are to be established. A combined and successive medical and ECs services network with shared resource, appropriate scale covering urban and rural areas, reasonable functions are to be formed. All institutes for medical & public care are to be able to open green channels to facilitate the older people’s registration and seeking medical advice. All EC institutes are able to provide medical & health care to the checked-in edged people. Demand of edged population for health and ECs are to be basically met.
125. The Ministry of Health and Family Planning’s opinions on health and social care integration (State Council, 2015 [84])¹¹⁸, along with other government directives such as “The opinions on the implementation of private capital involvement in the development of the EC industry, 2015 [33], support closer health and EC collaboration by forming formal collaboration agreement. Health care services offered in EC setting may be

¹¹⁷ http://www.gov.cn/zhengce/content/2015-11/20/content_10328.htm

¹¹⁸ http://www.gov.cn/zhengce/content/2015-11/20/content_10328.htm

covered by health insurance and vice versa. The government will also provide a subsidy for EC organization focusing on nursing care. Skills certification and the monitoring of health care employees in EC will be similar to those in health care setting.

3.1.11 Long term care insurance

126. According to the “Notice #80, 2016 – piloting LTC insurance”¹¹⁹ of the Ministry of Human Resources and Social Security, LTC insurance is to cover care for those who require assistance in activities of daily living and/or with disability. It will be closely linked to the current medical/health and social security insurance. It is based on risk pooling, shared responsibility and local affordability. Since the LTC insurance is new, a lot of details are unknown. What are known though:

- i. LTC fund will be created: initially, transfer a part of surplus of medical insurance pooling fund to the LTC fund. The next step is to explore the scheme of fund raising/contributions, perhaps, contribution from employers/employees, etc.
- ii. Population coverage: the initial target population will be the ones who has (urban) medical insurance.
- iii. benefits: the benefits seems to cover home-based services as well. The services, covered by the medical insurance, will not be covered by the LCT insurance.
- iv. existing social insurance management agencies appear to be expected to manage the LCT insurance.
- v. quality standards and management: who will be an insurer (local government?) is still unclear, but it looks an insurer is expected to manage and control the service quality.
- vi. private sector: the government wants to encourage involvement of the private sector, but what role the private sector is expected to play is not clear. Their responsibilities need to be aligned.

127. Haidian, Beijin has been experimenting LTC insurance scheme for some time. Here is the details of its LTC insurance scheme¹²⁰:

TABLE 11: LTC Premium in Haidain, Beijing

Age	Annual Premium pp (Yuan)	Government subsidy		Actual monthly premium pp (Yuan)	
		Urban	Rural	Urban	Rural
18-39	1140			75	65
40-59	1254 (1140 +10%)	20% of premium	120 Yuan annually	84	74
60+	1368 (1140+20%)			91	81

¹¹⁹ file:///Users/peterchan/Dropbox/ADB_Hebei/EC%20Sector%20Assessment/%E4%B8%AD%E5%8D%8E%E4%BA%BA%E6%B0%91%E5%85%B1%E5%92%8C%E5%9B%BD%E4%BA%BA%E5%8A%9B%E8%B5%84%E6%BA%90%E5%92%8C%E7%A4%BE%E4%BC%9A%E4%BF%9D%E9%9A%9C%E9%83%A8.html

¹²⁰ http://mp.weixin.qq.com/s?__biz=MjM5MTI2NTM2NA==&mid=2651255771&idx=3&sn=a1ab5050cfe87810f860722905c5c97a&scene=5&srcid=0901m1u7v7d9bhWo91gqV1PS#rd

128. Government subsidy is capped at 15 years. To be eligible for LTC insurance, one has to take part in the scheme for >15 years and to be assessed for LTC impairment. LTC benefits will be given according to levels of impairment: 900 Yuan for mild, 1400 for moderate and 1,900 Yuan for severe impairment per month.

3.2 PROVINCIAL POLICIES

129. HPG follows the EC policy framework of the central government, and faces the challenges of putting these policies into practice by giving practical advice and guidance to city and county governments within Hebei. For instance, preferential policies to promote private sector/capital involvement are spelled out in far more details at local level. Some of these policies can be found in Annex A. They are by no means to be inclusive and can be largely grouped under the following themes:

- i Plan to realize the three-tier EC system
- ii Government's role in EC
- iii Preferential policies in practice
- iv Health and EC integration
- v Long term care insurance pilot – Julu

3.2.1 Plans to realize the three-tier EC system

130. HPG follows the national plan of "9073." According to (1) "the Hebei's 12FYP for EC" and (2) "Opinions about accelerating the promotion of building an EC system by HPG", it was the HPG plan to meet the target of 9073 by the end of the 12th Five-Years Plan (from 2011 to 2015).
131. HCBC - Home-based services are: housework, activities of daily living, nursing, counseling, etc. The elderly can simply dial for services from home when they need. The community services mainly refer to adult day care, and also include community dining-room/canteen. In the urban area, adult day care and community canteen are to be integrated into the elderly community care center with in-home service center stations in the community and supported by the calling center. In the rural area, in-home and daycare services were to be provided through "Happiness (Xingfu) Garden".
132. RC – government will continue to achieve 3% RC rate. In addition, it was the government's plan to raise the proportion of privately operated RC beds to 50% by the end of the 12th Five-Years Plan as most existing RC facilities are public and primarily serve the vulnerable elderly.

Plans by 2020

133. In Jun. 2014, Hebei government issued another plan: "Opinions on accelerating the development EC(2014)." The new goals included: by 2020, (a) to develop community EC centers with in-home stations covering of all urban communities, 90% of townships; and

through Happiness Gardens in all villages; (b) to increase the proportion of RC beds by as much as 3.5% of the elderly population, (c) to increase the proportion of EC managers (100%) and care workers (>90%) with license to practice; (c) to make the private sector become the major EC provider.

134. Under the plan, a number of new initiatives pertaining to RC are:

- i. lowering the thresholds required to start an EC facility such as registered capital, land, and staff, so as to enable more private capital;
- ii. helping EC investors/providers to get finance by guaranteeing, interest subsidizing, and extending the scope of collaterals, expanding the credit supply for EC;
- iii. encouraging the insurers to offer the third party liability insurance for RC and long-term care insurance, and subsidizing premiums for insured institutions;
- iv. piloting reverse mortgage for elderly;
- v. trying various types of public-private-partnership (PPP) by separating finance, construction and operation, such as management contracts, transfer-operate-transfer (TOT), build-operate-own (BOO) etc.

3.2.2 Government's role in EC

135. EC has transitioned from “a welfare function” to “an industry concept”. The former focuses on the vulnerable elderly whereas the latter implies the creation of a favorable environment to involve private capital in the delivery of EC. Such a conceptual shift can be reflected in the provincial plans and the following policies:

- i. Public fund will be used to mainly support the most vulnerable elderly, whereas other elderly should meet their needs by using private EC services and/or paying for their services. Accordingly, the public EC facility must give priority to the “three-nos”, low-income elderly and impaired elderly, even though they are allowed to admit others as well.
- ii. The government will continue to focus on building EC infrastructure and standards, while more direct services and management work will be contracted out to private sectors or existing public EC operators, instead of being managed directly by government departments.
- iii. The government will use the leverage of various policies to get more private capital involved in the development and operation of EC, such as tax reliefs, fees remissions on public utilities, and support on land supply and subsidies to reduce the startup and running costs of EC. The government also adopts the principle of “value creation for EC investor and operators”, and a non-discriminative policy by welcoming all sorts of investment: sole, joint or partnership, regardless of whether they are domestic or overseas organizations.

3.2.3 Preferential policies

Tax reliefs

136. According to the “Notice of implementing tax reliefs for promoting the development of EC organization by the HPG, to be eligible for the tax reliefs, the organization should be

- i. welfare or nonprofit in nature;
- ii. registered with local Bureau of Civil Affair and licensed;
- iii. providing EC including activities of daily living, nursing, cultural and recreation activities.
- iv. registered with the local tax offices within 30 days after licensed.

137. The exemptions include the following items:

- vi sales tax on the charge for accommodation, catering, nursing and medical services;
- vii property tax and urban land use tax on the lands or buildings used by the facility;
- viii corporate income tax on donation income, subsidies from the government (excluding the government’s purchase), and interest accrued from the exempted income;
- ix agriculture usage tax if the organization needs to be built on farmland;
- x deed tax if the organization needs to lease buildings from public sectors.

138. In addition, any corporations, organizations or people who donate to the EC institutions can also receive a tax exemption for income donated. The amount can be deducted from the taxable income before taxation. The amount of donation cannot exceed 12% of the donor’s income.

Fees remission on public utilities

139. According to the document “Notice about Implementing the Policies on Price Charged to Elderly Service Institutions” issued by provincial bureau of price (2011), the rate of public utilities charges including water, gas, heating, telephone, television and internet, charged to welfare or nonprofit EC organizations, should be similar to that of other community residents. If the current rate charged to the EC organizations is lower than the rate of the residents, the current rate remains unchanged. In addition, the rate of water, electricity, gas and heating charges to in-home services providers, should be similar to the rate of the residents as well.

Awards and subsidies

140. According to the “Opinions on implementing the rewards and subsidies for EC organizations” issued by the Department of Civil Affairs (2012[81]) and the Department of Finance, the government will subsidize the EC organizations in the form of rewards if they meet certain conditions. There are two types of subsidy that the organizations can quality for.

141. The first type is called “one-off construction subsidy”. If an EC facility is built by using owned capital and meeting certain conditions, the institution can apply for this subsidy. The subsidy will be no less than 1,500 CNY per bed, and no more than 1 million CNY for each facility. The conditions for applying this subsidy include:
- i built after Jan. 1, 2012 and has been in use;
 - ii in operation for >1 year and passing the annual check;
 - iii having >50 beds and meeting the building standards for EC facility issued by the Ministry of Civil Affairs;
 - iv registered with the Department of Civil Affairs; and
 - v having not receiving this subsidy before.
142. The second type is “subsidy for bed in operation”. If an EC organization has been in operation for >1 year continuously and meet certain conditions, the organization can apply for this subsidy. The subsidy for each bed should be <50 Yuan per month, and the total amount should be based on the number of beds occupied by elderly whose hukou are registered in Hebei Province. The conditions for receiving this subsidy include:
- i in operation for >1 year and passing the annual check;
 - ii having no grave safety concern or serious disputes with service users within the past year;
 - iii >30 elderly living in the facility each month;
 - iv >90% service users satisfied with the service within the past year; and
 - v using the EC MIS of Hebei Province and updating users’ information monthly.
143. It is the provincial Department of Civil Affairs and Finance that will jointly decide whether to provide a subsidy to the applicants. However, the subsidy funding is shared by provincial, municipal and county-level finance. The local governments can provide a subsidy to a facility with <50 beds, provided that they come up with their policy and own funding.
144. The subsidies can only be used to improve the living conditions of the facility and/or to purchase equipment. The government may withdraw the subsidy if the subsidy is not used for the purposes designated. It is the responsibility of local Bureaus of Civil Affairs and Finance to monitor the use of subsidy.

Support on land supply

145. The “Notice of land supply for the construction of EC facility” issued by the Department of Land and Resources (2011[40]) and the Department of Civil Affairs provides supporting policies on land supply for EC organizations in Hebei Province. The key measures of the notice are:

- i the land for building EC facilities should be listed in the annual supply plan as a priority;
- ii the approval of an application for building elderly service facilities should be expedited;
- iii for new nonprofit EC organizations, they could obtain the right of use of land by allocation at no cost;
- iv for profit EC organizations, they could obtain the right of use of land by auction at market rate; and
- v the village committees could use the lands owned to build EC facilities at no cost if they got the permit.

Liability insurance

146. To comply with the central government directive on “introducing liability insurance to EC organizations”¹²¹, all EC organizations including public organizations have to obtain liability insurance to cover (1) accidental injury or death, (2) litigation expenses and (3) 3rd party liability insurance. The premiums of liability insurance are based on an agreed flat rate per bed.

3.2.4 Health and EC integration

147. According to “the methods of establishing health care services in EC setting as proposed by Hebei’s Department of Health and Family Planning and Department of Civil Affairs”¹²² 2014 [62]), health and EC integration takes place through the following methods:

- i To develop nursing, rehabilitation and end of life care in RC of >500 bed
- ii To allow county’s Health Authority to approve the establishment of health care services in EC setting
- iii Health Authority to assist the development of health care services with EC setting and to encourage physicians to visit and to give a talk, health care trainees to practice and graduates to seek employment in EC setting.
- iv To encourage EC to form a strategic alliance with health care sector.
- v To develop a green pathway between RC and Level II hospital so that residents can be transferred back and forth between health and EC sector seamlessly.

3.2.5 Long term care insurance

148. Hebei (i.e., Chengde and Julu) is one of the provinces selected by the Ministry of Human Resources and Social Security to pilot LTC insurance (Notice #80, 2016).^{123&124} Hebei

¹²¹ The Ministry of Civil Affairs’ opinions on introducing liability insurance to EC organizations, (2014) <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201403/20140300600030.shtml>

¹²² http://blog.sina.com.cn/s/blog_48e79ec30102wc8b.html

¹²³ General Office, Ministry of Human Resources and Social Security (2016) Guidelines on Conducting Long-term Care Insurance (LTCI) Scheme Pilot Projects (No 80, 2016). June 27, 2016.

¹²⁴ file:///Users/peterchan/Dropbox/ADB_Hebei/EC%20Sector%20Assessment/%E4%B8%AD%E5%8D%8E%E4%BA%BA%E6%B0%91%E5%85%B1%E5%92%8C%E5%9B%BD%E4%BA%BA%E5%8A%9B%E8%B5%84%E6%BA%90%E5%92%8C%E7%A4%BE%E4%BC%9A%E4%BF%9D%E9%9A%9C%E9%83%A8.html

will have to explore LTC insurance benefits, coverage (target population), fund pooling and payment to service providers and managing organization.

149. According to a document issued by Julu government (see Section 2.10.5), LTC premium will be jointly paid by the residents, the government and public funds such as medical insurance reserve, lottery fund etc. Eligible LTC users will receive nursing care worth 2,700 Yuan per month (or 90 Yuan per day) in a Level 1 hospital, 3,600 Yuan per month in a Level II hospital and 1,500 Yuan per month in a residential care facility.¹²⁵

¹²⁵ 巨鹿县人民政府关于建立长期护理保险制度的实施意见 (July 12, 2016).

4. AFFORDABILITY OF CURRENT AND FUTURE EC SERVICES

150. EC affordability, the extent to which EC is affordable as measured by its cost or price relative to the amount that the purchaser/user is able to pay. A few key factors affect EC affordability: EC fee charges, willingness of the elderly to pay or purchase EC, income of the elderly, children support and government subsidy.
151. Table 12 shows the current RC fees as identified by the IAs PPTA, which, more or less, reflected the overall RC fees in Hebei. The rough average of RC fee for independent elderly is about 1350 Yuan per month, semi-dependent is about 2,300, and total-dependent is about 2,600. EC fees in rural Hebei are much lower. For instance, in rural Julu, the Happiness Gardens charge 600 Yuan per month for independent elderly, 1,200 Yuan for semi dependent and 1,500 for total-dependent. In addition, Department of Civil Affairs provides 300 Yuan subsidy per month. It is almost half of the charges of urban area.

TABLE 12: Current RC Fees in different regions of Hebei

Regions	Fee charges per month (Yuan)		
	Independent	Semi-dependent	Total-dependent
Julu ^{*126}	1,200 – 2,600		1,500 – 3,000
Lixian ¹²⁷	1,200 – 1,600		1,800 – 2,300
Shexian ¹²⁸	800 – 1,200	1,500 – 2,000	2,200 – 2,500
Shuangluan ¹²⁹	1,300 – 1,800	2,000 – 3,500	3,000 – 5,000
Xinji ^{**130}	3,000		3,300
Zunhua ¹³¹	900 – 1,500		1,400 – 2,100

* meal and medical fee not included

** multi-bed room

152. Future EC fees can be showed in the proposed fee schedules by the IAs of this PPTA. Table 13 and 14 are the proposed RC and HCBC fee when all EC projects are completed and in operation. In general, the rough average of future RC fee for independent elderly will be about 2,060 Yuan¹³², 52% higher than the current rate of 1350 Yuan per month. It will be 2,720 Yuan for semi-dependent, 18% higher than the current rate of 2,300 Yuan; 3,150 Yuan for total-dependent, 21% higher than the current rate of 2,600 Yuan. For dementia care and rehabilitation, it will be about 2,640 Yuan. The fee schedule of HCBC is new in Hebei, it will be hard to make a historical comparison.

¹²⁶ Julu's FSR. Aug 2016. p. 101

¹²⁷ Lixian's FSR. Aug 2016. p. 202

¹²⁸ Shexian's FSR. Aug 2016. p. 34

¹²⁹ Shuangluan's FSR. Aug 2016. p. 31

¹³⁰ Xingjin's FSR. Aug 2016. p. 26

¹³¹ Zunhua's FSR. Aug 28, 2016. p. 289

¹³² $= (2800 + 1600 + (1500 + 2100) / 2) / 4$

TABLE 13: Future RC fee schedule by Districts as proposed by IA of this PPTA

Districts	RC fee charges per month (Yuan)			
	Independent	Semi-dependent	Total-dependent	Dementia Care
Julu ^{*133}	-	3,000 – 3,500	3,300 – 3,800	3,900 – 4,000
Lixian ¹³⁴	2,800	3,300	3,400 – 3,600	3,800 – 4,000
Shexian ¹³⁵	-	1,500	2,000	2,500
Shuangluan ¹³⁶	1,600	2,550	3,550	-
Xinji ¹³⁷	-	3,000 - 3,500	3,000 - 3,500	3,000 - 3,500
Zunhua ¹³⁸	1,500 – 2,100	2,300 – 2,600	3,000 – 3,200	2,000 – 2,500

* heating fee 500 Yuan extra

TABLE 14: Future HCBC fees schedule by Districts as proposed by IA

Districts	HCBC fee charges for HCBC (Yuan)			
	Adult Day Care	Home Care	Rehabilitation	ICT
Julu ¹³⁹	50 per day ^{***}	20 per visit	5 -10 per 40 min	2 per order
Lixian ¹⁴⁰	50 per day ^{***}	20 per visit	10 -15 per 40 min	2 per order
Shexian ¹⁴¹	40 per day	100 per day	-	-
Shuangluan ¹⁴²	50 per day	100 per day*	20 – 110 per 20 – 45 min	4 – 6 per month
Xinji ¹⁴³	40 per day	50 per visit	-	-
Zunhua ¹⁴⁴	67 per day ^{**}	60 per day	130 per visit	300 per elderly

* = 1800K/50/360

** = 2,000/30

*** = 1500/30

153. The study in Chengde and Zunhua asked about the maximum amount of money that the elderly are willing to pay for the RC, HCBC and Adult Day Care services. For RC, 14% were willing to pay less than 600 Yuan per month, 35% pay 601 – 1200 Yuan, 35% 1201 – 2400 Yuan and 16% over 2401 Yuan.¹⁴⁵ For adult day care: 48% of the elderly are willing to pay less than 100 Yuan, 33% 101 – 500 Yuan and 19% over 501 Yuan per month¹⁴⁶. The top three HCBC services wanted were housekeeping (30%), meal delivery (23%) and personal care (23%). 70% of the elderly are willing to pay 500 Yuan and more for personal care, 65% for housekeeping service and 52% for meal delivery.¹⁴⁷ In light of the highest fee that the elderly are willing to pay, comparing with that were proposed by

¹³³ Julu's FSR. Aug 2016. p. 102

¹³⁴ Lixian's FSR. Aug 2016. p. 202

¹³⁵ Shexian's FSR. Aug 2016. p. 180

¹³⁶ Shuanglun's FSR. Aug 2016. p. 178

¹³⁷ Xingjin's FSR. Aug 2016. p. 101

¹³⁸ Zunhua's FSR. Aug 28, 2016. p. 289

¹³⁹ Julu's FSR. Aug 2016. p. 213

¹⁴⁰ Lixian's FSR. Aug 2016. p. 202

¹⁴¹ Shexian's FSR. Aug 2016. p. 180

¹⁴² Shuanglun's FSR. Aug 2016. p. 178The

¹⁴³ Xingjin's FSR. Aug 2016. p. 101

¹⁴⁴ Zunhua's FSR. Aug 28, 2016. p. 289

¹⁴⁵ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126). Table E1.4 (Chi Square)

¹⁴⁶ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126). Table D5.1 (Chi Square)

¹⁴⁷ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126). Table B5.1 & B5.2 (Chi Square)

the IAs, both RC and adult day care fees are higher than what the elderly are willing to pay. Fees for HCBC are on par. People are willing to pay for more in personal care than housekeeping and meal delivery.

Table 15: HCBC Service Wanted and Highest Fee to Pay (Chengde & Zunhua)

HCBC Services Wanted	Highest Fee to Pay					Total
	0	20-100	101 - 500	501 – 1,000	Over 1,001	
Housekeeping	0	2	39	42	37	120
Meal delivery	0	1	44	29	19	93
Personal care	2	0	25	30	35	92
Congre. meals	0	2	36	9	5	52
Calling service	8	6	3	6	1	18
Escort service	0	0	5	2	4	11
Night care	0	0	4	1	4	9
Other	0	0	1	2	0	3
Total	10	11	157	115	105	399

154. Another independent study by the IA of Shexian found that out of the 100 elderly surveyed, 53% considered the following RC fee schedule reasonable: independent: below 1,000 Yuen, semi-dependent: below 2,000 Yuan, and total dependent below 2,500 Yuan, reasonable. 40% considered the following RC fee schedule reasonable: independent: 1,000 -1,500 Yuan, semi-dependent: 2,000 – 2,500 Yuan and total-dependent: 2,500 -3,000 Yuan. 7% were willing to pay an even higher rate.¹⁴⁸ Shexian proposed RC fee schedule of 1500 – 2500 Yuan appears to be on par with the amount that the elderly surveyed were willing to pay.
155. People's income affects their ability and willingness to purchase EC services. Presumably, people with higher income are likely to purchase services when needed. Based on the information of Table 17¹⁴⁹, most of the people may have sufficient income to cover the current fee but not future RC fee for independent living, both urban and rural. Future fee charges for independent living in a RC will see a 50% increase by 2020 - 21 when the proposed EC projects are in operation. People's 2013 disposable income, either in urban or rural Hebei, would be insufficient to cover RC fees for care at semi and total dependence levels. Elderly income as depicted in the Xinji study is even gloomier. The average monthly income of elderly in Xinji was about 756 Yuan with male (1,089 Yuan) has an average income higher than female (522 Yuan). 1/3 of the elderly had a monthly income of less than 100 Yuan.¹⁵⁰

Table 16: Monthly Disposal Income Per Capita in Hebei (2013)

District	Total Pop (10,000)	Annual Disposal Income (Yuan)	
		Urban	Rural
Hebei	7,332.61	1,852**	765

¹⁴⁸ Shexian FSR, Aug 2016. P.36

¹⁴⁹ Yu Qingnian (2016). Social Study Report, Hebei EC System Development. A report prepared for ADB (Contract # 114860 - S83126). Slide 5

¹⁵⁰ Xu Yuebin, Chen Lin and Wang Xiaobo. (2016). *Assessing Care needs of Urban Community Dwelling Elderly People in Xinji*. Asian Development Bank: SC 106398 PRC: Preliminary Survey Work to Support Development of the Hebei EC Development Project. Table 4.3.3 & 4.3.4

Julu*	41.29	1,371	435
Lixian (Boarding)	1,141.63	1,646	720
Shexian (Handan)	932.51	1,722	776
Shuangluan (Chengde)	351.51	1,575	503
Xinji	62.69	1,888	926
Zunhua	73.17	1,778	741

*Based on 2010 data

**=22,226/12

156. According to a report prepared for ADB in 2014, financial difficulty is the most important factor that one will consider when making a choice of RC. Most pensioners would be unable to afford RC costs, given the monthly average pension of 1,721 Yuan in 2012 for retirees from private sector, let alone those elderly receiving their government pensions from the urban residents' and rural schemes¹⁵¹. This is also echoed by the Xinji study, among those who had out-of-pocket expenditures on services, 51% were paid by self/spouse, and another 45% paid by children. For those who have unmet needs, over a half reported they cannot spend any money to purchase service, less than 30% can pay 500 Yuan, and only a small number are able to pay more than 1,000 Yuan per month¹⁵². According to the focus group meetings as conducted by this PPTA¹⁵³, if the elderly have a stable and sufficient source of income of their own such as pensions, they would consider moving into a RC. However, if they need financial support from children to do so, they would wait until they are severely impaired for they believe their children, by that time, may agree to do so¹⁵⁴ and would be willing to spend the money. The situation in rural community is slightly different most young people are migrant workers and cannot take care of their parents.
157. Thus, based on individual income and EC charges, many elderly people could not afford EC. The future EC fee schedules as proposed by the IAs, which will see a significant increase, will be even more unreachable. EC, however, may be more affordable if other incomes of the elderly are taken into consideration. These other incomes, in addition to that of the elderly include (1) support from children; (2) social/health insurance system such as long term care insurance; (3) liquidation of asset e.g., home (4) and government subsidy including significant increase in public pension amount.
158. The good new is that despite expressed concerns about 3 Nos. and empty nest elderly, a great majority of the elderly surveyed by this PPTA living with their children and/or at least having one child living in the same community. 56% and 14% of the elderly in Xinji and Chengde/Zunhua relied on the support of the children as sources of their income. The IA of Lixian is the only IA that studied children's willingness to pay (WTP) for EC

¹⁵¹ Xu Yuebin (2014). The EC system in China. ADB SC#102836. p.7

¹⁵² Xu Yuebin, Chen Lin and Wang Xiaobo. (2016). *Assessing Care needs of Urban Community Dwelling Elderly People in Xinji*. Asian Development Bank: SC 106398 PRC: Preliminary Survey Work to Support Development of the Hebei EC Development Project. Section 8.4

¹⁵³ Results of focus group meetings conducted by this PPTA in Xinji in Jan, 2016.

¹⁵⁴ Most participants in the urban community, sending parents to an old-age home as a non-filial behavior.

services for the parents, both RC and HCBC (adult day care), which is shown as Table 16.¹⁵⁵ Close to 76% of the children were willing to pay 3,000 – 3,500 Yuan and 73% 100-200 Yuan for RC and Adult day care respectively.

TABLE 17: Children's Willingness to Pay for EC for Parents in Lixian

Adult day Care			Residential care		
Fee range per month (Yuan)	#	%	Fee range per month (Yuan)	#	%
Under100	1	1.0	500 – 1,000	4	4.0
100 – 200	69	73.0	1,000 – 1,500	2	2.0
200 – 250	8	8.0	1,500 – 2,000	9	10.0
250 – 300	14	15.0	2,000 – 2,500	2	2.0
Above 300	1	1.0	2,500 – 3,000	0	0.0
N/A	2	2.0	3,000 – 3,500	71	76.0
			3,500 – 4,000	3	3.0
			4,000 – 5,000	2	2.0
Total	95	100.0	Total	93	100.0

*Based on children's willingness to pay for their parents

159. Another positive development is long term care insurance. Hebei (i.e., Chengde and Julu) is one of the provinces selected by the Ministry of Human Resources and Social Security to pilot LTC insurance.¹⁵⁶ So far the information about LTC insurance is still scattering. According to Julu government, the LTC premium is set at 50 Yuan per person per year. Employed residents will pay 10 Yuan per person per year whereas non employed residents pay 3 Yuan. The government will find ways to cover the difference. This appears to be very affordable. Eligible LTC users will receive nursing care worth 2,700 Yuan per month (or 90 Yuan per day) in a Level I hospital, 3,600 Yuan per month in a Level II hospital and 1,500 Yuan per month in a RC facility¹⁵⁷. LTC insurance will also covers HCBC. If what Julu's proposed to do is true, LTC insurance along with income, EC appears to be affordable.
160. 40% and 68% of the elderly surveyed owned their own house in Xinji, and Chengde/Zunhua respectively. However, due to mindset and tradition, many elderly are reluctant to liquidate their most valuable asset to support EC. Instead, many them prefer to preserve their asset for their children and grandchildren. There has been reverse mortgage which helps elderly to liquefy their home into monthly income, which can be pay for their care, if necessary. However, reverse mortgage has yet been a popular product among the elderly¹⁵⁸. More education may be needed.
161. Government subsidy priority is to help the destitute with no family support. This is done through *Wubao* (5 Guarantees) and *Dibao*. There are many other EC subsidies that are stipulated in Section 2.3. In general, subsidy is relatively small. For instance, HCBC subsidy for people aged 80+ is 30 Yuan in Zhangjizkau, which may be just sufficient to

¹⁵⁵ Lixian's FSR. Aug 2016. p. 200

¹⁵⁶ file:///Users/peterchan/Dropbox/ADB_Hebei/EC%20Sector%20Assessment/%E4%B8%AD%E5%8D%8E%E4%BA%BA%E6%B0%91%E5%85%B1%E5%92%8C%E5%9B%BD%E4%BA%BA%E5%8A%9B%E8%B5%84%E6%BA%90%E5%92%8C%E7%A4%BE%E4%BC%9A%E4%BF%9D%E9%9A%9C%E9%83%A8.html

¹⁵⁷ 巨鹿县人民政府关于建立长期护理保险制度的实施意见 (July 12, 2016).

¹⁵⁸ http://ijbssnet.com/journals/Vol_6_No_8_1_August_2015/18.pdf

pay for bathing service in designating community center – 30 Yuan.¹⁵⁹ Government pension, if any, is still relatively small in China. A quarter of the people in Xinji study did report to live on pensions. However, 80% of the respondents received a public pension (resident pension) of less than 100 Yuan per month.¹⁶⁰ All know that China need to profoundly improve its public pension system so that people can allocate their monthly pension towards EC service which is vital for a vibrant EC market.¹⁶¹ However, this is easier said than done, a small increase in pension will add significant burden to the government.

Local authorities have sought to protect the most vulnerable older people with the highest needs, while at the same time encouraging others to be independent, drawing on the resources of their families and communities, and to reduce dependence on support from the state. For many people the experience of needing to find and pay for care comes as an unpleasant surprise for which, in general, they are unprepared. Unpaid carers will also be expected to do even more.

Access to care depends increasingly on what people can afford – and where they live – rather than on what they need. This favors the relatively well-off and well informed at the expense of the poorest people, who are reliant on an increasingly threadbare local authority safety net – especially if they live in areas where local authorities have been least able to sustain spending levels – and who are at a higher risk of declining quality and provider failure.

Government needs to be honest. If the government is unable to provide more funding to support the elderly. Then, it should be clear to the public that primary responsibility for funding care sits with individuals and families and create incentives for people to plan ahead for their care needs

¹⁵⁹ http://hebei.hebnews.cn/2014-11/19/content_4326874.htm This is based on 2014 data.

¹⁶⁰ Xu Yuebin, Chen Lin and Wang Xiaobo. (2016). *Assessing Care needs of Urban Community Dwelling Elderly People in Xinji*. Asian Development Bank: SC 106398 PRC: Preliminary Survey Work to Support Development of the Hebei EC Development Project. Section 8.4

¹⁶¹ Christian J. (2015). China's Senior Care Market. Rubicon Strategy Group. www.HealthIntelAsia.com p.5

5. APPROPRIATENESS OF EC SERVICES MODALITIES

5.1 The concept of EC in China.

162. EC in China embraces various services for seniors including (1) services for the general elderly: social and recreational activities, finance, health and wellness, housing, safety and security, transportation, etc. and services for older people with care needs: HCBC, RC and medical rehabilitation center. This seems to give people an impression that when one get old in China, one will need care that include all the above services. With the new LTC insurance, the concept of EC will not get clearer. People will be confused what constitute EC and what constitute LTC. It may get clearer if LTC is for people with care needs and EC is for people with no care needs.
163. In other countries, HCBC and RC services are mainly for people who encounter daily functional limitations due to physical and/or cognitive impairments, e.g., stroke or dementia, etc. Thus, “HCBC and RC” in these countries are referred to as “Long Term Care (LTC),” as most service users are likely to use HCBC and RC services over a long period of time. In other countries such as United Kingdom (UK), which tries to differentiate the cost of providing care to persons with functional limitations from cost of providing health care in general, these services are called “social care”. Users of social care are people with long term conditions (chronic conditions). In UK, social care is under the jurisdiction of municipal governments whereas health care is the jurisdiction of central government (National Health Services in UK). To be eligible for publicly funded long term care or social care, the prospective users, will have to go through stringent assessment to determine the presence and level of functional impairment. Age is only a secondary determinant. This is to ensure only those prospective users who have functional limitations, are eligible for HCBC and RC. Ability to perform activities of daily living (ADL) such as mobility, toileting, grooming, eating etc., and/or instrumental activities of daily living (IADL), e.g., meal preparation, phoning, taking medication, banking etc. are being used to determine functional limitations. In recent year, due to increasing number of older people with cognitive impairment, e.g., dementia, cognitive limitation has also been included.
164. A mixed use of concepts can cause unrealistic public expectation. People can easily be misled to believe that they will be entitled to care when they get old whereas indeed, what they may get is general service for older people. Unrealistic public expectation may then lead to frustration and anger, and may be costly to the society. One of the reasons that UK relinquished the use of “long term care” but “long term conditions” (chronic conditions) was to avoid people expecting care when they have had long term condition(s). Many long term conditions, especially at their onset stage, do not require care at all.

5.2 Overarching guiding principles

165. China does not lack a policy and legal framework. However, EC stakeholders, government and nongovernment, do lack a clear overarching vision and good understanding on the following guiding principles: “Aging in Place”, “de-institutionalization” and “Active aging”. International good practices in developing EC systems that improve the quality of life for the elderly and significantly reduce the costs of long-term care follow three guiding principles. These include promoting: (i) aging in place by creating an enabling environment for elderly to remain at home, in their communities, supported by adequate services; (ii) “de-institutionalization” by developing systems that promote use of residential care facilities only for those in need of residential care services and (iii) active aging by supporting preventive health and social care programs that keep the elderly healthy and as contributing members of their communities. Application of these principles requires an appropriate balance of RC and HCBC services.

5.3 Demand for EC

166. Government planning capacity for EC at the local level is still limited. EC plans are rarely based on sound community and individual EC needs assessments. Projection of RC and HCBC demands are largely relied on the formula of 90:7:3 - 90% of the elderly to be cared at home, 7% in the community and 3% at RC setting. This may be based on past trend. However the projections of future EC need based on past trend and current usage can be misleading. As general health status of the elderly improves, factors such as shorter period of disability in older age and a reduction of the severity of disabilities; better environmental design and health care are leading to declining need in EC especially among OECD countries.
167. This PPTA conducted two EC need surveys, one based on LTC impairment in Xinji and one on elderly expressed EC need in Shuangluan/Zunhua. Xinji study showed 3.9% (2.8 - 5.3% at 95% confident level) of elderly in need of RC whereas 27% (24 - 30% at 95% confident level) in need of HCBC¹⁶². However, if the EC need is based on individual expressed need such as the study in Chengde and Zunhua, 4% of the elderly expressed their RC need at the time of survey. 1/3 of the elderly surveyed would never consider RC at all. The rest did not need RC at the time of survey but might need in future.¹⁶³ As far as HCBC is concerned, 50% of the elderly surveyed expressed need of HCBC and 50% did not. Whether in Xinji or Shuangluan/Chengde, RC need is on par with the national 9073 formula. The situation of HCBC is slightly different. However, it is a different story in need of HCBC.

¹⁶² Xu Yuebin, Chen Lin and Wang Xiaobo. (2016). *Assessing Care needs of Urban Community Dwelling Elderly People in Xinji*. Asian Development Bank: SC 106398 PRC: Preliminary Survey Work to Support Development of the Hebei EC Development Project. Table 6.4.1

¹⁶³ Shuangluan FSR Aug 2016, p.42

5.4 EC target population

168. Currently, EC has been widely used by the following target groups: (1) those who are alone due to one child policy – either these elderly lost their only child or their only child is severely disabled; (2) the 3 Nos who cannot work, no supporter or their supporters have below minimum income; (3) disability and (4) veteran or people who have made significant social contribution. Other than people with disability, use of EC to provide care for other target groups: 1, 2, & 4 is inappropriate and wasteful and may even be harmful.
169. Section #30: of the Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly, “Directives on good practice of government EC services purchasing (2014)”, “Directives on the establishment of a subsidizing system for impaired and old people with financial difficulties (2014)” and the 13FYP, state that public funded EC is to address elderly with nursing care needs and to provide a subsidy to those who are semi and totally dependent. Despite clear legal requirements and policy directives, such a requirement has not been properly observed in practice. Firstly, there is no centralized assessment system to determine service eligibility. Thus, many current EC users in Hebei have no obvious caring need. Secondly, subsidies of EC services are not well-targeted, they are given to the service providers rather than the service users, and they are not based on need. There is no incentive for EC operators to offer complex EC services.
170. The recently announced LTC insurance pilot project clearly stipulated target population of EC, which is to cover people requiring care in activities of daily living. Two of the IAs: Shuangluan (Chengde) and Julu have been selected as pilot sites in Hebei. Julu’s LTC insurance covers those with severe Parkinson’s disease and dementia, late stage rheumatoid arthritis, comatose, end stage cancer, permanent catheterization (gastro feeding, tracheostomy tube, etc.), unhealed fracture, paralysis, etc. (Section 7). LTC insurance eligibility will mainly be based on the results of ADL assessment by specialists designated by the County’s Human Resources and Social Security Department (Section 8). The introduction of LTC insurance will eventually shift the focus of EC from a general to a more targeted elderly population. Eligibility of EC will be focused on frail and disabled elderly. Hopefully, the LTC insurance will be a more powerful mechanism than policies in refocusing the target population of EC.
171. Government funding mechanism has to be reformed to address unmet elder care needs. Apart from shifting the general eligibility criteria of the 3 ‘No’s to the care of more elderly population with disability, increasing capacity of the EC providers is another direction of change by integrating medical and EC services, which would expand the function of RC and HCBC to deliver both medical, health and social care to the frail elderly at home, in the community and residential facilities¹⁶⁴.

¹⁶⁴ Report on “LTC for Elderly in Asean Plus Three: Research and Policy Challenges”. Organized by Changing Families in Asia Cluster, Asia Research Institute, National University of Singapore. March 1-2, 2016. p. 24

5.5 HCBC

172. Hebei EC is based on 9073 and a three-tier system: “home-care as the foundation, community services as backbones, and residential care facilities as supplements.” In practice, allocation of EC resources does not follow the proposed mix. It is RC lopsided, HCBC services to support older people in their homes and their communities is only a very small portion of EC resources. In addition, local governments tend to prioritize their resources for the expansion of RC and/or infrastructure HCBC neglecting investment in HCBC services.
173. In China, home-care services are often differentiated from community-based services. The former is often used to refer services that old people receive at their own homes, which may be delivered to them by specialized service agencies such as the privately operated housekeeping or home-care service agencies. The latter is usually referred to as services operated in and by the community where the elderly lives such as the community elderly center/stations, day care centers, and some small scale (<50 beds) RC facilities in the community. Services cover a wide range of services such as homemaking, meal service, rehabilitation and nursing care, and spiritual support. Street or resident committees usually manage these services. The daycare centers serve frail older people whose children cannot take care of them during the workday. In many places, such centers can also provide care for old people for an extended period of time.¹⁶⁵
174. HCBC services have largely been unclearly defined. Its target has been unclear – both abled and disabled, and its service is largely unprofessional. Many so called HCBC, are in fact, RC in nature especially those HCBC in rural area such as Happiness Gardens. In those HCBC settings, many older people residing in the HCBC centers on a long-term basis. Services provided by HCBC centers seem to limit to social and recreational activities with some meal delivery. Presumably, there should be well-developed program of activities along with a well-planned and regular daily schedule for the users of the adult day care center. In practice, this is not the case in most adult day care centers and many day care center users are completely able to ‘self-care.’¹⁶⁶
175. Central government does encourage local government to invest in HCBC. The local government responded by adding HCBC centers as part of the local public enquiry centers without considering their appropriateness. Thus, many HCBC centers are located above the public enquiry centers with no elevator. Both central and local governments have set preferential policies to encourage private sector to invest in HCBC, however, coverage and subsidies levels are generally low. HCBC has failed to attract investors and providers, as it has been viewed as a nonprofitable business.¹⁶⁷

¹⁶⁵ Xu Yuebin (2014). The EC system in China. ADB SC#102836. p.5

¹⁶⁶ Meredith Wyse, Xu Yuebin (2016). PPTA – EC development in Hebei Province. Technical report: output 1: Home and Community Based Care. p.31

¹⁶⁷ Xu Yuebin (2014). The EC system in China. ADB SC#102836. p.6

176. The general public have a limited understanding of HCBC service and what these services can do to help them to age in their most familiar community. In a recent focus group meetings conducted by this PPTA, the participants have rarely used HCBC services. Most of the participants considered it as a kind of waste to purchase services on the market if the services are not necessary or can be done by oneself. In addition, many people are willing to employ housekeepers or caregivers by informal channel rather than formal channel; because they think the housekeepers or caregivers who are introduced by acquaintances are more trustworthy and cheaper.¹⁶⁸
177. Most of the elderly in in-depth interviews and focus group meetings prefer HCBC over RC and consider HCBC as the future choice of care because HCBC is closer to the elderly's home. Elderly people will not be forced to separate from their children. What they need from HCBC is (1) personal care (ADL), (2) medical care and (3) recreational activities. What they need from the government is more funding for HCBC, increase HCBC staffing, allocating more HCBC space.¹⁶⁹ As far as children are concerned, the use the HCBC depends on two factors: availability of medical care and cost. They could afford 27- 40 Yuan for a live-in bed at the HCBC center.¹⁷⁰

5.6 RC

178. According to Statistical Communiqué of the People's Republic of China on Social Development 2014 (Ministry of Civil Affairs, 2015): there were 94,110 EC organizations and facilities: 33,043 RC facilities, 18,927 community EC centers, 40,357 mutual-aid EC facilities, 1,783 veteran nursing homes - providing 5,778,000 beds (27.2 beds per thousand elders), accommodating 3,184,000 elderly people. Of this total, community institutions provide 1,875,000 beds for staying over-night and day care. In Hebei, there were 500 EC organizations and facilities, with 210,000 beds. It is expected RC beds will increased to 400,000 by 2020 when there will be 30 beds per 1,000 elderly.¹⁷¹
179. Apart from high cost (See Section 4) and low quality (See Section 7), RC in China and Hebei has two major problems: (1) the contradicting phenomenon of bed supply and demand and (2) mismatch of RC resources – (a) majority of the RC users tend to be people with no care needs; (b) people with care needs tend to concentrate in resource-poor private operators whereas people with no care needs in resource rich public providers.

In 2012 China had 44,304 residential care facilities, containing 4.165 million beds. The occupancy rate in many homes of the aged was low. In 2012, less than 3 million elderly were cared in RC facilities with a 50 - 75% of the occupancy rate. The under demand of RC beds is widely alleged to low quality and high cost of RC. There have been social stigmas

¹⁶⁸ Wang Hsiaopo. Focus group meeting notes as per email on August 25, 2016.

¹⁶⁹ Yu Qingnian and team - interview note 1 & 2 – interview 1 & 6

¹⁷⁰ Yu Qingnian and team - interview note 1 – interview 4

¹⁷¹ HMM FSR, p.10

associated with RC especially those RC facilities admitting low income elderly. Instead of fixing the problems of low quality, high cost and social stigma so as to improve the utilization rate of current RC, most governments opt to add more RC beds as their policy directive. In addition, there is no incentive for the RC operators to fill unoccupied beds. As part of the government RC subsidizing policy, the operators will be awarded 4,000 Yuen for each RC bed added regardless if these beds are occupied or not. In an in-depth interview of private operators, it was told the breakeven point of a RC business is when 50% of the beds are occupied. Any bed occupied after the breakeven point will be a bonus (profit) to the operator.¹⁷²

180. It is common that RC beds in China are being occupied by able-bodied or people with no obvious care needs. Other than those whose RC fees are covered by the government such as 3 Nos, access to RC depends in the first hand the financial ability of the elderly and their families, which prevents many low-income elderly with care needs from seeking RC services. In addition, many small or privately operated RC are not staffed and equipped to handle care needs. Many elderly people with care needs usually have difficulties in finding an affordable RC bed. As a result, many RC beds end up taking up by the well-to-do and able-bodied old people.
181. In China, privately operated RC facilities tend to accept older persons who are total dependent. Public nursing homes, on the contrary, are more inclined to accept healthy and non-disabled older persons. At the same time, the quality of RC services in the private sector is generally poor due to resource constraints. Public RC facilities, which are entirely funded by the government, are with better resources and quality¹⁷³.
182. In an ideal world, there should have two types of RC facilities: (1) one for elderly with care needs and (2) one for low income or “three no’s” elderly. In China, these two groups of people are mixed together. Mixing people with care needs and with no care needs counteracts the international trend of ageing in place and deinstitutionalization. It can be demoralizing as this will promote dependency, helplessness and boredom among those who are able. Research evidence suggests that those who are helpless, bored and lonely tend to have a higher mortality rate, heart disease rate, etc. than those who are not. Unless there is evidence to support otherwise, mixing residential care for older people with care needs and housing facility for “low income” elderly does not sound like a good business case. Care of elderly with care needs is far more expensive than simply addressing the housing need of the elderly. This can be a waste of public resources especially when care is delivered to people with no care needs. Elderly with low income who has housing need can be addressed by an entirely different service program e.g., income security or elderly housing, which may be at a lower cost to the government. The resources saved including elder care manpower can be concentrated in the care of elderly with care needs.

¹⁷² Wang Hsiaopo. Interview notes with private operator. As per email Aug 25, 2016

¹⁷³ Economic and Social Commission for Asia and the Pacific, UN. (2016). *Long Term Care for older persons in China*. Social Development Division, UN.

183. People in China have a strong view on RC - they don't like it and think of it as extremely low quality. Most of the community dwelling elderly consider moving into a RC facility as disgraceful as this might imply that they do not want to live with their children and thus disgrace their children by making a choice of moving into a RC facility, which may eventually hurt their relationship with their children.¹⁷⁴ When their ability to selfcare deteriorates, they will first consider help by family, then by nanny before RC. In-depth interview of children of elderly in Chengde and Zunhua told a mixed story. These children who are aged 50+ considered RC not a bad choice in old age especially when most of the elderly have only one child. Financial difficulty and living in rural area may prevent people from using RC service. Many of the them did consider the quality of care generally low and there had been reports about elderly abuse in RC. If given a choice, they would prefer public than private RC. Public RC receives government subsidy and has better quality, and the fee is modest. They do not trust the private RC providers because the latter are there not to serve the elderly but to make money.¹⁷⁵ RC users in Zunhua told a different story. Most of the elderly interviewed like the RC service because of: (1) good environment – right location, cool in summer and warm in winter (2) good food – meal on time (3) diligent and responsible staff and (4) closer to the hospital.¹⁷⁶ Some even like the CCTV to monitor resident care around the clock.¹⁷⁷

5.7 ICT (Information and Communication Technology)

184. The use of ICT in China for the elderly is largely confined to the call center. ICT has not been adequately applied and used. In accordance with both national and provincial policy, almost all counties and township of Hebei have built call centers as part of the HCBC to support the elderly residing at home. For instance, in Shuangluan, Hebei, the IT call center operates the “12349” for the elderly. Every resident of Shuangluan aged 75+ is eligible for a free mobile phone and monthly phone fee subside of 15 Yuan. By July 2016, there were 1,906 elderly joined the “12349” hotline with 1,494 service providers. There are approximately 40 calls per day. Most of the services requested are: home making service, home repairs, medical care, EC, health care, legal service, etc. The IT call centre served as a middle-man between the elderly and service providers. Some of the IT call centers also provide meal delivery service. In Baoding (Lixian), people aged 60+ and over is eligible for a free phone and 100 minutes of free call along with 10 Mb data plan per month. Elderly can call three designated members free. In Baoding, the vision of “12349” hotline is to create a “RC without walls”¹⁷⁸. In a recent survey of the elderly, most of the elderly tended to treat the free phone as a mobile telephone but hardly use the hotline service. The reasons are two: they did not know how to use the technology and they did not trust the service providers. Some of the elderly used the service once and found the useful but due to whatever reason, did not continue the

¹⁷⁴ Wang Hsiaopo, notes of focus group meeting, as per email Aug 25, 2016.

¹⁷⁵ Yu Qingnian and team - interview note 1 – interview record 4 and 6

¹⁷⁶ Yu Qingnian and team - interview note 2 – interview record 6

¹⁷⁷ Yu Qingnian and team - interview note 1 – interview record 2

¹⁷⁸ http://www.ccg.gov.cn/specialtopic/cgggfwjtjzk/dxfw/201406/t20140605_3503367.shtml

service. Most of the elderly were interested in emergency call such as the push button of lifeline.¹⁷⁹ This is supported by in-depth interview in Shuang An of Shuangluan. All the elderly interviewed received the free phone but not too many heard of the “12349” or “96096” hotline and only a few have actually used the service. One of the elderly reported that the hotline saved his life by transporting him to the local hospital and notifying his daughter. The call center looks good on paper but is not well known in practice.¹⁸⁰

185. It is clear that the IT call center serves a purpose of facilitation between individuals elderly and service providers and leads to the development of appropriate home supporting services, such as housekeeping and home maintenance. The IT call center and hotline services for the elderly are under-utilized in general. Apart from those reasons mentioned above, the IT call center also has a number of drawbacks. Firstly, the IT call center, however, may be inadequate to determine the needs of full coverage of home care, such as personal care, home safety assessment and home modification etc., which are important home bases care to support the elderly to reside in their own homes. In other words, it is still far from reaching the vision “RC without walls.” Secondly, many IT call centers have limited coverage for the rural populations. Older people in rural areas may not be IT savvy and have the income to use the service, and therefore, may not use the service at all. Finally, all existing call centers rely on government subsidies for construction and operations, and most of the call center users receive government subsidies to use the services, thereby driving demand for services. Without government support, most of the IT call centers may not be financially sustainable. If the functions of call center do not change, the best way to use IT call centers may be¹⁸¹:

- i. Checking and warning in times of potential hazard: extreme heat, cold, air quality
- ii. Regular calls to high risk older people to ‘check in’ with their current well being
- iii. Information on available services
- iv. Medication reminders, and medication delivery (subject to legal license)
- v. A hub of organizing social and volunteer activities, providing befriending services, arranging volunteers to help with house work, meal delivery, companion, delivery of shopping for those unable to purchase such services
- vi. Helpline, manned by trained staff/volunteers for providing advice and counseling if required to older people, their families.
- vii. Referral of persons at potential of high risk to HCBC providers, or resident committees for follow up

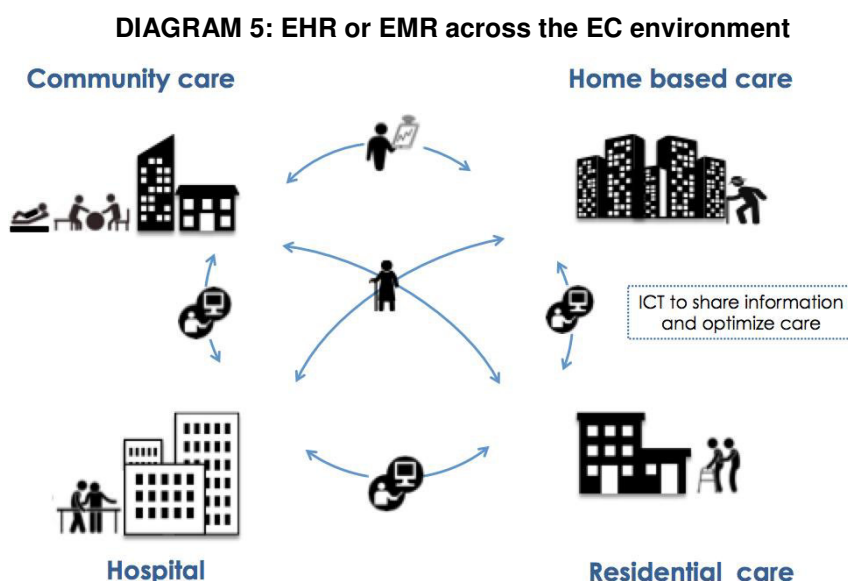
186. If IT call center is one of the function of ICT, ICT has yet fully realized its potential in Hebei. One of the functions of ICT, which can significantly improve quality of care is electronic health/medical record (EHR/EMR). Such a record is designed to contain and

¹⁷⁹ Shuangluan FSR, Aug, 2016. p. 37

¹⁸⁰ Yu Qingnian (2016). Interview notes 1 – Interview record 1 and Interview notes 2 – Interview record 4

¹⁸¹ Meredith Wyse, Xu Yuebin (2016). PPTA – EC development in Hebei Province. Technical report: output 1: Home and Community Based Care. p.32

share information from all providers involving in the care of the elderly. It can be created, managed and consulted by authorized providers and staff from a full spectrum of EC services including HCBC, RC and hospital such as the diagram below. The EHR/EMR can help to (1) to track EC over time, (2) identify EC users who are due for preventive intervention e.g., flu shot, (3) monitor how EC user measure up to certain parameter such as blood pressure and (4) improve quality of care. EHR/EMR has been quietly evolved in other provinces but not obvious in Hebei. In 2009, 35 cities, 2,406 community health centers and 9,723 community health stations in China adopted EHR/EMR.¹⁸² There is room for Hebei to catch.



187. Another function of ICT in EC is the use of internet of things (IoT). EC has long been criticized for being a low productive industry as it is still largely labor intensive and low technology in nature. IoT is the network of interconnected things /devices which are embedded with sensors, software, network connectivity and electronics that enable them to collect and exchange data. For instance, the use of wearable, e.g., watches and health monitoring devices to provide security and fall monitoring for the elderly. The future of home care may have to rely on the smart home technology such as smart doorbells, smart lighting, smart smoke and carbon monoxide alarms, etc.
188. Finally, it is the use of data collected from ICT for EC planning, identifying elderly at risk, quality monitoring etc. This is done through the application of big data analysis. For service monitoring, Qingdao of Tianjin used to data collected to rank EC providers

¹⁸² 中国社会科学院社会学研究所 (2014). 中华人民共和国 老龄化问题相关的信息收集与确认调查 最终报告书. 日本国际协力机构 (JICA). p.29-30. Available at - <http://open.jicareport.jica.go.jp/pdf/12153284.pdf>

according to a 5 stars system¹⁸³. This helps elderly to pick the best EC provider. Beijing uses “Beijing Connect” to track the elderly as they take buses and go shopping. The data is then used to predict whether the elderly will become disabled in the future and what services will be needed in future¹⁸⁴. These are some examples of better use of ICT, which Hebei still need to catch up with the rest of the nation.

5.8 Medical/health care and EC integration

189. Given the increasing complexity of care needs as age advances, a better integration between medical/health care and EC is key to ensuring elderly wellbeing. Medical/health and EC integration may occur in two levels: horizontal and vertical. At vertical level, EC may expand its service to include medical and health care especially in areas such as sub-acute, post-acute, rehabilitation and palliative. At horizontal level, EC may form strategic alliance with other medical and/or health organizations such as hospitals and community health clinics so that EC users may have easier access to medical and health care. In China, this has been referred to as greenway - a priority access for older persons. The recent policy on medical/health care and EC integration by the central government and the HPG (see Section 3.1.9 and 3.2.4) seem to support either way.
190. Hebei has been experimenting medical/health and EC integration since 2008 through the “Care-with-Love” project as stated in Section 2.10.2. Services to be delivered by the “Care-with-Love” project are skilled nursing, rehabilitation, hospice etc. These services are exactly what the new policy on medical/health care and EC integration calls for. However, the outcomes of the project have yet been known. Or if known, only known to a few people.
191. All IAs of this PPTA plan to pilot medical/health and EC integration through i the establishment of a medical rehabilitation center. Traditionally, skilled nursing such as tube feeding, rehabilitation such as occupational therapy and physiotherapy and hospice care are not part of the EC under Civil Affairs. This may be due to (1) skilled nursing care is not the focus Civil Affairs and (2) Civil Affairs is reluctant to assume the risk of highly complex care. Under the new integration policy, the government does expect the EC sector to pick up more health care services with the support of the local hospital or medical clinics: sub-acute care (tube feeding, dialysis, etc.), post-acute care (transitional care), end of life care, rehabilitation, etc. These services are common in EC of developed countries but not so common in China, and have not been seen in Hebei.
192. The inclusion of these services will for sure enhance EC in Hebei. Medical/health care and EC integration so far is good on paper. To realize a fully-fledged integration, there is still a number of conceptual issues that needs to be verified in China and particularly in

¹⁸³ 中国社会科学院社会学研究所 (2014). 中华人民共和国 老龄化问题相关的信息收集与确认调查 最终报告书. 日本国际协力机构 (JICA). p.29-30. Available at - http://open_jicareport.jica.go.jp/pdf/12153284.pdf

¹⁸⁴ <http://bigstory.ap.org/article/57e128c2703440bda0ff8998a54044a8/beijing-tracks-elderly-they-take-buses-go-shopping>

Hebei. Firstly, medical care differs profoundly from EC. The purpose of hospital/medical care is curing disease. Hospital/medical care has two foci: diagnosis and treatment. Thus, it is episodic and short term. The purpose of EC is to maintain health status and to delay deterioration. It is ongoing and long term, which has never been the forte of acute medical care. Many medical and health care professionals are not keen to work in EC setting, as EC users are less likely to respond quickly to treatment and to recover from their chronic conditions and, if they do recover, their progress can be very slow. Thus, encouraging the medical and health care to offer EC service is a good idea. In practice, there is a need to build EC capacity in medical and health care especially when geriatric care is complex in nature and requires a multidisciplinary approach.

193. Secondly, HCBC and RC can play a key role in chronic diseases management, rehabilitation and palliative services. HCBC and RC are well posited for vertical integration by expanded their services to include medical and health care. International best practice is increasingly supporting the delivery of some clinical services in the home, through home care nursing and rehabilitation and increasing the tasks home nurses are trained and legally permitted to conduct in the home¹⁸⁵. This does not necessarily mean the HCBC operators need to provide clinical services themselves (such as nursing services, medication reviews). However they may work closely with the health care providers, both hospitals, community health clinics, primary care practitioners, etc. to ensure that older people to have convenient access to such services, and that case management is available for complex cases. To ensure smooth transition along medical, health and EC continuum, there needs to be consideration of how the different service providers share information, organize referrals and follow up, and use care pathways. Community centers for the elderly can be a useful hub for the provision of services such as different types of therapy (physical, occupational, speech therapy), vaccinations, health monitoring and health education.
194. Thirdly, incentive to provide health care services for the elderly is still unclear. There are two encouraging developments. Firstly, it is the suggestion that medical insurance may reimburse medical and health care services delivered in EC setting. Secondly, the proposed LTC insurance will cover people with conditions such as neuro-degenerative diseases - stroke, severe Parkinson's disease, severe dementia, etc., in coma and end stage cancer¹⁸⁶. However, these two new developments are just on paper and have yet been implemented in Hebei. Many EC operators in Hebei are not that optimistic about the medical insurance reimbursement for medical/health care delivered in EC setting. They believe that they will have to meet many preconditions before receiving medical insurance coverage. The conditions that likely be reimbursed by the proposed LTC insurance will be those highly complex EC cases that are currently under hospital care.

¹⁸⁵ Meredith Wyse, Xu Yuebin (2016). PPTA – EC development in Hebei Province. Technical report: output 1: Home and Community Based Care. p.29

¹⁸⁶ LTC insurance in July

195. Finally, it is the regulatory barriers pertaining to Medical/Health Care and EC integration. It may be easier for Medical/Health Care to integrate with RC than HCBC. Expanding medical and health care beyond current hospital and clinics to HCBC settings still has a long way to go. Other issues such as professional qualification requirements, compliance of medical regulations, scope of practice (e.g., who do what, etc.), are just some of the examples of barriers (Qu Michael, 2016).

5.9 Cost effectiveness

196. From a societal perspective, HCBC is more cost-effective to RC. However, it is not the case from the service provider's perspective especially those from private for profit providers. From other countries experience, hospital care is 5-6 times more expensive than RC, which in general is 2-3 times more expensive than HCBC.¹⁸⁷ Thus, the longer the elderly requiring care can be maintained in HCBC than in RC, the more cost effective it will be. In reality, most of the EC providers appear to favor RC than HCBC. This is because most of the RC operations already have a more successful business model. HCBC providers are still struggling to make money or break even and there are not too many successful providers.¹⁸⁸ This may be due to the fact that HCBC still in its infancy. Unlike RC, which has more government funding support and preferential policy, HCBC has very little government support. Government may have to increase its support to HCBC in order to make the realization of bigger social gain possible.
197. Health and EC integration, at least in most developed countries, is driven by two factors: (1) client care excellence and (2) system efficiency. Users achieve client care excellence through better access to a medical/health care and EC continuum after integration. System excellence is through system efficiencies and improved service levels. Service users, who do not need medical care should be able to shift from a more expensive, e.g., hospital to a less expensive form of care, e.g., RC setting or medical rehabilitation center. Thus, health and social integration are also about cost saving for service users, EC providers and the government. If the integration of medical/health care and EC does not come with cost saving, or at least cost neutral, the integration may neither be adequate nor appropriate.

6. HUMAN RESOURCES DEVELOPMENT

198. Section 2.5 discussed key HR issues/ This section is dedicated to HR development in EC especially training, education, certification and registration of EC workforce

¹⁸⁷ Hollander, M. J. (1999). The Cost-Effectiveness of Community Based Long Term Care Services for the Elderly Compared to Residential Care: A British Columbia Perspective. Victoria, BC, Canada, University of Victoria.

¹⁸⁸ <http://www.scmp.com/news/china/article/1302835/chinas-bid-provide-care-system-elderly-faces-hurdles-warn-experts>

199. Inadequate and underprepared EC staff is one of the key factors contributing to the poor quality EC in China and Hebei. The 2015 Chinese Longitudinal Healthy Longevity Survey, which showed an increased rate of institutionalization among older adults but a lack of qualified staff knowledgeable in providing care. The report also lamented that there are few qualification standards for staff training and little consistency between facilities and regions in how staff were prepared for their roles. The growing health concerns and eroding traditional family elder care, in addition to an underprepared workforce and regional disparities on the quality of LTC have contributed to the unmet LTC needs of the elderlies in China.¹⁸⁹
200. Despite the government effort¹⁹⁰ of encouraging colleges to set up EC majors, including elderly health and nutrition, psychology of aging, geriatric nursing and bioethics, only a few of these graduates select jobs in EC. The EC prospective and current employees, and EC operators hold different views. Here are two examples reported by the China Daily USA in Sept 2016. (1) Zhang graduated in elderly service and management at Beijing Youth Politics College in 2013, but among his 30 classmates only three have jobs serving the elderly. In addition, Zhang found that the academic training she learned at college was disconnected from reality. She found herself with no spare energy to organize activities or address the psychological needs of the elderly, as other day to day caring work already kept her exhausted. (2) Zhang Meng, 20, is a sophomore majoring in elderly service and management at Beijing Youth Politics College. She wants to work in EC after graduation, but her interest is only to chat with the elders and organize activities for them and not in providing bedside nursing. While many graduates shrug their shoulders at nursing jobs, EC operators prefer workers without diplomas, as they are more experienced in nursing and demand lesser salaries. As one operator pointed out: "Graduates demand high salaries and better benefits, but they lack experience taking care of the elderly."¹⁹¹
201. Geriatric care in general is not a well-developed competency in China's medical, nursing, or vocational schools. This is an issue both for professional workers like doctors, facility managers, nurses, and physical therapists as well as frontline care workers. Thus, policies to address EC shortage of the workforce need to be strengthened to develop general and specialized vocational and professional training, expand the scope of practice in EC by inviting other professionals such as social work, occupation therapy, physiotherapy, speech therapy dietary etc, to enter into this new and increasingly professionalized EC sector. A comprehensive HR development strategies should at least include but not limited to the following.

¹⁸⁹ Report on "LTC for Elderly in Asean Plus Three: Research and Policy Challenges". Organized by Changing Families in Asia Cluster, Asia Research Institute, National University of Singapore. March 1-2, 2016. p. 24

¹⁹⁰ the Ministry of Education and eight other government departments issued a joint circular in July 2014 about "Speeding up the HR development in EC sector" - 教育部等九部门《关于加快推进养老服务业人才培养的意见》(教职成〔2014〕5号, 2014年6月10日)

¹⁹¹ http://usa.chinadaily.com.cn/chia/2016-08/23/content_26571895.htm

- i. long-term HR planning in EC
 - ii. comprehensive HR training system
 - iii. certification and registration of EC staff
 - iv. continued education including on the job training
 - v. training for geriatric and gerontological professionals
 - vi. inclusion of volunteers.
202. Many EC operators in Hebei train their own care staff. One of EC operators interviewed has been accredited and certified by the Department of Civil Affairs to train care workers in Shijiazhuang. Other EC operators would send their care workers to his facility for training. The training usually takes a week and the fee is about 500 yuan per trainee. After the training, the trainees would sit for the certification examination and get the license if passed.¹⁹² What the operators like the most is the practicality of his training program. Unlike training in school which tends to be theoretical, operators directed training program focused on day to day care. There may be merits of operator directed training as it addresses the basic job requirements in EC. It may not enable the graduates to deal with more complex care needs which quite often are only available in formal school. There have been expressed concerns about the quality and consistency of operators directed training. One encouraging development in Hebei is that the HPG will provide fee subsidy for EC workers to sit for the certification examination.
203. Vocational and post-secondary schools are the key training hub of EC worker especially frontline care workers. In Hebei, most post-secondary training institutes in Hebei are located in Shijiazhuang in 2014, with 12 high schools and 11 colleges. How many of them are involved in the training of EC workers is unknown. Presumably, tertiary education will also be a major source of training of EC professionals such as physicians, nurses, rehabilitation specialists, dietitians etc. and managerial training for EC investors and operators. In 2016, Hubei Medical University has submitted two EC specific training programs: (1) EC services and management and (2) EC rehabilitation and nursing, to the Hebei Education Department for approval.¹⁹³ Yanshan University is another tertiary institute that is planning to develop a center of excellence in EC training and is also an IA of this PPTA.
204. Overseas EC investors/operators realize that identification, training, and retention of qualified EC staff must be a top priority if they want to be successful in EC sector. Several foreign operators have made it a priority to find partners in China who have access to pools of Chinese vocational labor, regardless of whether these workers are focused on healthcare or not. Then, these foreign operators partner with someone in China who knows how to structure a training program that imparts EC entry level knowledge and

¹⁹² Wang Hsiaopo, notes of interview, as per email Aug 25, 2016.

¹⁹³ Yip Anna. (2016). Technical Report - Human Resources Development Component. PPTA – EC Development in Hebei Province. ADB

skills to the average Chinese worker and then build a EC training model in conjunction with their partner, including importing EC training model from their headquarters. The ideal partners can include vocational schools as well as small but growing group of China-based healthcare companies that offer training programs¹⁹⁴. As more investment is poured into the EC sector, growing competition will prompt EC providers to upgrade the quality of services, including more trained EC staff. Potential partnership between overseas investors/operators and local vocational schools may help to make changes of and hopefully improve the training program of existing vocational schools.

7. QUALITY OF EC

205. Due to the support of government preferential policies, many new players have entered EC sector especially the high-end EC market for affluent elderly and/or their family. Most of these new players are real estate, insurance and finance companies, both local and overseas. According to a report done by the Institute of Sociology, Chinese Academy of Social Science and sponsored by Japan International Cooperation Agency in 2014, these new players have developed housing projects that are suitable for the general public but are not for the elderly with care needs. Many of them have limited experience in EC and EC management. Quite often, the EC services provided are not supported by adequate professional service.¹⁹⁵ Thus even though most of these housing projects look appealing, the quality of service provided is doubtful.
206. Quality of EC for those middle-low income elderly is not better off. Quality of care is generally low due to multiple deficiencies, including poor financing, low number and quality of human resources, poor monitoring and deficient regulations. The fact that there are consistently more available RC beds than older adults admitted to these facilities, speaks for itself. About 25 – 50% of RC beds in the districts of IAs of this PPTA are empty, quality of care is the key factor. Chinese general hold an extreme view of RC which is low quality. Although government has issued many EC standards and regulations, most of them are on the building standards such as room requirements but less on the quality of care.
207. Here is how a typical RC facility in a Hebei rural area looks like. It may consist of 50 beds with half of the beds unoccupied. The residents age ranges from 60 to 98. Half of them are confined to their beds. The home is dimly lit, and 4-6 people share each 30-sq.-meter room. This small space is simply furnished, with beds, a toilet and dressers. There are no railings on the beds or handrails on the walls, and the floor is seamed and uneven. The female resident entered the RC facility because she was alone and there was no one to look after her. Her only son works in other province and she sees her son about

¹⁹⁴ <http://www.chinabusinessreview.com/senior-care-in-china-challenges-and-opportunities/>

¹⁹⁵ 中国社会科学院社会学研究所 (2014). 中华人民共和国 老龄化问题相关的信息收集与确认调查 最终报告书. 日本国际协力机构 (JICA). p.26. Available at - http://open_jicareport.jica.go.jp/pdf/12153284.pdf

once a year, usually during the Chinese New Year. Asked whether she felt lonely, she suddenly turned serious and said with a resigned look, "I'm happy having a game with my fellow residents." There have been reports about the elder abuse and the sanitary of care especially for those who cannot self-care, e.g., feeding several elderly with same spoon and chopsticks.¹⁹⁶

208. Specifically, EC in China and Hebei has to two quality issues. Firstly, it fails to design with care in mind. Secondly, it lacks a quality of care monitoring system.
209. EC design without care in mind - most of the EC standards are facility construction related especially pertaining to space allocation and room designation. This is a reflection of government focus: paying more attention to hardware than software. Governments are very specific about construction requirements, but less specific about care of the frail and impaired elderly. For instance, there will be 6-room and 1 school in all newly built HCBC center: sleeping, dinning, reading, cultural, recreational room and small gymnasium and medical treatment room along a elderly academy¹⁹⁷. For RC, there will be functional areas such as: (1) resident area: bedroom, bathroom, dining room, etc., (2) health care: physician room, laboratory, ECG room, medication room, etc., (3) rehabilitation: physiotherapy and occupational therapy rooms; (4) social work room, (5) administrative office and (6) others: security office etc. These standards intend to bring some consistency across the nation and province, but they are set with care in mind. These standards may be sufficient for people with high functioning but will be inadequate for people with low functioning including those with disability and cognitive impairment, etc. For instance, better wayfinding and lighting, and reduced noises are far more important than room designation for people with memory loss and cognitive impairment.
210. EC quality management system - the current EC quality standards are related to input/structure standards only, such as number of beds provided, number of different rooms to be provided, number and qualification levels of staff to be provided, etc. Whilst this is a good starting point, such standards in themselves are insufficient to assure quality. Good quality standards should apply to processes (safety standards, record keeping and so forth) and outcome measures (quality of life, change in ability to conduct ADLs for example). These are important to ensure the services being provided are suitable, meaningful and appropriate for older people with care needs. Standards of care are usually applicable to all those receiving care, without discrimination between ability to pay. In addition, a complete quality management system should also focuses on input and structural indicators.
211. There is a also a lack of regulations covering quality standards for human resources as well as a government-sponsored accreditation processes that would allow consumers to judge reputable facility-based care from those that should not be trusted. In the United

¹⁹⁶ Yu Qingnian and team - interview note 1 – interview record 6

¹⁹⁷ <http://www.zhikunedu.com/YangLaoBaoXian/569735.html>

States, RC and HCBC operators and providers are governed by a variety of federal and state regulations in addition to third parties that advocate for users' rights. In UK, the Care Quality Commission, which is appropriately staffed and resourced to oversee the development of applicable standards, and quality indicators both at national or local levels. It is responsible for the dissemination, and if required explanation of, the quality assurance system to operators, training providers, EC users and the public. Monitoring reports are freely available to allow potential EC users to review.¹⁹⁸ In China, Department of Civil Affairs is responsible for EC quality monitoring. Quite often the local Civil Affairs Department is short staffed and with limited resources. The department may be able to respond to EC users' complaints, but will be incapable of monitoring EC quality proactively.

8. ARRANGEMENT OF HEALTH CARE FOR THE ELDERLY

212. EC in China can be divided into social and health care. The former is under the jurisdiction of Ministry/Department of Civil Affairs whereas the latter is under the Ministry/Department of Health and Family Planning.
213. Social care, in other countries, refers to all care and services to frail and disabled person other than health care, such as activities daily living e.g., bathing, and eating, and home support services e.g., shopping and cleaning. Family has been and will continue to be a major social care provider. In China, social care has a special meaning and refers to care supported by the government and public revenue. The care of the elderly including the disabled elderly traditionally has been the responsibility of the family. Government's responsibility, which is led by the Department of Civil Affairs, has been on the economically destitute elderly such as the 5 guarantees and 3 Nos. Due to increased number of elderly people with care needs/disability resulting population ageing and shift of morbidity pattern, governments and public attentions on EC have been expanded to include physically and cognitive impaired. What makes government role more crucial in EC is the erosion of family care system due to empty nest, 4-2-1 family structure resulting from the one child policy, etc. The care of people in poverty has been the forte of the Department of Civil Affairs and EC providers whereas the care of people with physically and cognitive impaired has not. These new tasks are beyond the capacity of the departments of Civil Affairs and current EC providers.
214. For health care needs, majority of the elderly are covered by various medical insurance schemes. The proportion of people covered by these schemes has increased from 34% in 2003 to 91% in 2008¹⁹⁹. As of August 1, 2016, 90% of inpatient care expenses in Hebei

¹⁹⁸ Meredith Wyse, Xu Yuebin (2016). PPTA – EC development in Hebei Province. Technical report: output 1: Home and Community Based Care. p.27-28

¹⁹⁹ 中国社会科学院社会学研究所 (2014). 中华人民共和国 老龄化问题相关的信息收集与确认调查 最终报告书. 日本国际协力机构 (JICA). p.26. Available at - http://open_jicareport.jica.go.jp/pdf/12153284.pdf

will be covered. Outpatient care is capped at 500 Yuan per year.²⁰⁰ This is a significant advancement in health care protection for the elderly, particularly for those of low income family and living in rural areas. However, there are still some concerns. Firstly, the premium of medical insurance has been considered high (3.5–3.8% of the one's salary) especially when there are many other social insurance premium that a person has to pay. Secondly, what medical expenses can be reimbursed by the scheme is very limited. For instance, transfusion, many medications and some of the hospital expenses cannot²⁰¹. Finally, long term care (LTC), which is the care of impaired persons who need care on a long term basis, is still out of the reach of the elderly. It is neither a focus of the Civil Affairs nor Health. Ministry/Departments of Civil Affairs, do not see LTC as part of their functions and they lack the capacity to offer LTC. On the other hand, LTC has never been a priority of Ministry/Departments of Human as it has never been part of health care reform agenda for the last 3 decades. Health care reform has embraced many agenda but LTC: increased health protection, public health, public hospital, medication, and primary care reform.

215. Two latest EC policies shows some encouraging development in the arrangement of health care for the elderly – (1) medical/health care and EC integration and (2) trial of long term care insurance in selected cities and counties including Chengde and Julu, Hebei (see Section 2.9, 3.1.11 and 3.2.5).
216. In Hebei, medical/health care and EC integration embraces 6 major themes (1) It promotes the formation of contractual agreement between EC and health care providers including hospital and community health care center. (2) 50% of EC providers can include health care in EC settings. For instance, there will be medical treatment room in EC facility and medical insurance will be expanded to cover health care services in EC setting. (3) 80% of the health care providers will create priority path or greenway to enable elderly to have easier access to health care services. For instance, when receiving hospital care, there will be priority pathway for elderly during registration, consultation, fee payment, medication collection and admitting. (4) 70% of the people aged 65+ will be enrolled in health management program. This will be done through the establishment of family physician system. (5) There will be more professionalization of EC including the development of geriatric medicine and Chinese medicine.²⁰²
217. Under the policy of medical/health care and EC integration, some local governments encourage local hospitals and primary care centers to offer geriatric or nursing care beds. For instance, some Level II hospitals in Shanghai, have been converted into medical rehabilitation centers or geriatric hospitals. In Dongying City, Shandong, the local government requested community health centers and stations in urban areas and health center in rural areas to offer geriatric or nursing care beds. This helps to address the

²⁰⁰ <http://www.rmzxb.com.cn/c/2016-08-31/1009298.shtml>

²⁰¹ Yu Qingnian and team - interview note 1 – interview record 1

²⁰² http://hebei.news.163.com/16/0116/10/BDEN0KLT02790J2L_all.html

issue of “social hospitalization” when the elderly who, due to the lack of LTC, are admitted to hospital but with no acute care needs. This is a waste of medical resources and this is a concern.

218. China's morbidity pattern is shifting - from communicable to non-communicable or chronic diseases, such as high blood pressure, heart diseases, stroke, etc. The latter is particularly prevalent among elderly people. As of August 1, 2016, medical insurance in Hebei will cover 70% of medical fee for those with multiple chronic diseases and high medication fee. The maximum annual coverage is capped at 20,000 Yuan. This will ease the financial burden for people with chronic conditions. Another issue chronic diseases management is the mindset of current primary care providers which are still treatment and cure oriented. This is important in tackling communicable diseases but does not fit well with non-communicable or chronic diseases. Focus of chronic disease management is on putting the disease under control and to minimize the acuity of a chronic conditions, e.g., reducing the reoccurrence of heart attack. In addition, under the policy of medical/health care and EC integration, there will be health and chronic disease management, as well as the involvement family physicians in the care of elderly. Hopefully, this will enhance health care for the elderly.

9. OVERALL EC PERFORMANCE

219. The overall performance of EC in China and Hebei can be summarized by the findings of the 2015 Chinese Longitudinal Healthy Longevity Survey:
220. China has showed an increased rate of institutionalization among older adults, due to their ailing health in a rapidly ageing population. Owing to the lack of qualified staff knowledgeable in providing care. They also lamented that there are few qualification standards for staff training and little consistency between facilities and regions in how staff were prepared for their roles. The growing health concerns and eroding traditional family elder care, in addition to an underprepared workforce and regional disparities on the quality of LTC have contributed to the unmet LTC needs of the elderlies in China. The encouraging news is that the government is developing LTC policies to address the unmet needs. However, government funding mechanism has to be reformed to address unmet elder care needs. One way would be to shift the general eligibility criteria of the 3 'No's to the care of more vulnerable elderly population. Increasing capacity of the LTC providers is another direction of change by integrating LTC and Acute Care system, which would expand the function of RC and HCBC to deliver both medical, health and social care to the frail elderly at home, in the community and residential facilities. Other limitations that should be addressed by the state are creating innovative care delivery models and testing the efficacy of interventions for frail elders and caregivers to improve LTC services and caregiver well-being.
221. Inadequate EC facilities and services, untrained EC staff and meagre pensions are turning China's EC into a ticking time bomb that could derail an already faltering economy.

10. CONCLUSION AND RECOMMENDATIONS

10.1 Conclusion

222. President Xi Jinping summarized the current elderly issues including EC in China in three superlatives: (1) largest, (2) fastest growing, and (3) toughest to cope with.²⁰³ Hebei is no exception. To control the size and the growing rate of the elderly population is beyond the scope of this report. However, this report does identify a number of tough challenges and recommend some strategic directions and workable solutions to address these challenges. It is hope that with these recommendations, challenges may become opportunities for the betterment of EC in Hebei

10.1.1 Lack of clear guiding principles and focus of EC

223. EC in China has been part of Chinese culture of “filial piety,” and imbedded in the vision of “all elderly will have support, medical care, a purpose, education and entertainment” as stipulated in the law on “Protection of the Rights and Interest of the Elderly” of PRC. Family will continue to be an essential source of EC and China should continue to support these national values and regulations. As suggested by Wu Yushao, deputy head of the office of the China National Committee on Aging, family care satisfies elders with love from children and psychological comfort, which cannot be provided by other forms of EC²⁰⁴. However, there is a lack of clear principle and a common purpose to guide the planning and development of EC. There are international good practice principles to guide EC development that China may like to consider to endorse.

224. The lack of clear guiding principles may make China favor infrastructure development such as large size EC institution than software building such as a home-like and caring environment. Elderly, though healthy and active, may find themselves ending up in a large EC residential facility far away from their most familiar environment, and feeling lonely and bored. EC is not acute care, which focuses on treatment and curing. The focus of EC is on maintaining functions, slowing progression of impairments, and promoting active ageing. These foci should be used in guiding EC development especially when more integration with medical/health care is warranted.

10.1.2 No comprehensive EC system and plan

225. EC is a complex system. EC consists of many policies and components: RC, HCBC, etc., involves diverse stakeholders and cuts across multiple sectors: health, social, housing, etc. There appears to be no attempt to bring all seemingly unrelated components together and a plan to provide a clear roadmap on how the system will evolve. Because of this, human resources requirements is severely lagging behind the development of EC, medical/health and EC have been walking a different paths and at

²⁰³ http://news.xinhuanet.com/politics/2016-05/28/c_1118948763.htm

²⁰⁴ http://usa.chinadaily.com.cn/china/2016-09/17/content_26809497.htm

times, may work against each other, and quality of EC has been compromised. EC is more than brick and mortar, it is about building a system that will bring all seemingly unrelated EC components together so that every EC player has a clear idea of how the big EC picture looks like, know where they posit in the big picture and how they can contribute to the realization of outputs, outcome and impact of EC.

10.1.3 EC services are not well targeted

226. All the EC policy statements point to the direction that EC is for those with LTC needs: nursing and ADL, and/or financial difficulties such as 3 Nos. In practice, the target of EC is very confused. Majority of elderly in EC, both HCBC and RC, are healthy with no care needs. Not only is this a waste of public resources, it also takes away precious EC resources from those who are in need. People with real care needs do have hard time to find an appropriate RC bed. Many RC facilities are either inadequate to admit cases with complicated care needs or fully occupied by healthy individuals. It is fine for those people who prefer to live in a nursing home, as long as no public funding support is involved.
227. It is unwise to use EC to address other psychosocial problems such as loneliness, family conflict, housing, etc. There are better ways of addressing these problems at lower cost. Many developed countries have separated housing from care. For instance, In Canada and Japan, there are two types of facilities for the elderly: (1) nursing homes, chronic care, or long-term care hospitals (2) residences or collective residences for senior citizens. Category (1) facility is for people with care needs after proper assessment and is subsidized by public funding and social insurance. Majority of category (2) is for people with no care needs, who move into these facilities entirely based on individual lifestyle choices. The Hong Kong government operates compassionate housing for those elderly with housing but no care needs.

10.1.4 Imbalanced development of RC and HCBC

228. Like the rest of China, EC in Hebei is a three-tier system: “home-care as the foundation, community services as backbones, and residential care facilities as supplements.” In practice, it is RC lopsided and HCBC received very little attention. In addition, local governments tend to prioritize their resources for the expansion of RC and/or infrastructure of HCBC neglecting investment in HCBC services. Many people, including the EC and family members, are unaware what HCBC can do for them. Many used it as social recreational center for the elderly. HCBC centers in the community are not designed to fit the need of the impaired.

10.1.5 ICT is under-utilized

229. The use of ICT in EC in Hebei has been largely limited to IT call center, which has been useful for those who have used it. However, the proportion of elderly users of IT call center has been relatively small. A large portion of the elderly population have yet to realize the benefits of an IT call center. Most of them obtain the free phone but hardly use it to reach the call center hotline. More education of the elderly may be needed.

230. IT call center may be one of the functions of ICT. There are many other things that ICT can do to enhance EC services, improve quality of EC, and ease the workload of EC workers. For instance, electronic medical/health record (EMR) enabling care professional to access essential information in the care of the elderly; internet of things (IoT) such as the use of wearable providing timely feedback to warn of health concerns etc., care just some examples. EC has always been criticized as a low productivity industry – labor intensive and low tech. Failure to fully realize the potentials of ICT again reinforces people’s image of EC.

10.1.6 Scarcity of EC talents and workforce

231. This has been well discussed under Section 2.5 and Section 6. It was documented by ADB²⁰⁵, the Sociology Institute - China Academy of Social Science²⁰⁶ and the Economic and Social Commission for Asia and the Pacific, UN.²⁰⁷ HR scarcity in EC has compromised EC users’ well-being and becomes a quality of care and risk management issue. The scarcity of EC workforce and talents are not due to shortage of policy support. They are largely due to: (1) EC work has been poorly paid and poorly appreciated and (2) EC work force lack of professional knowledge and skills.

10.1.7 Underprepared EC stakeholders including providers

232. Many government officials and providers entering the EC sector with very little knowledge and experience. The government officials may be familiar with issues such as financial difficulties but not complex care issues with multiple psychosocial needs. Many prospective EC operators are executives and managers of other industries like steel mill, garment factory etc. However, running an EC operation is far more sophisticated than an industry as it engages people from all sorts of professionals and non-professionals, and involves service users with complex care needs. Annex D is a number of clinical issues need to be addressed in EC setting. Without proper knowledge, the government cannot develop implementation standards and guidelines for the local officials to monitor. Similarly, the prospective operators may not realize the potential care and financial risks in the development and implementation of an EC plan.
233. The lack of appreciation of the complexity in EC care may be one of the main reasons why:
- i. Majority of EC users are healthy and independent when the policy requires EC priorities be given to those with care needs and/or financial difficulties²⁰⁸;
 - ii. EC in China still favors RC than HCBC whereas the policy stated is otherwise;

²⁰⁵ ADB

²⁰⁶ 中国社会科学院社会学研究所 (2014). 中华人民共和国 老龄化问题相关的信息收集与确认调查 最终报告书. 日本国际协力机构 (JICA). p.29-30. Available at - http://open_jicareport.jica.go.jp/pdf/12153284.pdf

²⁰⁷ Economic and Social Commission for Asia and the Pacific, UN. (2016). *Long Term Care for older persons in China*. Social Development Division, UN.

²⁰⁸ The Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly (2013)

- iii. HR of EC in Hebei continues to be a major concern hindering EC development, despite repeated policy directives including 12YFP and 13YFP call for speeding up training in EC personnel training; and
- iv. The whole spectrum of clinical services in EC was omitted in the multiple rounds of submission and resubmission of FSR for this PPTA.

10.1.8 Inadequate setup and service to provide health services to the elderly in EC

- 234. Many existing EC facilities, RC and HCBC, are not well designed to meet the needs of the people with care needs. Accessibility has been an issue. Many elderly community centers where the adult day care centers are located, are situated on the upper floor of a building without elevator. Many RC facilities have been designed for people who are independent and mild impairment. These facilities are designed to exclude than include people with moderate to severe physical and/or cognitive impairment.
- 235. The encouragement of the policy on medical/health care and EC integration, which allows health providers to be reimbursed via the medical insurance scheme for providing health care services in EC setting. This creates incentive for EC providers to include more health care services in EC and to establish medical rehabilitation center. According to the policy, health services to be provided may include, but not be limited to post-acute (e.g. transitional care) and sub-acute care (e.g., oxygen therapy), rehabilitation and palliative care. These new programs will push the EC to a new level of complexity which may require more professionals such as skilled nursing, rehabilitation specialists and social work. Regulatory issues such as scope of practice, professional qualifications and compliance with complex medical regulations are just some of the challenges to be resolved.

10.1.9 No incentive to provide quality and appropriate level of EC

- 236. EC especially RC in China has been criticized for being low in quality and over in supply. This was discussed in Section 5.6. One of the reasons is that the EC subsidies and preferential policy are not well targeted. They are made to the service providers rather than the elderly, and they are not given based on need. For instance, the EC operating organization will be awarded 4,000 Yuan for each EC bed added and then 1,200 Yuan per year for each occupied bed regardless if the bed is being used by elderly with care or no care needs. Providers, hence attempt to maximize government subsidy by adding more RC beds, without considering if these beds are really needed. As a result, 25 - 50% of the beds are unoccupied. The EC providers also become selective by favoring those elderly with less/no care needs than those with more care needs because there is no difference in subsidy for doing otherwise.

10.1.10 EC service is unaffordable

- 237. Many experts believed EC will be predominately a private pay market.²⁰⁹ If EC service is to be paid privately, many people in Hebei will not be able to afford the high EC cost

²⁰⁹ Christian J. (2015). China's Senior Care Market. Rubicon Strategy Group. www.HealthIntelAsia.com

without other sources of income such as family support, LTC insurance, government subsidy, etc. Except public EC service with substantial government subsidy, EC in Hebei in general is unaffordable when measured by its fee schedule to the amount that the prospective user is able and/or willing to pay. There is a significant gap between fee charges and elderly's willingness to pay and/or ability to pay.

238. Income affects one's ability to pay. In 2013, average disposable income for all ages was 1,850 Yuan in urban and 770 Yuan rural Hebei. In Xinji, the average monthly income of elderly was about 756. 1/3 of the elderly had a monthly income of less than 100 Yuan.²¹⁰
239. Current RC fees ranged from 800 – 5,000 Yuan depending on care level (see Table 12). RC fees in urban Hebei is more expensive than in rural Hebei. However, urban residents have higher income than their counterpart in rural Hebei. Future EC fee schedule proposed by prospective operators of this PPTA in general will be more expensive than current rates. RC ranges from 2,000 – 3,200 Yuan a month depending on care level. It will cost 50 Yuan a day for adult day care center service. In terms of willingness to pay, about 70% of the elderly surveyed are willing to pay between 600 – 2,400 Yuan a month for a RC bed, 0 - 500 Yuan a month for adult day care and 500 Yuan a month for personal care at home.

10.1.11 Lack of breakthrough thinking in EC

240. This is not to suggest that Hebei never has breakthrough projects. There were “care-with-love project” – a prototype of medical/health care and EC integration” in 2006 and “merging of EC facilities in rural Hebei” in 2009 (see Section 2.10). The latter project's experience was even mentioned by the Ministry of Civil Affairs at the “National Urban and Rural *Dibao* Work Conference” in Hainan in 2011. What is missing is that the outcomes of these projects have been known to a few, no one else can learn from the success and failures of these projects. More importantly, there is no new care model evolved by using the lessons learned.
241. It is a different story in Shanghai and Beijing which have taken integration and merging of EC to a new level. For instance, Community Senior House in Beijing and Elderly Home in Shanghai are just examples of seamless integration within EC. RC and HCBC are all grouped under one roof, one organization, one management and one care team. Typical services of these facilities include (1) RC (about 50-100 beds): for dependent seniors whose care needs is above level three according to a care need appraisal; (b) Medical rehabilitation center: short-term accommodation for seniors who might retrieve from hospital (post-acute) and need rehabilitation service or families who need respite care; and (c) HCBC: home visiting and care services to seniors residing in the community. Services can be extended to other EC related areas, such as training for family

²¹⁰ Xu Yuebin, Chen Lin and Wang Xiaobo. (2016). *Assessing Care needs of Urban Community Dwelling Elderly People in Xinji*. Asian Development Bank: SC 106398 PRC: Preliminary Survey Work to Support Development of the Hebei EC Development Project. Table 4.3.3 & 4.3.4

caregivers, etc. Medical rehabilitation center. This type of integrated EC has increased in number and the local governments have been very supportive. Not only did the government build the facility and contract out to private provider to operator, the government has been very generous in providing necessary subsidy. The occupancy rate has been high and close to 100%. Hebei EC stakeholders appear to be unheard of this development. The proposed EC model in general has been very traditional and large in size.

10.1.12 Under-educated family caregivers and the general public

242. Family have been and will be the main sources of EC in China especially when a great majority of the elderly are linked to and supported by their children. Not only does supporting the family to care for the elderly in need fit well with the Chinese culture, it is also more economical than formal EC. Thus the role of family in the care of elderly should never be undermined when promoting EC.
243. Most of the public including the elderly have limited knowledge of EC. This may be another reason why EC is RC lopsided. Not only do the government and providers want to build more RC, the public also consider RC as the preferred option. Without knowing the other EC options and what these options can do to help the impaired elderly, prospective EC users and family will not be able to make a smart EC decision.

10.2 Recommendations

10.2.1 Adopt principles and develop strategies for EC planning and development

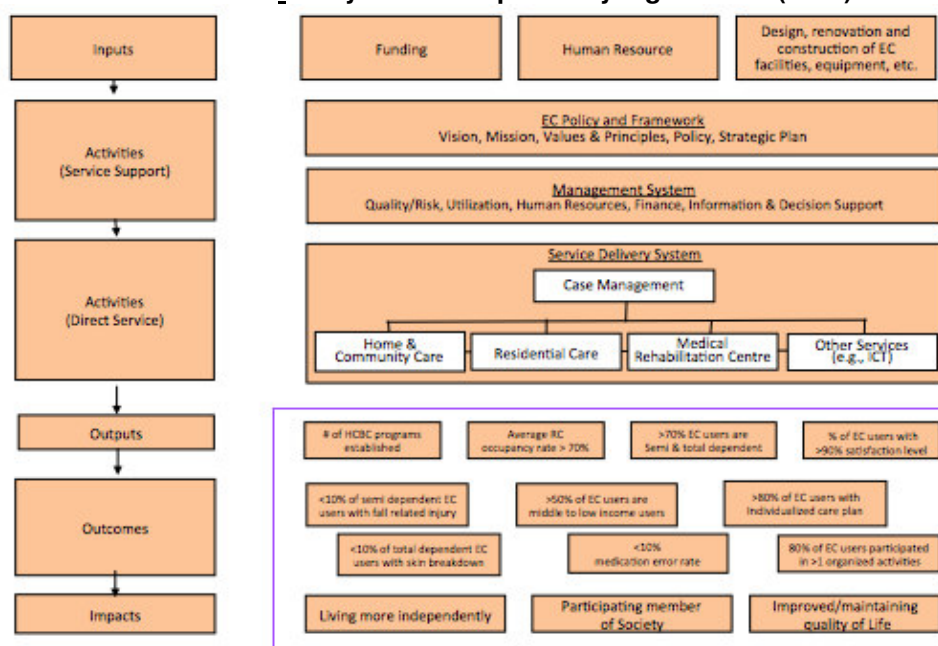
244. That the key EC stakeholders in Hebei including the HPG, investors and operators, continue to support China's great tradition of "filial piety" and "law and policy" of EC. In addition, China/HPG will consider the adoption of international good practice principles in EC development. These principles have been found to improve the quality of life for the elderly and significantly reduce EC costs. These principles are to promote: (i) aging in place by creating an enabling environment for elderly to remain at home, in their communities, supported by adequate services; (ii) "de-institutionalization" by developing systems that promote proper use of EC services. For instance, residential care facilities only for those in need of residential care services and (iii) active aging by supporting preventive health and social care programs that keep the elderly healthy and contributing members of their respective communities. Application of these principles will also lead to an appropriate balance of investment in HCBC, RC and Medical Rehabilitation Center.
245. In addition, that key stakeholders will endorse, but not limited to, the following key EC objectives,
- (a) stay healthy and fit (health promotion),
 - (b) prevent people with impairment from getting worse (health prevention - chronic disease management),

- (c) ensure a smooth path between hospital and home (transitional care) when hospitalization is needed; and
- (d) slow the progression of increasing dependence (e.g., long term care) including care at the end stage of life (e.g., hospice and palliative care facilities).

10.2.2 Establish an EC system and system plan at all levels

246. That the key EC stakeholders in Hebei will develop a EC system by using the logic model (or decision-making framework: DMF) and EC system plan. The logic model includes a logical relationship between inputs - resources, throughputs - key activities, and outputs - outcomes and impact. It starts with the end in mind: project outputs, outcomes and impact. The wellbeing of the elderly should always be the center of measures and matrices of EC outputs, outcomes and impact. Client care outcomes should always take precedence. These measurements, when comparing to infrastructure measurement such as the number of beds/facilities completed, are harder to define and measure. But they are doable. One important of the model is to enable project stakeholders: government, IAs and service providers to think outside the boundary of resources: funding, human resources, building, etc. and to search for ways on what need to be done or changed for the achievement of EC outputs and outcomes. "What need to be done or changed" are the key activities of the EC system, which include, but not limited to (1) EC policy and framework, (2) management support and (3) direct service delivery.

DIAGRAM 6: EC system as depicted by logic model (DMF)



247. Along with an EC system, there should be an EC strategic plan at all levels: provincial and municipal levels, providers' organizations, tertiary training institute, etc. The plan provides a clear roadmap on how the system will evolve. The EC plan does not mean to replace central and/or provincial FYP. Instead it is to support the realization of FYP in a

more concrete manner, which will include strategies/tactics, deliverables, milestones, champions, output and outcome indicators etc. The plan will stipulate what each EC stakeholder will do in the next 5-10 years, which include (1) EC services to be delivered and other enabling strategies; (2) financial sustainability such as government subsidy, user fees, long term care insurance etc.; (3) risk and service quality management; (4) human resource plan and (5) intra and inter sector collaboration including (a) health and social (elder) care integration and (b) management of public expectation.

248. The HPG fully realizes the importance of building an EC system and intends to rely on this PPTA to improve the functions and to build the software of EC in Hebei²¹¹.

10.2.3 Differentiate between elderly with care needs and those with no care needs

249. That provincial and local Departments of Civil Affairs develop a mechanism to determine EC eligibility for people with care needs and requiring government subsidy. This requires an assessment of impairment and classification of level of care. This may include service matching, planning, coordinating and monitoring. Eventually, it may require a case management system. LTC insurance operating agencies provide simple and straightforward criteria for determining people eligibility of long term care benefits. This should be a good start. As the government is also responsible for the financially destitute, the assessment of eligibility may also include a means testing.

250. For those who have no impairment and choose to receive EC, this is a personal lifestyle choice and should not be supported by public funding. Public funding should not compete with the private market for services to the elderly who have no impairment but prefer EC as a lifestyle choice. For the wellbeing of the elderly and cost effectiveness, it will be less costly for the Chinese government in long run to develop compassionate housing options for people with no care needs but cannot afford elderly housing in the private market.

251. Able-bodied elderly with other economic, housing and psychosocial needs such as income assistance, housing, psychosocial support, etc., will be met by other public programs or services more appropriately.

10.2.4 Strike a balance between RC and HCBC

252. That key EC stakeholders make the development HCBC a priority in Hebei by investing more resources such as funding and manpower. The current EC system is RC lopsided. There have been far more RC and HCBC providers.

253. To begin, a clearer definition of HCBC is required. HCBC is designed to help older people stay independently in their own homes. In China, HCBC is divided into home and community care. Home care is often used to refer to services that old people receive at their own homes, which may be delivered to them by specialized service agencies such as the privately operated housekeeping or home-care service agencies. Community care

²¹¹ Hebei provincial DRC, Department of Finance and Civil Affairs Bureau. (2015). ADB Financed Hebei EC Service System Development Project (July 16th, 2015)

is usually referred to services operated in and by the community where the elderly lives such as the community elderly center/stations, day care centers, and some small scale (<50 beds) RC facilities in the community.²¹² HCBC may include the use of RC on a temporary basis such as respite care. Home care may also include specially designed or adapted living arrangements to guarantee a high degree of autonomy and sense of control.²¹³

254. The next step of strengthening HCBC is to significantly increase the variety of HCBC services especially in medical and health services. In countries where HCBC is more mature, HCBC is more than just homemaking and adult day care center. HCBC services are diverse and many: homemaking, home modification, home care nursing and rehabilitation, elderly companion, elderly outreach, community canteen, elderly community center, elderly community health center, adult day care, day hospital, short stay and assessment center (STAT), independent and assisted living facilities, etc. Because of enhanced health support, HCBC is able to deal with more complex and impaired cases such as dementia and neuro-degenerative diseases. In Hong Kong where there are 200+ adult day care, 20+ of them are specifically catered for dementia care, who need both physical and mental care²¹⁴. For instance, an elderly with dementia may receive 3 days home care nursing and rehabilitation, homemaking and visit by elderly companions, and 3 days adult day care service per week. The elderly may be admitted to a short stay and assessment center 2-3 weeks per year as respite care so as to relieve the family from the burden of care. All services are coordinated, monitored and adjusted closely with the help of a case manager. The intensity and cost of HCBC may very much equivalent to RC.
255. Thirdly, a good case management system is needed, This involves a profession such as a social worker or nurse as the primary contact who is responsible for person (the client) and system link, and service coordination. The Case Management Society of America (CMSA, USA) defines case management as 'a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health and social needs through communication and available resources to promote quality cost-effective outcomes' (CMSA website).²¹⁵

10.2.5 Make ICT an integral part of EC

256. That key EC stakeholders in Hebei may consider hiring external consultant to identify ICT opportunities for EC in Hebei. It may include visits to other regions and/or countries to get an understanding on how ICT is being used for the enhancement of EC.

²¹² Xu Yuebin (2014). The EC system in China. ADB SC#102836. p.5

²¹³ Chan Peter, et.al. (2015). Study Report on the National and International Experience on EC. ADB Project# 48004-001. Glossary of Terms.

²¹⁴ <http://www.scmp.com/lifestyle/health-beauty/article/2019974/who-will-care-rising-number-hongkongers-dementia>

²¹⁵ <http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx>

10.2.6 Develop comprehensive HR development plan for EC

257. That key EC stakeholders in Hebei including the Department of Civil Affairs, Department of Finance, Department of Health, Department of Human Resources and Social Security, tertiary training institutions, vocational school representatives and EC providers work together to come up with a systemic solutions. The solutions should include measures to address push factors – that push people away from EC such as low pay and poor image, and to improve pull factors that pull people to join the EC industry such as education and career path and planning.
258. Pushing factors
- i Increase pay and subsidy for the care workers, e.g., pay for performance, gratuity, dividend, sign on bonus, end of contract bonus, etc.
 - ii Increase EC employees' insurance coverage and fringe benefit
 - iii Increase government subsidy e.g., education allowance, examination fee allowance, etc.
 - iv Improve work environment making the workplace more employee friendly such as the use of ICT e.g., EHR/EMR, fall alert devices, etc.
 - v Promote the social image of EC work
259. Pulling factors
- vi Long term HR planning in EC
 - vii Comprehensive HR training system
 - viii Certification and registration of EC staff
 - ix Continued education including on the job training
 - x Expanding the professionals in EC e.g., social workers, rehabilitation specialists, dietitians, etc.
 - xi Training for geriatric and gerontological professionals
 - xii Training for EC leaders and managerial staff
 - xiii Inclusion of volunteers and family members.

10.2.7 Build the capacity of EC stakeholders

260. That key EC stakeholders in Hebei agree to increase their capacity in EC by participating in all capacity building activities.
261. Generic EC knowledge: both clinical and non-clinical
This should start with the major principles and objectives (see Section 10.2.1) in mind and include major clinical, personal care and other non-clinical issues of EC such as skin care, falls, psycho-geriatric problems, poly-medication, social recreational activities, food, etc.
262. The Government: assessment and service monitoring.
The provincial and local governments should strengthen the EC expertise of the staff and increase the size of staff to man the local EC office. There should be knowledgeable and sufficient staff at the local Civil Affairs Office to develop a gatekeeping mechanism including a service matching and a waiting list management systems, and to monitor EC quality - maintaining ongoing liaison with service providers and addressing service users concerns

and complaints. The Civil Affairs may want to coordinate with the Human Resources and Social Security in the development of EC assessment as the latter will have to conduct LTC eligibility assessment when LTC insurance is implemented.

263. Investors and Operators: utilization and quality management

Utilization management is to keep track of use of EC resources by ensuring all EC services are fully occupied e.g. RC beds and HCBC places; and HR are fully engaged. An under-utilized EC resource implies wastage of organization resources. Remedial measures are thus required to stop wastage. Quality management ensures adequate risk management to deal with emergency and accident, and continuous improvement to quality of care.

10.2.8 Design EC facilities and service with a geriatric focus

264. That key EC stakeholders in Hebei develop detailed standards and guidelines of health care to be delivered in EC setting.

265. EC hardware and software design should be geriatric focused and with care in mind. For construction, it should consider dementia care and infection control. Care of people with cognitive impairment may be even more challenging than people with physical impairment. Designing and building of RC and HCBC facilities, better way finding, lighting, and reduced noises are important to support people with memory loss and dementia. RC and HCBC produce a large amount of medical and bio hazardous waste. There must be provision to support waste management including designated and separated areas for soiled and clean materials, areas for waste storage and disposal.

266. In the caring of frail and impaired elderly, there are a number of geriatric specific clinical issues stipulated in Annex D. There should be also programs to deal with these issues across the HCBC, RC and the medical rehabilitation center.

10.2.9 Create incentive for better EC quality and resources utilization

267. That HPG revised the practice of its EC subsidy and preferential policy by target them more on EC users than service providers.

268. This can be done by converting construction and operating subsidy into EC service vouches, which will be given directly to the elderly eligible for EC. This allows the users to use their purchasing power to influence the supply of EC service, pricing and quality. EC users can use their subsidy along with LTC insurance benefits, family financial support, personal income etc., to shop around different providers, and to buy EC service from the quality providers at an affordable price. Ultimately, the market force will eliminate low quality providers including those with inadequate staffing. Those with high quality and low cost should thrive.

269. Government will continue to be a major buyer of EC service despite the increasing EC involvement by private investors and providers. The HPG should therefore use its EC funding as incentive for bettering EC service quality and utilization. Government EC funding, in other countries, have been used in four different manners:

- i. Global funding - the provider is contracted for the delivery of ES for a fixed period of time in return for a fixed amount of funding. This type of funding will have minimal impact on the quality and utilization of EC. The providers will get the funding anyway regardless if they provide quality of care or if their EC beds are fully occupied.
- ii. Activity-based funding – the provider is funded based on type (e.g., levels of impairment) and amount of service provided. This type of funding creates the economic incentive for the providers to take on more complex cases.
- iii. Pay for performance (P4P) - the provider will be paid for achieving pre-set specified objectives such as reaching the thresholds of keeping a proportion of designated elderly, i.e., moderately impaired, in the community without using RC services. This type of funding will have more impact on the quality and utilization of EC than other funding mode. The providers will get the funding only if they achieve the preset goals on service quality and utilization.
- iv. Bundles of care – the provider will be paid for providing a package of services such as HCBC and RC to a designated elderly population. This type of funding will encourage the providers to provide integrated care so as to maximize economy of scale and scope of EC. For instance, the rehabilitation facility can be shared among users of RC, HCBC and the Medical Rehabilitation Center.

270. In practice, these funding modes have been used in combination. Thus the government can maximize the impact of its funding to achieve high quality of care and service utilization. The government will define EC target population, specify EC issues to address and identify the desired results.

10.2.10 Make EC service in Hebei affordable

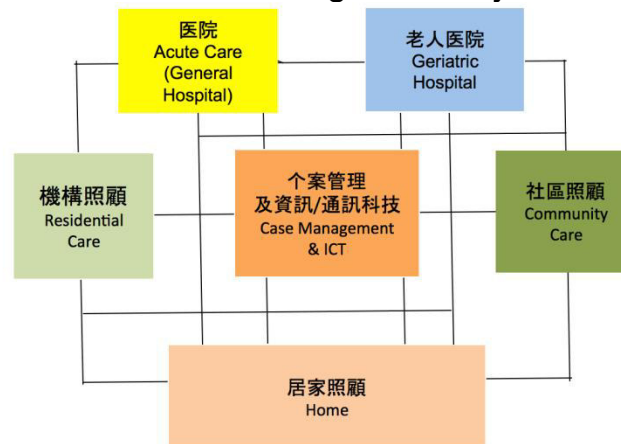
271. That the HPG makes substantial change in its EC subsidy so as to make EC service affordable. This can be accomplished by considering the following steps:
272. Firstly, the HPG should disallow profiteering in EC especially EC services receiving public subsidy and/or benefitting from government preferential policy such as low land cost. In many other countries, the profit margin of EC with public support is capped. For instance, when providers bidding for government funded EC projects, prospective bidders have to include proposed fee schedule as part of their bidding proposals. The fee schedule will then be used as an essential criterion in determining successful bidder. High profit margin in EC has been acceptable as long as there is no public funding or preferential policy support involved.
273. Secondly, HPG adopts the practice of LTC insurance by linking benefits with care level. People with more impairment will receive more benefits than people with less impairment. This inevitably will involve impairment assessment similar to that of LTC insurance eligibility assessment.

274. Thirdly, HPG ensures there are multiple financial sources to support EC including personal saving, children support, long term care insurance, government subsidy etc. Government will provide subsidy to cover the difference between EC fee and combined multiple incomes. This will inevitably include means testing, which has been a practice for people receiving public welfare benefit such as *Dibao* in China.

10.2.11 Try innovative EC model that supports quality and integrated care

275. That key EC stakeholders in Hebei will try innovative EC model that promote quality and integrated care.
276. Integration occurs within and outside current EC system. Within the EC, it is the integration of home, community, residential care and medical rehabilitation. The elderly will gradually move from home to community care and may end up in residential care and medical rehabilitation as their conditions deteriorate and their age advances. Thus, the current bundle of HCBC, RC and medical rehabilitation under one service provider is a better arrangement than stand-alone services. In many countries, this is called bundled care when the operator is asked to deliver RC and HCBC as a bundle. There are at least two advantages: economy of scale and economy of scope. In economy of scale, for instance, the same kitchen preparing meals for RC residents can be expanded to prepare meals for community dwelling elderly with limited additional cost. In economy of scope, RC offers far more clinical services than HCBC, HCBC users may benefit from, for instance, the rehabilitation programs of RC. On the other hand, RC users may benefit from the social recreational programs of HCBC. Outside EC, there is a need to better integrate health, housing, transportation, social recreation, etc. Elderly's needs are far more than HCBC, RC, and medical rehabilitation. They, at times, will need primary and acute care support, housing, transportation and social recreation. Inter-sector collaboration is far more complex than integration within EC. This may require government leadership and support. Under the policy of medical/health care and EC integration
277. Diagram 7 is an integrated EC system - all related components of EC are linked to form a holistic EC delivery system. Diagram 7 has two important features. Firstly, all lines are bi-directional. All components are interlinked for back and forth movement. Secondly, case management along with integrated electronic health record system through ICT coordinate the movement of elderly along the integrated EC system.

DIAGRAM 7: An integrated EC system



278. An elderly residing at home, when encountering an acute condition such as fracture hip, may be admitted to an acute hospital for diagnosis and treatment including surgery. The elderly may take time to become fully mobile and the process can be slow. Assuming this process takes 5-6 months, the elderly can first be transferred to a medical rehabilitation center for further rehabilitation. After 2 months of stay in a medical rehabilitation center, the elderly will be discharged home with home and community support, and continue rehabilitation for another 4 months. In case fully recovery is impossible, elderly can either continue to receive home and community care and continue to stay at home. Only when the elderly fail to thrive after home and community care, the elderly can then be considered for RC if RC is the elderly's preferred option. A designated professional – the case manager, will coordinate all these services and activities.

10.2.12 Manage public expectation of EC through public education

279. That HPG launch public education to manage public expectation of EC.
280. Firstly, public education is needed as the general public may not have sufficient and/or appropriate knowledge of EC. Public need to acquire sufficient knowledge on the types of EC services available in the community and know how the system works. They will then be able to make smart decision based on good EC knowledge, personal preference and affordability.
281. Secondly, public need to understand that EC is not general service for all elderly persons such as recreational activities, library service, etc. EC is for people with care needs. EC will be available only after a stringent assessment is completed to determine eligibility. For elderly with no care need but requiring EC are entirely a lifestyle choice based on individual preferences and resources. However, for elderly with functional impairment and requiring public funding support, those choices are no longer a personal preference, they are public concerns as they affect the use of public resources.

282. Thirdly, informal care continues to play a critical role in providing EC. The HPG should recognize the burden of informal care through caregiver supporting programs such as caregiver education; and should create financial incentives (e.g., financial allowance and tax exemption, etc.) and support (e.g., respite care) so that the family can continue to perform this vital role.
283. Finally, people should be encouraged to prepare for their old age. Government cannot do all. People will have to take action to protect their risk of becoming impaired in old age including saving and buying LTC insurance. The HPG may consider the provision of tax incentive to encourage saving for LTC in old age and provide options of social or private insurance.

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ANNEXES

A. Policies and Legal Framework of EC industry in China and Hebei

State Council and all other Departments (国务院及各部委)²¹⁶

2015

- (1) 国务院《在交通环保医疗养老等领域推广 PPP 模式》(2015 年 5 月 14 日)
- (2) 国务院办公厅转发民政部等部门《关于进一步完善医疗救助制度全面开展重特大疾病医疗救助工作意见的通知》(国办发〔2015〕30 号 2015 年 4 月 28 日)
- (3) 国家发展改革委办公厅 民政部办公厅 全国老龄办综合部《关于进一步做好养老服务业发展有关工作的通知》(发改办社会〔2015〕992 号, 2015 年 4 月 22 日)
- (4) 民政部 国家开发银行《关于开发性金融支持社会化养老服务体系建设的实施意见》(民发〔2015〕78 号, 2015 年 4 月 14 日)
- (5) 国家发改委办公厅《关于印发<养老产业专项债券发行指引>的通知》(发改办财金〔2015〕817 号, 2015 年 4 月 7 日)
- (6) 国家发展改革委 民政部《关于规范养老机构服务收费管理促进养老服务业健康发展的指导意见》(发改价格[2015]129 号, 2015 年 3 月 3 日)
- (7) 民政部 发展改革委等十部委《关于鼓励民间资本参与养老服务业发展的实施意见》(民发〔2015〕33 号, 2015 年 2 月 3 日)
- (8) 国家发展改革委 民政部《关于规范养老机构服务收费管理促进养老服务业健康发展的指导意见》(发改价格〔2015〕129 号, 2015 年 1 月 19 日)
- (9) 教育部办公厅 民政部办公厅 国家卫生计生委办公厅《关于遴选全国职业院校养老服务类示范专业点的通知》(2015 年 1 月 13 日)

2014

- (10) 财政部 国家税务总局《关于支持文化服务出口等营业税政策的通知》(财税〔2014〕118 号, 2014 年 12 月 30 日)
- (11) 财政部 民政部 工商总局 关于印发《政府购买服务管理办法 (暂行) 》的通知(财综[2014] 96 号, 2014 年 12 月 15 日)
- (12) 商务部 民政部《鼓励外国投资者在华设立营利性养老机构从事养老服务》公告 (2014 年第 81 号, 2014 年 11 月 24 日)
- (13) 财政部 国家发展改革委《关于减免养老和医疗机构行政事业性收费有关问题的通知》(财税〔2014〕77 号 2014 年 11 月 23 日)

²¹⁶ http://mp.weixin.qq.com/s?__biz=MzA3ODIwNTMxOQ==&mid=209704943&idx=1&sn=7b50693f93086a79dfa5b2af23ca00b9&scene=5&srcid=whciyKroMC8bE0Olzap#rd

- (14) 商务部《关于推动养老服务产业发展的指导意见》（加急 商服贸函〔2014〕899号，2014年11月14日）
- (15) 国家卫生计生委办公厅关于印发《养老机构医务室基本标准（试行）》和《养老机构护理站基本标准（试行）》的通知（国卫办医发〔2014〕57号,2014年10月31日）
- (16) 民政部 发展改革委等六部门《关于开展养老服务和社区服务信息惠民工程试点工作的通知》（民函〔2014〕325号，2014年10月30日）
- (17) 财政部 民政部 全国老龄办《关于建立健全经济困难的高龄 失能等老年人补贴制度的通知》（财社〔2014〕113号 2014年10月23日）
- (18) 国家发展改革委 民政部等部委《关于加快推进健康与养老服务工程建设的通知》（2014年9月19日）
- (19) 财政部等部委《关于做好政府购买养老服务工作的通知》（财社发〔2014〕105号，2014年8月26日）
- (20) 民政部办公厅 发展改革委办公厅《关于做好养老服务业综合改革试点工作的通知》（民办发〔2014〕24号，2014年8月26日）
- (21) 住房和城乡建设部等部委《关于加强老年人家庭及居住区公共设施无障碍改造工作的通知》（建标〔2014〕100号，2014年7月8日）
- (22) 民政部办公厅《关于开展国家智能养老物联网应用示范工程的通知》（民办函〔2014〕222号，2014年6月20日）
- (23) 保监会《关于开展老年人住房反向抵押养老保险试点的指导意见》（保监发〔2014〕53号，2014年6月17日）
- (24) 国家发展改革委等部委《关于组织开展面向养老机构的远程医疗政策试点工作的通知》（发改高技〔2014〕1358号，2014年6月16日）
- (25) 教育部等九部门《关于加快推进养老服务业人才培养的意见》（教职成〔2014〕5号，2014年6月10日）
- (26) 民政部等部委《关于推进城镇养老服务设施建设工作的通知》（民发〔2014〕116号，2014年5月28日）
- (27) 国土资源部办公厅关于印发《养老服务设施用地指导意见》的通知（2014年4月28日）
- (28) 政部 中国保监会 全国老龄办《关于推进养老机构责任保险工作指导意见》（民发〔2014〕47号，2014年2月28日）
- (29) 国务院《关于建立统一的城乡居民基本养老保险制度的意见》（国发[2014]8号，2014年2月21日）

- (30) 住房和城乡建设部等部门《关于加强养老服务设施规划建设工作的通知》(建标〔2014〕23号, 2014年1月28日)
- (31) 民政部等部委《关于加强养老服务标准化工作的指导意见》(民发〔2014〕17号, 2014年1月26日)
- (32) 住建部 关于发布国家标准《养老设施建筑设计规范》的公告

2013

- (33) 国家卫生计生委《关于加快社会办医的若干意见》(国卫〔2013〕54号, 2013年12月30日)
- (34) 民政部办公厅 发展改革委办公厅《关于开展养老服务业综合改革试点工作的通知》(民办发〔2013〕23号, 2013年12月27日)
- (35) 民政部《关于开展公办养老机构改革试点工作的通知》〔2013〕369号, 2013年12月13日)
- (36) 民政部《关于建立养老服务协作与对口支援机制的意见》(民发〔2013〕207号, 2013年12月13日)
- (37) 国务院《关于促进健康服务业发展的若干意见》(国发〔2013〕40号, 2013年9月28日)
- (38) 国务院《关于加快发展养老服务业的若干意见》(国发〔2013〕35号, 2013年9月6日)
- (39) 民政部《关于推进养老服务评估工作的指导意见》(民〔2013〕127号, 2013年7月30日)
- (40) 民政部 财政部《关于做好2013年度中央专项彩票公益金支持农村幸福院项目管理工作的通知》(民函〔2013〕236号, 2013年7月19日)
- (41) 《养老机构管理办法》(民政部令第49号, 2013年6月28日)
- (42) 《养老机构设立可办法》(民政部令第48号, 2013年6月28日)
- (43) 财政部 民政部关于印发《中央专项彩票公益金支持农村幸福院项目管理办法》的通知(财综〔2013〕56号, 2013年4月28日)
- (44) 商务部 民政部《关于香港、澳门服务提供者在内地举办营利性养老机构和残疾人机构服务有关事项的通知》(商资函〔2013〕67号, 2013年2月17日)

2012

- (45) 《中华人民共和国老年人权益保障法》(主席令第72号, 2012年12月28日)
- (46) 民政部 国家开发银行《关于贯彻落实<支持社会养老服务体系建设的规划合作协议>共同推进社会养老服务体系建设建设的意见》(民〔2012〕209号, 2012年11月6日)

(47) 民政部《关于鼓励和引导民间资本进入养老服务领域的实施意见》（民发〔2012〕129号，7月24日）

2011

(48) 国务院《关于印发中国老龄事业发展“十二五”规划的通知》（国发〔2011〕28号，2011年9月17日）

(49) 国务院办公厅《关于印发社会养老服务体系规划建设规划（2011 - 2015年）》（国办发〔2011〕60号，2011年12月16日）

(50) 民政部《社区老年人日间照料中心建设标准》(2011/3/1)

(51) 民政部《老年人养护建设标准》(2011/3/1)

Hebei

1. “The 12th Five-Years Plan for EC in Hebei Province”

河北省老龄事业发展“十二五”规划

2. “Opinions on speeding up the building of an EC System” (2014/6/24)”

河北省人民政府《关于加快推进养老服务体系建设的意见》

3. “Opinions on speeding up the development of EC”, was issued by the provincial government (2014)”.

河北省人民政府《关于加快发展养老服务业的实施意见》

4. “Notice about implementing tax reliefs to support the development of EC organizations (2011)”

河北省民政厅《关于落实国家支持老年服务机构发展税费减免政策的通知》

5. “Opinions on the implementation of rewards and subsidies for EC organizations (2012)”

河北省民政厅财政厅《关于对养老服务机构实行奖补的意见（试行）》

6. “Notice about land supply for the building of EC organizations” issued by the Department of Land and Resources and the Department of Civil Affairs (2011)”.

河北省民政厅国土资源厅《关于做好建设养老机构用地工作的通知》

7. “Notice about providing free training and accreditation for current EC workers” (2011)”.

河北省人保厅财政厅民政厅《关于对在岗养老护理员开展免费职业培训和技能鉴定工作的通知》

8. “Guiding opinions on speeding up the implementation of subsidy for elderly in advanced age” was issued by the Department of Civil Affairs (2012)”

河北省民政厅《关于加快建立高龄老人生活补贴制度的指导意见》

B. National legislation and policies

1. The Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly (2013)²¹⁷

This legislation is an overarching framework, which outlines the rights of the elderly of PRC. It includes rights of elderly to receive:

- vi. Care and supports from their families
- vii. Social security such as people requiring long term care as target population of EC (#30)
- viii. Social services including EC: services (#37 & 38); priority for the widows disabled and advanced age (#41); services standards for EC facility construction, service and manpower, classification of EC facilities, assessment, service monitoring and fee charging (#42).
- ix. Priorities of service and social benefits such as housing, legal aids etc.
- x. Livable environment
- xi. Social participation and development
- xii. Legal protection and responsibility

2. A development plan for EC system (2011)

This document operationalizes the 12th Five Year plan by providing a definition of the EC system and its components, which is issued by State Council.

- ii. The EC system is defined as: home-based care as the base, community care as backbones, and residential care as supports. Among them, home-based care is defined as to include personal care, home care, rehabilitation, medical and nursing care, and psychological comforting. Community care includes day care and supports for home-based care. Residential care includes all residential facilities such as nursing home and other forms where old people are supported in their daily living and activities.
- iii. Multiple sources of funding are proposed such as land, taxation and government purchase of services. Welfare lotteries funds are required to prioritize the development of EC facilities. Local government is required to design policies to attract social organizations to provide services.

3. Opinions on government purchasing services from social organizations (2013)

This is the major document governing government purchasing services from social organizations, which was issued by State Council in September 2013. It was expected that by 2020 a well-developed system of government purchasing services from social organizations will be in place all over the country.

²¹⁷ <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201302/20130200418213.shtml>

- i. Definition of the contractual parties: Government, institutions with public administrative responsibilities and public funded mass organizations are all allowed to purchase services from social organizations. All social organizations that are registered through civil affairs, and enterprises and other social entities registered in the industry and commerce department are eligible for entering contract with government for providing services.
- iv. What can be purchased? All public services deemed suitable for provision through the market, and which social organizations have the capacity to provide, can be provided through purchasing services. The scope of government purchasing service should gradually expand in such basic public services as education, employment, social security, culture and physical education activities, and services for people with disabilities; other public services should be provided as much as possible through social organizations; and those services that should be provided by the government directly should not be provided through purchasing services. Local government is required to make a list of service items suitable to be purchased from social organizations.
- v. Methods of government purchasing services: Government purchasing services should be conducted transparently. Providers can be selected through different methods such as open bidding, inviting providers, competitive negotiation, selecting a single provider, or through price comparison.
- vi. Funds used by government purchasing services are part of government budget.
- vii. Performance management: Comprehensive performance evaluation mechanism should be established with participation of government, the service provider, and service users. The results of the evaluation should be disseminated to the society.

4. **State Council (Circular No. 35). Opinions on Promoting the Development of EC Service Industry, 2013.** ²¹⁸

This document provides the overarching guidelines for the development of the EC system in China, which was issued by State Council. It reaffirmed the principle of home-based care as the base, community care as the backbone, and residential care as support, and it called for the setting up of such a system all over the country by 2020. By then, all urban communities should have established a day care center and an activity center for old people with defined quality standards; over 90% of townships and 60% of rural communities should have a comprehensive community service center in place, which include the provision of EC services. The development of EC service industry will be based on four principles:

- i. System reform by simplifying administrative interference, strengthening policy support and monitoring, enhancing quality and efficiency.
- ii. Protecting the basic needs of the elderly especially the 3 “Nos” and elderly in rural areas.
- iii. Coordinated development so as to realize the effects of integrated care and services.

²¹⁸ <http://jnjd.mca.gov.cn/article/zyjd/zcwj/201310/20131000534003.shtml>

- iv. Perfecting the market system.

This document comes with an annex, which provided further deliberation about human resources development and planning. This includes means for attracting more people to enter the EC industry through professional/vocational training, credentialing and employment subsidy.

5. Announcement of good practice in government purchasing of EC services (2014)

This is the major policy guideline for government purchasing EC services. It was jointly issued by the Ministry of Finance, National Development and Reforms, Ministry of Civil Affairs, and National Aging Committee in 2014.

- i. Target population: government purchasing EC services should be demand-based, focusing on needs of the elderly for daily living activities and rehabilitation. Priority should be given to the needs of widows, impaired old people and those of advanced age, who have financial difficulties.
- ii. The role of the government: leading, planning, providing policy support and funding, and monitoring and evaluation.
- iii. The types of HCBC services to be purchased: 1) home care services include meal services, personal care, health services, and nursing care for old people eligible for government subsidies; 2) community care include day care, rehabilitation, and cultural and physical education activities; 3) residential care include residential care and nursing care for “three no’s” and dependent and semi-dependent elderly people with low-income and financial difficulties; 4) training and continuous education for caretakers and nurses; and 5) needs assessment and evaluation of quality of services.
- iv. Service standards: Local government is required to formulate service standards for EC HCBC services and organize regular monitoring and evaluation activities.
- v. The department of finance will lead the purchase of services. Civil affairs and other concerned parties are required to provide coordination.

6. Opinion on the implementation of involvement of private capital in EC industry development. (Civil Affairs Circular 33) (2015) ²¹⁹

This is a joint statement by Ministry of Civil Affairs, Reform and Development Committee, Ministry of Education, Ministry of Finance, Ministry of Human Resources and Social Security, Ministry of Land and Resources, Ministry of Housing and Urban-Rural Development, National Health and Family Planning Commission, China Banking Regulatory Commission, China Insurance Regulatory Commission. The statement encourages private sector

- i. in the provision of home and community care including the use information platform (ICT) in EC

²¹⁹ <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201502/20150200777798.shtml>

- ii. in the provision of franchised and sizeable residential care through share and PPP to realize economy of scale and scope.
- iii. In the provision of grey market such as rehabilitation aids, medicine and nutritional products, clothing, etc.

This is done through enhancement of investment policy in EC, e.g., government guaranteed loan, increasing the proportion of lottery fund available to EC, taxation benefits.

It also covers the development of health and social care integration, allowing health care professionals, e.g., physicians, to practice in social care setting, allowing some health care services provided in social care setting to be reimbursed by national health insurance,. National Health and Family Planning Commission helps to credential health care professionals in social care setting, etc.

7. Civil Affairs directives on the promotion of active involvement of private capital in EC industry development. (2016) ²²⁰

Civil Affairs issued this statement on May 30, 2016 after the Chinese President made an speech on EC on May 27, 2016. The statement summarized government directions on the following areas:

- i. Promoting the Development of EC Service Industry, which reinstates (1) State Council (Circular No. 35). Opinions on Promoting the Development of EC Service Industry, 2013 and (2) Civil Affairs Circular 33 - Opinions on the implementation of involvement of private capital in EC industry development, 2015. The latter is a joint statement by multiple ministries.
- ii. Government role in creating friendly environment for investment by the private sector such as
 - (A) establishing legal structure (Section #2.1): (1) Legislation on the management of residential care (RC) (2013) and (2) Permission for the establishment of EC/RC facility (2013);
 - (B) enhancing government service function (Section 2.2): (1) transparency, (2) direction, (3) speed up inspection and (4) optimize EC permits application.
 - (C) Enhancing government leadership role in EC investment. For instance, no less than 50% of lottery fund will be invested in EC industry.
 - (D) Supporting fund raising of private sector through different venues: shares, funding pool, insurance, PPP, etc.
 - (E) Creating a fair competition environment for EC industry, e.g., pricing management and EC manpower recruitment and retention.

²²⁰ <http://www.mca.gov.cn/article/zwgk/mzyw/201605/20160500000681.shtml>

8. Announcement of establishing subsidizing system for impaired and senior old people with financial difficulties (2014)

Jointly issued by the Ministry of Finance, Ministry of Civil Affairs, and National Aging Committee in 2014, this announcement is aimed to operationalize the State Council's 2013 Opinions on Speeding up the Development of EC industry, which required the establishment of a subsidizing system for impaired and senior old people with financial difficulties. It expects to set up such a system by the end of the 12th Five-Year plan period (2011-2015).

- i. Target population: impaired and senior old people with financial difficulties. Eligibilities for subsidies for “senior old people with financial difficulties” are determined by county level civil affairs, and that of “impaired old people with financial difficulties” is to be determined by county level health institutions.
- ii. Benefits: EC subsidies are for care needs; if these old people meet with difficulties in daily living, they should be provided through pensions, *dibao* and other social assistance programs. Elderly are subsidies can be paid either in cash or vouchers.
- iii. Benefit standards: local government determines the standards based on local economic and financial conditions and changes in the prices of goods. Provincial government can make provincially unified standards if conditions allow, and other places can determine the rate by the city or county government according to their local conditions.
- iv. Funding: local government bears the funding for EC subsidies.

9. Legislation on the management of residential care (RC)(2013)²²¹

Ministry of Civil Affairs and covers issued this legislation:

- i. Services to be delivered by RC: ADL/IADL, nursing, rehabilitation, mental health and social recreational activities (Section #9); ADL/IADL including eating, dressing, toileting, bathing, in and outdoor activities (Section #12); preventive health care including periodical functional and health assessment (Section #13); emergent health care and infection control (Section 14)
- ii. Management support in RC: risk and safety management (Section #17, 21, 22, 23 and 24); professional staffing requirements and credentialing (Section #19); privacy (Section #25) and periodical collection of users' feedback (Section #26).
- iii. Monitoring by local Civil Affairs Departments including periodical comprehensive evaluation of RC operation: staffing, facilities, service, management and reputation (Section #29); statistical report by RC operators (Section # 30); inspection on spot and making the inspection reports available to the general public (Section #28); and handling of complaints (Section #31).

²²¹ <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201306/20130600480076.shtml>

- iv. For those RC operators who repeatedly failed to comply with the law, a fine of not more than 30K Yuen will be imposed,

10. Permission for the establishment of EC/RC facility (2013)²²²

The Ministry of Civil Affairs and aims at providing a general framework for the establishment of EC/RC facilities in China issued the directive. It includes the operation permit application, renewal and cancellation procedures (e.g., >10 beds), monitoring and liability.

11. Opinions on strengthening the standardization of EC (2014)²²³

This is a joint directive by the Ministry of Civil Affairs, Standardization Committee of China (SAC), Ministry of Commerce, General Administration of Quality Supervision, Inspection and Quarantine of the People's Republic of China (AQSIQ) and The National Working Committee on Ageing. The directive is set to achieve universal standards of all EC service, management and products covering home, community and residential care (Section #3.1). The directive also suggested the establishment of EC quality management and ranking (e.g., ranking by star) systems through accreditation by an independent 3rd party (Section #3.4). Another important message of this directive is about the standardization of human resources development in EC especially for professionals and managerial; as well as standardization of EC information sharing of EC through the use information technology (Section #4.3). All these can first be proven by pilot and/or demonstration projects before a national roll out.

²²² <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201306/20130600480075.shtml>

²²³ <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201402/20140200585735>

C. Key Points of National Policy on Health and Social (Elderly) Care Integration²²⁴

On November 18, 2015, the Office of the State Council issued The Guidance Opinions for Integrating Health and EC. Its supporting policy was enacted Family Planning Commission at April 1, 2016, that is the Collaborative Approach for Ministries and Commissions to Integrate Health and EC in Key Areas. The main policy points are presented herein.

- The existing long term care institutions are encouraged to enter into formal binding agreements with the existing health care organizations in the communities.
- Health care organizations are required to provide timely appointments for the elderly who need outpatient and inpatient health care services.
- The existing hospitals are allowed referring elderly patients to the existing long term care facilities qualified to deliver medical services.
- The existing hospitals and long term care institutions are encouraged to support and integrate with each other to address the total care of all patients/residents, including hospice care.
- The health insurance covers medical care services delivered by the qualified medical component of the long-term care institutions.
- Encourage the existing community health centers to provide continuous health managements and services, including home health care, for the frail older people, the disabled, the seriously diseased, and the families lost their single child. Integrating hospital and home health care is encouraged.
- Improve the capabilities of community health centers to deliver home health care. Qualified home health services are reimbursed by the health insurance.
- There are opportunity priorities for private adventures to integrate health and EC without any policy barriers.
- Increase financial supports for integrating health and EC; and the PPP model is encouraged to practice for this purpose.
 - Long-term care insurance is encouraged to pilot in some provinces with better conditions.
 - Developing any curricula related to EC will be supported to train more professionals in geriatric medicine, rehabilitation, nursing, nutrition, mental health, and social work.
 - Plan to select pilot projects for integrating health and EC as successful models.
 - Enhance monitoring seamless EC between health and EC organizations.
- The integrated health and EC system and mechanisms will be developed and resources of both sectors will be shared by the year 2020 in the context of mainland China.

²²⁴ In Appendix 1 of "Targets for integrating health and EC" a paper prepared by Andy Qinggong Li, ADB consultant (national), on April 28, 2016.

D. Clinical issues in EC

1. Abuse/Neglect of Clients/Residents
2. Acute Confusion (Clinical Practice Guidelines)
3. Activities of Daily Living
4. Advance Directive and Levels of Intervention (Clinical Practice Guidelines)
5. Agitated Behaviour (Clinical Practice Guidelines)
6. Bereavement (Clinical Practice Guidelines)
7. Bowel Care and Bowel Record Form
8. Catheter Drainage System: Maintenance
9. Catheters: Indwelling Urinary
10. Constipation, Management of (Clinical Practice Guidelines)
11. Dental Services
12. Depression, Management of (Clinical Practice Guidelines)
13. Dysphagia
14. Eye Care
15. Eye Prosthesis: Care of
16. Falling, Management of (Clinical Practice Guidelines)
17. Feeding Techniques
18. Gastrostomy & Jejunostomy in Established Tract: Maintenance
19. Hygiene
20. Least Restraint Policy
21. Medication Update
22. Medications: Obtaining After Regular Pharmacy Hours
23. Medication: Storage and Distribution of Narcotic and Controlled Drugs
24. Mental Status Examination (MMSE)
25. Mouth care
26. Pain, Chronic, Management of (Clinical Practice Guidelines)
27. Perineal Care
28. Podiatry Services
29. Rehabilitation Service
30. Skin Integrity, Management of (Clinical Practice Guidelines)
31. Sleep: Chart and Survey Focus Review
32. Social cultural recreation Services
33. Tracheostomy Tube: Care of Established
34. Vital Signs
35. Wandering Persons
36. Management of Urinary Incontinence (Clinical Practice Guidelines)
37. Management of Wound (Clinical Practice Guidelines)
38. Supplemental Services for Residents

Hebei Elderly Care Development Project

Final Report

Volume Two

Document 2-B

Technical Report on the Development of Home- and Community-Based Care

PPTA – Elderly Care development in Hebei province

**Technical Report:
Output 1: Home- and Community-Based Care**

Meredith Wyse, Xu Yuebin

**TA No. 8996-PRC
September 2016
People's Republic of China**

CURRENCY EQUIVALENTS

(as of 9 May 2016)

Currency unit – Chinese yuan (CNY)

CNY1.00 = \$0.016

\$1.00 = CNY6.1

ABBREVIATIONS

ADB	—	Asian Development Bank
DMF	—	design and monitoring framework
EC	—	elderly care
FSR	—	feasibility study report
HC	—	home care
HCBC	—	home- and community-based care
IA	—	implementing agency
LTC	—	long-term care
PPTA	—	project preparatory technical assistance
TA	—	technical assistance
TR	—	technical report
USD (\$)	—	US Dollars
WHO	—	World Health Organization

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1. DETAILED SITUATIONAL ANALYSIS

A1. National legislation and policies relating to elderly care

There are a number of relevant national and provincial policies providing the framework for the development of EC care.

A.1.1.Opinions on Advancing HCBC Services Comprehensively (2008)

This is the first formal policy guidelines regarding HCBC services, which was jointly issued by the National Committee of Aging (NCA), National Development and Reforms, Ministry of Education, Ministry of Civil Affairs, and Ministry of Finance in 2008. The key points of which are summarized below:

- i. Policy agenda: By the end of the 11th Five Year-Plan period (2005-2010), all urban communities would have established HCBC service networks providing a wide range of HCBC services, 80% of the townships set up a comprehensive elderly welfare service center providing residential and HCBC services, and one third of village committees and natural villages would establish a service center to provide cultural activities and services for the elderly.
- ii. Tasks: To accomplish the above goal, government at all levels is required to formulate plans for developing HCBC services. All urban communities and most rural townships were to set up a comprehensive HCBC service center or station, which can provide health service, rehabilitation, cultural activities, information, and education for the elderly.
- iii. Definition of HCBC services: HCBC services should include personal care, nursing care, homemaking services, cultural entertainment, and psychological consolation.
- iv. Methods of service provision: It is expected that these HCBC services centers or stations will attract independent elderly people to come over to take part in social and cultural activities and receive services; and for those who are unable to take care of their daily activities, the centers or stations will arrange for their workers to make home visits and provide services to them at their own homes. It also encourages the establishment of community-based information platforms, hotlines, and emergency calls as channels for old people to seek support.
- v. Administrative responsibilities of HCBC services centers: The HCBC service centers or stations are also responsible for managing elderly services including establishing an information system for elderly people in their administrative area, assessing eligibilities for old people for government subsidies, inspecting the qualifications of care takers, monitoring and evaluating the quality of services, and receiving complaints from service users.
- vi. Promoting private provision of services: Government is required to take measures to attract the participation of the social sector in providing HCBCs through “public support for private operation”. Current HCBC services operated by the government should be handed over to social organizations, enterprises or other market organizations for operation.
- vii. Funding and preferential policies: local government is encouraged to set up earmarked funds if the local economic conditions allow, and implement preferential policies for elderly care facilities with regard to land allocation and taxation.

A 1.2 A development plan for elderly care system (2011)

This document operationalizes the 12th Five-Year Plan by providing a definition of the elderly care

system and its components, which is issued by State Council.

- i. The elderly care system is defined as: home-based care as the base, community care as backbones, and residential care as supports. Among them, home-based care is defined as to include *personal care, home care, rehabilitation, medical and nursing care, and psychological comforting*. Community care includes *day care and supports for home-based care*. Residential care includes all residential facilities such as nursing home and other forms where old people are supported in their daily living and activities.
- ii. Multiple sources of funding are proposed such as land, taxation and government purchase of services. Welfare lottery funds are required to prioritize the development of elderly care facilities. Local government is required to design policies to attract social organizations to provide services.

A.1.3 Opinions on government purchasing services from social organizations (2013)

This is the major document governing government purchasing services from social organizations, which was issued by State Council in September 2013. It was expected that by 2020 a well-developed system of government purchasing services from social organizations will be in place all over the country.

- i. Definition of the contractual parties: Government, institutions with public administrative responsibilities and public funded mass organizations are all allowed to purchase services from social organizations. All social organizations who are registered through civil affairs, and enterprises and other social entities registered in the industry and commerce department are eligible for entering contract with government for providing services.
- ii. What can be purchased? All public services deemed suitable for provision through the market, and which social organizations have the capacity to provide, can be provided through purchasing services. The scope of government purchasing service should gradually expand in such basic public services as education, employment, social security, culture and physical education activities, and services for people with disabilities; other public services should be provided as much as possible through social organizations; and those services that should be provided by the government directly should not be provided through purchasing services. Local government is required to make a list of service items suitable to be purchased from social organizations.
- iii. Methods of government purchasing services: Government purchasing services should be conducted transparently. Providers can be selected through different methods such as open bidding, inviting providers, competitive negotiation, selecting a single provider, or through price comparison.
- iv. Funds used by government purchasing services are part of government budget.
- v. Performance management: Comprehensive performance evaluation mechanism should be established with participation of government, the service provider, and service users. The results of the evaluation should be disseminated to the society.

A.1.4 Opinions on speeding up the development of the elderly care industry (2013)

This document provides the overarching guidelines for the development of the elderly care system in China, which was issued by State Council. It reaffirmed the principle of home-based care as the base, community care as the backbone, and residential care as support, and it called for the setting up of such a system all over the country by 2020. By then, all urban communities should have established a day care center and an activity center for old people with defined quality

standards; over 90% of townships and 60% of rural communities should have a comprehensive community service center in place, which include the provision of elderly care services.

A.1.5 Announcement of doing a good job in government purchasing elderly care services (2014)

This is the major policy guideline for government purchasing elderly care services. It was jointly issued by the Ministry of Finance, National Development and Reforms, Ministry of Civil Affairs, and National Aging Committee in 2014.

- i. Target population: government purchasing elderly care services should be demand-based, focusing on needs of the elderly for daily living activities and rehabilitation. Priority should be given to the needs of widows, impaired old people and those of advanced age, who have financial difficulties.
- ii. The role of the government: leading, planning, providing policy support and funding, and monitoring and evaluation.
- iii. The types of HCBC services to be purchased: 1) home care services include meal services, personal care, health services, and nursing care for old people eligible for government subsidies; 2) community care include day care, rehabilitation, and cultural and physical education activities; 3) residential care include residential care and nursing care for “three no’s” and dependent and semi-dependent elderly people with low-income and financial difficulties; 4) training and continuous education for caretakers and nurses; and 5) needs assessment and evaluation of quality of services.
- iv. Service standards: Local government is required to formulate service standards for elderly care HCBC services and organize regular monitoring and evaluation activities.
- v. The department of finance will lead the purchase of services. Civil affairs and other concerned parties are required to provide coordination.

A.1.6. Announcement of establishing subsidizing system for impaired and senior old people with financial difficulties (2014)

Jointly issued by the Ministry of Finance, Ministry of Civil Affairs, and National Aging Committee in 2014, this announcement is aimed to operationalize the State Council's 2013 *Opinions on Speeding up the Development of Elderly care industry*, which required the establishment of a subsidizing system for impaired and senior old people with financial difficulties. It expects to set up such a system by the end of the 12th Five-Year Plan period (2011-2015).

- i. Target population: impaired and senior old people with financial difficulties. Eligibilities for subsidies for “senior old people with financial difficulties” are determined by county level civil affairs, and that of “impaired old people with financial difficulties” is to be determined by county level health institutions.
- ii. Benefits: elderly care subsidies are for care needs; if these old people meet with difficulties in daily living, they should be provided through pensions, *dibao* and other social assistance programs. Elderly care subsidies can be paid either in cash or vouchers.
- iii. Benefit standards: local government determines the standards based on local economic and financial conditions and changes in the prices of goods. Provincial government can make provincially unified standards if conditions allow, and other places can determine the rate by the city or county government according to their local conditions.
- iv. Funding: local government bears the funding for elderly care subsidies.

A.2 Provincial policies in Hebei Province

Between 2010 and 2015, the provincial government of Hebei issued 22 documents about the establishment of the elderly care system. Most of them are focused on residential care and only two documents are directly related with home- and community-based care services.

A.2.1. Announcement on constructing community comprehensive information platforms and home-based elderly care call centers throughout the province (2010)

- i. In April 2010, Hebei provincial Civil affairs decided to implement home care IT call centers throughout the province. It requires all cities and urban districts to set up an IT call center at four administrative levels: city, district, sub-district, and the community by the end of August 2010. These centers should be able to provide home-delivered services at the touch of a button by old people living at home. The services should include personal care, housekeeping, rehabilitation, psychological consolation, and emergency rescue.
- ii. This document was jointly issued by Hebei provincial civil affairs and Hebei China Unicom, which is the partner of the civil affairs in constructing the IT platform. It encouraged service providers to voluntarily participate in the provision of elderly care and other public services. The China Unicom Hebei branch is responsible to provide an “elderly calling phone” for 1% of old people free of charge.

A.2.2. Opinions on advancing the construction of home-based elderly care centers (2012)

This document was issued by Hebei provincial civil affairs based on the Twelfth Five-Year Plan for Elderly Care System of Hebei. Subsequently policies were mostly built on this document. The main points are summarized below:

- i. Policy agenda: By 2015, all sub-districts should establish a demonstrative home-based elderly care service facility, and 80% of urban communities should have such a facility in place. This was updated in the 2014 Hebei government’s Opinions on Speeding up the Development of Elderly care system in Hebei as cover all urban communities, 90% of townships and all rural villages through the “happiness yards”.
- ii. Size and amenities: For elderly care centers in new communities, each should have a minimum space of 300 square meters, which should include “six rooms and one school”: 1) 3 rooms for taking rest with each having at least 12 beds; 2) a dining room; 3) a reading room; 4) an activity room for cultural entertainment with facilities; 5) a health and rehabilitation room; and 6) a clinic with basic medical facilities and medicine, and 7) a school for the aged with basic teaching facilities. For those in old communities, each should have a minimum space of 150 square meters, which should include “five rooms and one classroom”: 1) 2 rooms for taking rest with each having at least 8 beds; 2) a dining room; 3) a reading room; 4) an activity room for cultural entertainment; 5) a medical and rehabilitation room with basic medical and rehabilitation facilities and medicine; and 6) a classroom with basic teaching facilities.
- iii. Services: home-based care services should include a minimum number of four types of services: 1) care supports, including supervision and rest for those who have no caregivers in the day time but can go outdoors, and home visit service for those unable to go out; 2) meal services including both aggregate and home delivered meals; 3) health service,

including exercises, rehabilitation, and emergency relief. There should be 1-2 doctors providing health guidance; and 4) social support such as learning, entertainment and other social interactions.

- iv. Administration: Multiple modes of operation are allowed for the operation of the service centers, including: 1) direct operation by residents' committees through outsourcing community workers or social workers to manage the services; 2) contracting out services to nonprofit elderly care agencies; 3) contracting out services with residential care providers; 4) contracting out services to other social organizations.
- v. Government supporting policies: 1) Home care elderly care services should be established with funding mainly from the government. Local government (city and county) should provide subsidies for construction and operation based on local economic conditions, and provincial government will provide financial support in the form of award for best practices; 2) residents' price should apply to the utilities in the facilities; 3) where conditions allow, local government should design subsidies policies for old people with financial difficulties; 4) Local government should also encourage public institutions, social organizations and individuals to provide home-based care services through "public support for private operations", "public constructed facilities contracted out for private management", and "government purchase of services".
- vi. Price: home-based care should be provided free of charge for old people without incomes, and for those with incomes should be provided at a low to full price.
- vii. Health services: Grass-roots urban and rural health institutions should set up health record and provide free medical check for old people aged 60 and above, and for those with limited mobility, provide home health services (effective since December 2014).

A3 Best practice models

A 3.1 National best practice models

HCBC services for the elderly in China are generally underdeveloped. The main measures include subsidies for old people with special difficulties to use home delivered services and day care centers which provide mainly entertainment activities for functionally independent old people. The subsidies are generally low, with Guangzhou topping the list, which is CNY\$ 400 per person per month for old people without incomes and family caregivers. Although HCBC services are defined as including a wide range of services ranging from nursing care to social support, most care providers provide only domestic help and have limited capacity in providing a higher level of care needed to enable old people to “age in place”.

Case 1: Integration of residential and home-based care services in Beijing and Shanghai

Starting from early 2014, to facilitate the provision of home- and community-based care for old people, Beijing municipal government required all districts to set up an Elderly Care Center in each sub-district and township. These centers can be established through either renovating disused facilities such as schools, hotels or factories or by upgrading current residential care homes. Construction subsidies are provided based on the number of beds, which is CNY\$ 20,000 for each bed with a maximum of CNY\$3 million for each newly constructed center. For those built on the base of current residential facilities, government would cover 50% of the renovation costs with a maximum of CNY\$1.5 million. Operational subsidies are provided to service providers based on CNY\$300 per independent resident and CNY\$500 for each dependent resident. The municipal government encouraged districts to raise subsidies by sharing 50% of the raised amount. By the end of 2015, a total number of 100 Elderly Care Centers were established throughout the city, covering all districts and townships.

These facilities are intended to function as a comprehensive platform for providing both residential and home-based care services for old people living in communities. The services include 1) residential care for functionally dependent old people; 2) home-based care service for community dwelling elderly people in its catchment area, which include meal services, housekeeping, personal hygiene such as bathing and hair-cutting, medical services, and psychological consolation; 3) day care and respite care; 4) training for informal caretakers. In its 2015 Regulations on Home-based Care for Old People, home-based care services were defined as including eight categories: nursing care, personal care, health services, meal services, emergency relief, day care, companion services, and cultural activities. Within each center, the residential facility is expected to radiate home- and community-based services.

Further in early 2016, the municipal government began to pilot community-based Elderly Care Stations in Chaoyang and Haidian districts, making services closer to old people living in their own homes. A total number of 90 stations were expected to be set up in 2016. These stations will provide cultural entertainment, day care, psychological consolation, and meal services for old people in the community. Together with the sub-district and township based Care Centers, a network of home and community services was formed.

Meanwhile, in early 2016 Beijing Civil Affairs and Aging Committee jointly developed a needs assessment instrument to assess the level of old people’ disabilities and eligibilities for government subsidies. The instrument covers such items as daily activities, mental health, cognition, communication and social participation. Residential care facilities will accept only functionally dependent old people, and others are expected to rely on home-based care provided

through the care centers and stations.

In Shanghai, a number of demonstrating “One-stop Comprehensive Elderly Care Centers” were established to provide both residential and home- and community-based services for old people based on assessment of needs. In terms of home care, items of services were specified with service quality standards attached to each item, covering a wide range of services including nursing and personal care, housekeeping, meal services, mobility service, rehabilitation, chatting, and escorting services.

These measures have the potential of integrating residential and home and community services by providing services to old people based on assessment of needs. Home and community care services are defined clearly with service standards, which are able to meet most of the needs dependent and semi-dependent elderly people living at home. However, affordability and incentives for providers to keep old people in the community need to be tackled.

Key points for EC project in Hebei

- Residential care should be reserved only to functionally dependent old people.
- Home- and community-based care services should cover nursing and personal care.
- Affordability for home- and community-based care should be dealt with through subsidies.
- Service providers need to have incentives for keeping old people as long as possible in the community.

Case 2: Direct subsidies for old people

Most cities provide care subsidies directly to functionally dependent old people based on both needs and financial difficulties. In Beijing, three categories of old people receive subsidies from the government: 1) old people who have no family caregivers, income and working ability (urban three nos and rural five-guarantees households) if they are assessed as having care needs or if they are aged 80 or above; 2) old people who live in low-income or social assistance households if they are functionally dependent or are aged 80 or above; and 3) old people with a single child who have care needs or are aged 70 years or above. The municipal government required districts to set the levels of the subsidies with a minimum of CNY\$300 each month. The subsidies will be directly entered into old people’s bank account, which can be used only for purchasing care related services.

In Shanghai, four categories of old people are eligible for government care subsidies if they are assessed as having care needs: 1) full amount of subsidies for old people who live in low-income or social assistance households; 2) 80% of subsidies for old people living in low-income households; 3) 50% of subsidies for old people with income falling between low-income and average income old people; and 4) 20% of subsidies for low-and below-average income old people if they are aged 90 years old or above and have no children. Standards of subsidies also differ by degree of impairments: 30 hours for mild impaired old people per month, 40 hours for moderate impaired and 50 hours for severely impaired elders. In 2015, the costs of care were set as CNY\$18 for care for mild to moderately impaired old people and CNY\$20 for severely impaired for each hour of service. Service providers get reimbursed from the government after they provided the services. Funding for subsidies were shared between municipal and district governments and allocated from government revenues, and 60 million were allocated from the welfare lottery funds.

In Guangzhou, government subsidies for old people with special difficulties such as those in Beijing and Shanghai ranged between CNY\$ 200 and CNY\$ 400 per month depending on the degree of difficulties. Community committees would assess the needs of old people eligible for the subsidies and then contract the services to providers by specifying the type and amount of services. Similar to the practice in Shanghai, the funds would be given to the service providers by the government after they provided the services.

One good point of these policies is that the amount of subsidies is differentiated based on both needs and financial difficulties. However, the subsidies are low and limited only to old people with special difficulties.

Key points for EC project in Hebei

- Government subsidies should cover poor and low-income elderly people to enable them to purchase needed services through their own choice.
- The amount of subsidies should be based on means tested access to HCBS for old people with care needs and financial difficulties.

Case 3: Support for informal caregivers

In 2014 Nanjing first piloted subsidies for informal caregivers whereby family members can receive subsidies for taking care of their elderly members at home. Five categories of old people are eligible for government purchase of services from family caregivers: 1) urban three nos and rural five-guarantees households; 2) dibao recipients and marginal poor; 3) dependent and semi-dependent old people with a single child who are aged 70 or above; 4) dependent and semi-dependent old people with financial difficulties; and dependent and semi-dependent old people aged 100 or above. The amount of subsidies were CNY\$400 per person per month for dependent old people and CNY\$300 for semi-dependent ones. In 2016, it is reported that Beijing will adopt similar subsidy policies for family caregivers. Similar supportive measures were also implemented in other provinces. In Zhejiang, family caregivers are eligible for eight hours' training from residential care facilities to learn care-giving skills.

Key points for EC project in Hebei

- Programs for supporting family caregivers should be built into the elderly care system. As the survey report in Xinji found that about 97% of old people are cared solely by their family members and many severely impaired ones remained in their homes. This shows the potential of family caregiving as an important source of LTC care provider.
- Supportive policies can include respite care, tax incentives, direct cash transfer and training of caregivers on for caregiving knowledge and skills.

Case 4: Volunteer service by young old to senior old people in Shanghai

In 2012, Shanghai Civil Affairs and Aging Committee jointly initiated a program called "Old Companion". Over 20,000 old people aged 70 years or below were recruited as volunteers to provide companion and health education services for old people of advanced age. Old people aged 80 years and above and who are singles or functionally dependent are eligible for being served by the volunteers. With each volunteer serving 5 old people, it was estimated that a total number of 100,000 oldest old people will benefit from the program. A total amount of CNY\$ 14 million was allocated from the welfare lottery funds for implementing the program, and social organizations were contracted for organization and provision of these services.

Key points for EC project in Hebei

- Voluntary services can be organized to provide HCBC services to old people either through home visits or in the day care centers, such as companion or escorting services, which do not require a high level of professional skills.
- If funds from the welfare lottery funds can be used to provide subsidies for the voluntary services, this will end up with a small amount of money helping a large number of old people remain at their homes.

Case 5: Age-friendly home renovation for *dibao* elderly people in Shanghai

In 2012, Shanghai Civil Affairs and Aging Committee jointly initiated a home- and community-based care program, which aimed to renovate the homes of 1,000 elderly people who were *dibao* recipients in the year. The renovation aimed to improve conditions for safety, accessibility and sanitation in the homes of these elderly households. Old people who were *dibao* recipients and aged 70 or above were each eligible for a total amount of CNY\$20,000 for the renovation, and the funds all came from the welfare lottery funds.

Key points for EC project in Hebei

- Home renovation is an effective measure to support old people to remain in their own homes and can be adopted as part of the EC project in Hebei.
- Old people may be willing to cover part of the costs if government can provide some matching funds.

A 3.2 International best practice models

Given the early stages of development of elderly care services in China, six case studies of international best practice are highlighted for consideration by Civil Affairs to consider implementation in consultation with the IAs. It should be noted though that effective HCBC models in middle income countries similar to China's level of development, are at the nascent stage of development, as care is still an emerging area. Secondly common to all these case studies is that subsidized or paid for by the government, or rely on utilizing social capital. In summary these best practices are not fully privatized. Therefore for the purposes of this elderly care project, how the IAs and Civil Affairs can ensure the lessons of the models are adapted to the local context needs consideration.

Case study 1: Using community based organizations to provide elderly care, suitable for rural and low resource settings

Building on the potential of community based older people's associations (OPAs), in Vietnam a new model, the intergenerational self-help club (ISHC), has been developed. ISHCs are village-based community organizations of approximately 50-70 members. The majority of members are women over the age of 55 years old. The clubs organize a range of regular and structured activities from micro-credit loans, simple health check-ups, regular social and physical activities, community improvement, and community disaster risk reduction activities. The club management board is also trained to help people access government entitlements such as pensions or health insurance.

In the area of elderly care the clubs provide the following services:

Club

- provision of cash or in kind goods and labor assistance for home repairs, farming work, and provision of assisted devices
- home modification and repairs

- facilitate health check-ups from the health service at least twice a year
- organize, train and manage homecare program through the use of homecare volunteers and in some cases, paid care assistants

Homecare volunteers

Most clubs will have about 5-13 homecare volunteers for one village or community. After basic training the role of the homecare volunteers is to provide:

- befriending
- home help services (laundry, cooking, shopping)
- accompaniment, in particular to social events and health centers and hospitals
- act as their emergency 'buddy' in times of vulnerability from natural disasters, adverse conditions, and contact with family members as needed

Homecare volunteers must commit to making two visits to their assigned client each week.

In addition in some ISHCs a paid care assistant has been introduced. The role of the paid care assistant is to

- Provide training and support to homecare volunteers and family members on how to care for older people with such needs.
- Provide basis health monitoring and support with medication adherence
- Provide referrals to the local health clinic if needed
- Provide personal care to frail older people without sufficient family support

The paid care assistant is expected to provide services for 3-4 hours, at least 4 times a week. The payment comes from the income generated by the club. In most cases the paid care assistant is a retired health worker.

After an initial grant for micro-credit, funding for the club's activities is self-generated through fundraising activities, interest on micro-credit loans and membership fees. Training, initial funding, and on-going monitoring is provided by the provincial or district level by either one of the mass organizations such as Vietnam Women's Union, Fatherland Front and Vietnam Association for the Elderly or by the Departments of Health or Invalids, Labour and Social Affairs. Funds have come from a wide range of sources including provincial level public fund raising campaigns, poverty alleviation funds or from a range of international donors. There are currently over 830 ISHCs in Vietnam, and the National Action Program for Older People (2012-2020) has a target to establish at 5000 similar organizations by the end of 2020.

This models requires initial set up resources, capacity building to the community provided by local authorities or social organization, and good levels of civic engagement. Recent evaluations have highlighted the importance of ongoing support and encouragement from local authorities to ensure the sustainability of the model.

Key points for Hebei EC project

- There are unmet health and social care needs in rural areas. The use of resourced community organizations, such as Older People's Associations can meet some of this unmet needs
- Social organizations require resources in terms of capacity building, and funds, as well as ongoing institutional support from local authorities

- The constructed Rural Happiness Yards could provide the physical environment as a base for activities
- Social organizations can be a useful tool for building social cohesion
- Volunteers can only provide some care services. There is still a need to build better provision of care services in rural areas

Case study 2 – integrated home and community care, Thailand

The Thai Lam Sonthi model in Lopburi Province, which provides community care services, is an example of collaboration between local governments (local administration authority), community hospitals, and communities. Here, the aim is to prevent the frequent hospitalisation of chronically ill and dependent older persons and adapt to a shortfall of the family caregivers due to the emigration of adult children or their unavailability due to work requirements. In addition to health care, services include personal care such as assistance with bathing, dressing, mobility and household chores such as cleaning and assisting in finding accommodation. Originally these services had been provided by local volunteers, but as the complexity and number of cases increased these services are now provided by care assistants paid by the local government. Care assistants have received training in basic care for older persons, receive on-the-job training and work under the supervision of health professionals from the local hospital.

Key points for Hebei EC project

- Payment for care assistants comes from local authority (under Ministry of Interior) but they are trained and managed by community hospitals, which have more institutional capacity at local level
- Combination of outreach health and care work
- Prioritisation of government funding for care in rural areas

Case study 3 – Home and community care in Hong Kong and Singapore

Hong Kong

In Hong Kong there is a standard care assessment, carried out by the Standardised Care Need Assessment Management Offices, who then match applications for subsidised long term care services with the needs of the elderly.

For home and community care there are five types of service offered based on the preference of clients and assessed using the standardised assessment tool

Name	Scope of services and detail	Eligibility for service/ Target group
Integrated home and community care service	<p>The services provided to Frail Cases include :</p> <ul style="list-style-type: none"> • Care management • Basic and special nursing care • Personal care • Rehabilitation exercises • Day care services 	<p>Target Groups</p> <ul style="list-style-type: none"> • Elderly persons aged 60 or above living in the community • People with disabilities • Individuals and families with social need

	<ul style="list-style-type: none"> • Carer support services • Home respite service • Day respite service • Counselling services • 24-hour emergency support • Environmental risk assessment and home modifications • Home-making and meals delivery services • Transportation and escort services <p>The service provided to Ordinary Cases include:</p> <ul style="list-style-type: none"> • Personal care • Simple nursing care • General household or domestic duties • Escort service • Child-minding • Home respite service • Environment risk and health assessment • Purchase and delivery of daily necessities • Provision of meals and laundry service • Other services, e.g. carer services etc. 	<p>Category Cases: IHCS are classified into two categories according to the needs of the above target groups:</p> <ul style="list-style-type: none"> • Frail Cases: <ul style="list-style-type: none"> - Frail elderly persons: elderly persons assessed to be in the state of either moderate or severe level of impairment by the Standardised Care Need Assessment Mechanism for Elderly Services and have the genuine need for a well-coordinated package of home care and community support services • People with disabilities: persons with severe physical disabilities who have the genuine need for a well-coordinated package of home care and community support services <p>Ordinary Cases:</p> <ul style="list-style-type: none"> • Service users who suffer from no to mild level of impairment or disability • Priority will be given to individuals and families with no or poor support from friends or the community and are financially disadvantaged, applicants on the waiting lists of IHCS (Ordinary Cases) or discharged cases from Enhanced Home and Community Care Services or IHCS (Frail Cases).
Enhanced home and community care service	<ul style="list-style-type: none"> • Care management • Basic and special nursing care • Rehabilitation exercises • Environmental risk assessment and home modifications • Personal care • Elder sitting • On-site carer training • Carer support services • Home-making and meals delivery services • Counselling services • Transportation and escort services • Day care services • Respite services • 24-hour emergency support 	<ul style="list-style-type: none"> • Elderly persons aged 65 or above (persons aged between 60 and 64 may receive the services if there is proven need); • Elderly persons assessed to be in the state of either moderate or severe level of impairment by the Standardised Care Need Assessment Mechanism for Elderly Services, and have the genuine need for a well-coordinated package of home care and community support services

	The scope and frequency of services will be designed according to the needs of individual elderly persons by the EHCCS Teams.	
Day respite care	<ul style="list-style-type: none"> Day care or short term residential service, to provide temporary relief for main caregivers 	<ul style="list-style-type: none"> +60 In need of general personal care and/or limited nursing care Suitable for communal living Not suffering from a contagious disease
Day care center	<ul style="list-style-type: none"> Services Personal Care Nursing care Rehabilitation exercise Health education Carer support services Counselling and referral services Meals Social and recreational activities Transportation service to and from the center <p>Usually open Monday – Saturday 08:00 – 18:00</p> <p>Full-time: attend for 4 days or more in a week (suitable for elderly persons with low self-care ability and lacking the care of carers during daytime)</p> <p>Part-time service: attend for less than 4 days in a week (suitable for elderly persons with higher self-care ability and having carers to provide them with partial care during daytime)</p>	<ul style="list-style-type: none"> Elderly persons Aged 60 or above living in the community and not receiving institutional service; Assessed to be in state of either moderate or severe level of impairment by the Standardised Care Need Assessment Mechanism for Elderly Services and suitable for day care services; and Whose carers are unable to provide full-time care Carers
District elderly community centers	<ul style="list-style-type: none"> Collaboration with and provision of support to other elderly service units in the district Referrals to other HCBC services Community education Case management Reaching out and networking Support team for the elderly Health education Educational and developmental activities 	<ul style="list-style-type: none"> Elderly persons aged 60 or above living in the locality Carers The community at large Operate a membership fee plus fee for some individual services

	<ul style="list-style-type: none"> • Provision of information on community resources and referral services • Volunteer development • Carer support services • Social and recreational activities • Meal and laundry services • Drop-in service, etc. 	
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Reference: <http://www.swd.gov.hk/en/index/>

Singapore

Home-based services

Home-based services are provided within the homes of frail and home-bound elderly. The services address the health and social needs of the person and support families in the care of their seniors.

Service	Service provided
Home Medical Care	Doctors visit the patient to provide services such as consultations, and the assessment and management of the patient's condition from his or her own home. The primary aim of home care is to keep clients healthy and functionally independent at home and in the community for as long as possible, hence delaying institutional care (such as admission into a nursing home).
Home nursing care	Nurses provide nursing care such as wound dressing, stoma care and insertion of nasogastric tubes in the patient's own home. These nurses may also play a key role in managing and reviewing the care plan of the patient, in consultation with doctors, as well as training caregivers in basic care.
Palliative Home Care	Palliative home care provides holistic support (e.g. medical and nursing care) to terminally ill patients and their families. Patients and their loved ones are supported in their homes by a multi-disciplinary team of doctors and nurses, and for some service providers, social workers as well. The focus of home palliative care is to improve the quality of the patient's remaining days through services such as pain control, symptom relief, nursing care and counselling.
Meals on wheels	Daily meals are provided at the doorstep of the elderly who is unable to buy or prepare meals for him/herself.
Escort service	The service allows for arranged transportation for the senior's medical appointments if he/she is unable to utilise public transport due to his/her semi-/non-ambulant status, or if the frail and/or working caregiver requires such assistance. A medical escort will accompany the elderly, if required.
Home personal care	The senior may choose from a variety of care services, such as personal hygiene, housekeeping, medication reminder service, mind-stimulating activities and other personal care tasks, that best meet their needs.

Center-based services

Center-based healthcare services cater to older persons who require care services during the day, usually on a regular basis. These centers are mostly located within the community, enabling those in need to receive services in a familiar environment close to their homes, and allow working caregivers to conveniently drop off their seniors at during work.

Service	Service provided
Community Rehabilitation Services	Community rehabilitation services provided by day centers (e.g., Day Rehabilitation Centers, Senior Care Centers) refer to the provision of physiotherapy and occupational therapy services targeted at people suffering from conditions that impair their functional abilities (e.g. strokes, fractures, lower limb amputation). The key aim is to improve the client's functional status to the maximum level medically possible, hence allowing them to regain their ability to perform activities of daily living (washing, feeding, dressing, toileting, mobility etc.) and remain active in the community.
Dementia Day Care Services	Dementia day care services provided by day centers (e.g. Dementia Day Care Centers, Senior Care Centers) refer to the provision of maintenance day care (i.e. primarily general monitoring and personal care) and a range of activities (e.g. therapeutic, social and recreational) to engage, empower and care for clients with dementia in the community. These centers serve to support working family caregivers who are unavailable during the day, who can drop off their elderly family members at a place that provides the necessary care and supervision required for the patient's safety and well-being.
Social Day Care Services	Social day care services provided by day centers (e.g. Social Day Care Centers, Senior Care Centers) refer to the provision of care for seniors who need supervision when their family members are at work. Typically, a social day care programme includes the following core components: (i) simple maintenance programmes (e.g. exercises) to help maintain health and functional status, (ii) activity programmes (e.g. handicraft, reading, karaoke) to promote social interactions and quality of life and (iii) caregiver support programmes (e.g. support groups, talks) that help support family caregivers to continue caring for their seniors.

Reference: Intermediate And Long-Term Care (ILTC) Services

https://www.moh.gov.sg/content/moh_web/home/our_healthcare_system/Healthcare_Services/Intermediate_And_Long-Term_Care_Services.html

It should be noted that in Singapore the government are currently promoting **Senior Care Centers** which are one-stop facilities integrating day care, community rehabilitation and nursing or dementia care. This is to ensure older people can get the care they need close to their homes and provide a continuity of care, rather than having to move facility as care needs change.

Key points for EC project in Hebei

- Clear target customer for different type of services

- Holistic range of services provided to enable people to stay at home for as long as possible, including a mix of home and community services and clinical and social services
- Support services for families and carers

Case study 4: Elder-centered Programme of Integrated Comprehensive Care (EPICC), Hua Mei Center on Ageing, Singapore: Providing day care for people with complex conditions.

Hua Mei EPICC's program provides day care services to older people who want to continue to live in their community and not transfer to residential care, in spite of their multiple chronic medical conditions, physical frailty and weak family and social support network. In its essence, EPICC is team-managed, person-centered, integrated comprehensive care, with a day club program. It is modelled on the widely accepted American-originated Program of All-inclusive care for the Elderly (PACE).

EPICC participants are brought to the Hua Mei Center each day of the program. As the program is aimed at people without carers at home, transport is provided to and from the elders homes.

During the day at the center there is a 6 hours program day, in which participants receive medical care and physiotherapy, engage in stimulating activities, and find social support. Their attendance at the day club supports person-centered care delivery. It enables close monitoring of their physical, emotional and social situations. Whenever the client is unable to attend the center, the staff will deliver critical medication to them and provide home help services.

The EPICC team consists of a physician, nurse, social worker, physiotherapist, occupational therapist, day center manager, programme assistants, administrative assistant, and driver.

Services provided include

- Day club program inclusive of transport and meals
- Medical and nursing care
- Physiotherapy
- Social Engagement activities and outings
- Medication delivery and home help services when critical

Client criteria

- Aged 60+
- Classified as 'high Category 2 - Category 3' under Singapore's standard care assessment form the Residence Assessment Form (RAF), and as such are eligible for community care or nursing homes
- who are not bed-bound, do not have infectious/ communicable diseases, dementia and behavioral problems; and are not undergoing dialysis treatment, radiotherapy or chemotherapy
- Live in the vicinity of the center

Reference: <http://tsaofoundation.org/what-we-do/services-programmes/center-based-comprehensive-care>

Key points for EC project in Hebei

- Well planned and resources day care enables older people with multiple conditions to remain at home
- Requires wide range of skilled staff
- Not suitable for all day care centers. However such a program could be considered as a pilot in one of the day care centers, embedded with the residential care centers. Such a pilot would be suitable in a few years time when the IAs have more experienced staff in EC.

Case study 5: Senior Citizens Home Safety Association (SCHSA), Hong Kong

Established in 1996 SCHSA provides care and services for the elderly and needy population in Hong Kong, including a 24-hour emergency service. Through information technology and communication systems, SCHSA provides senior citizens and others with 24-hour lifeline assistance called the Personal Emergency Link. Subscribers simply press a remote trigger on their alarm system to contact an operator who identifies and assesses their needs. In case of an emergency, staff will notify ambulance services, the appropriate hospital and family members to ensure prompt assistance. Funding comes from monthly subscription of its members. 20 per cent of members, those without means to pay, have their subscription waived. SCHSA also offers Elder Ring Hotline, a phone-line attended by social workers and trained volunteers providing emotional support, short-term counselling and referral services free-of-charge. The Easy Home Service is an on-demand home support and care service for hundreds of the needy elderly and families. More than 1,000 middle-aged Easy Home Service Teammates have been trained to address the required services of those subscribers.

Reference: <https://www.schsa.org.hk/en/home/index.html>

Key points for EC project in Hebei

- The IT infrastructure proposed in the IT call centers has the potential to be used much more proactively than currently planned
 - Counselling, emotional support, and referral services
 - Regular check ins and promotive advice (preparation for weather changes for example)
 - Use MIS system to identify high risk clients
 - Use of volunteers

Case study 6: standards and specification for day care centers

Currently the specifications for day care centers in PRC rely heavily on input factors (number of beds, rooms and so forth) To drive quality in community care quality monitoring indicators should be developed that cover a wider range of domains. Singapore's Ministry of Health has developed some suggested best practice guidelines for centers which cover four domains and provides guidelines in an number of areas in each domain.

Domain	Sub domain	Definition
Provision of care services: The client receives good care that	Access to care	The client has access to services based on the client's identified needs in an appropriate setting.
	Care Assessment,	The client is assessed for his/her care needs and

addresses his/her identified needs.	Planning and Review	receives an individualized care plan that is appropriate to his/her needs. The client's needs and individualized care plan are regularly reviewed and updated.
		The client receives appropriate and person-centered care delivered by trained staff, according to the individualized care plan.
	Caregiver involvement and support	The client's caregiver(s) is involved and supported in the care of the client.
	Care coordination	The client receives holistic, multi-disciplinary care delivered by the center and its network of health and social care partners.
	Transport	The client is provided transport services as necessary.
	Discharge and transfer	The client's care needs are supported by an integrated care system that addresses the transfer to another care setting or discharge from the center
Safety: the client is assured of his/her safety and is protected against identifiable risks by the center's culture of safety	Hygiene	The client, staff, and visitors are protected against the spread of infection by the center's good hygiene practices.
	Assistance with medication	The client is appropriately assisted in medication tasks, to ensure safe and effective outcomes.
	Preventing falls and injuries	The client is safeguarded against the risk of falls and injuries.
	Food safety	The client is provided with food that is safely prepared and handled to meet his/her nutritional and hydration needs.
	Physical environment and amenities	The client receives care in a safe, conducive and clean environment.
	Equipment	The client is cared for using equipment that is safe and suitable.
	Fire safety	The client and staff are protected against the risk of fire, by adequate precautions taken by the center.
	Safeguards on the use of restraints	The client is safeguarded against the use of restraint, except in situations of 25 immediate safety risk, and only as a last resort.
Dignity of care: The client is cared for in a center that respects his/her right to independence,, privacy, the breach of data confidentiality; and the risk of abuse	Incident management and reporting	The client's safety is supported by a prompt and effective incident management and reporting system
	Involvement and independence	The client is provided with information and education that enables the client to make informed decisions about care, and promotes his/her independence
	Dignity, privacy and confidentiality	The client is treated with dignity and protected against the invasion of privacy, the breach of data confidentiality, and the risk of abuse.
	Feedback and management	The client's feedback and complaints are fairly and promptly managed, and without retribution.
Organizational excellence: The client is assured that care services received are supported by the center's good organizational and	Staffing requirements	The client receives safe care and services delivered by an adequate number of staff at all times.
	Staff qualifications and training	The client receives safe care and services delivered by appropriately qualified and competent staff.
	Staff rights	All staff are treated fairly and safeguarded against illness, injury and abuse in the center.
	Volunteer	The center ensures that volunteers (if any) are

human resource practices.	management	engaged in the center's activities in a safe and appropriate manner.
	Corporate governance	The center implements effective corporate governance processes, to ensure that the center focuses on its purposes and outcomes for its client, resulting in the center's long term success and stability
	Financial management	The center implements effective financial management and reporting processes that ensure financial responsibility and solvency.
	Continuous improvement	The center demonstrates a commitment and actively pursues the continuous improvement of practice and quality of care.
	Risk management	The center actively identifies, evaluates and addresses potential risk to ensure the safety of clients, caregivers, staff and the organization

Full details of the guidelines for center based care, developed by the Center-based Care Workgroup, Ministry of Health, Singapore can be accessed: https://www.moh.gov.sg/content/dam/moh_web/Publications/Guidelines/Intermediate%20and%20Long%20Term%20Care%20Guidelines/Center-based%20Care%20Guidelines%20%282015%29.pdf

In Hong Kong quality in care service provision are driven by the funding service agreements between the Department of Social Welfare and operators of community centers also detail specific service requirements. The list below is a comprehensive list for a day care center in Hong Kong:

	Area of services specification	Specific requirement for service providers:
1	Management of clinical issues:	<ul style="list-style-type: none"> Prevention and management of: <ul style="list-style-type: none"> Falls, wounds, pressure sores, constipation, chronic pain, depressions, cognitive impairment, agitated and aggressive urinary and fecal incontinence, behavior Supervision of medication (with specifications) Nutrition and dietary management, including special diet and tube feeding Special nursing e.g. oxygen therapy, tracheotomy
2	Needs of service users with dementia	<ul style="list-style-type: none"> Special training for staff in commination and mood and behavioral symptoms Measures to minimize disturbance of service users Physical set and programs to minimize stress (lighting, noise) Appropriate level of stimulation (signage, orientation)
3	Personal care	<ul style="list-style-type: none"> Transfer Personal hygiene Food feeding or assistance with eating Getting dressed and changing clothes Showering or bathing Grooming Toileting
4	Equipment	<ul style="list-style-type: none"> Health care equipment and activity items to meet therapeutic, rehabilitation and activity needs of users
5	Support services for	<ul style="list-style-type: none"> Family activities

	carers	<ul style="list-style-type: none"> • Support groups • Training for carers, especially on understanding long term conditions
6	Other services	<ul style="list-style-type: none"> • Facilities (heating, water, lighting) • X meals a day • Counseling, social service and supportive groups • Group and individual activities • Transportation and/or escort service to and from home, to attend medical appointments and community activities

Reference: http://www.swd.gov.hk/doc_sc/whatsnew/201204/Service_spec.pdf

Key points for Hebei EC project

- For day care centers in Hebei, it is not recommended to start with providing such a wide range of services, given the regulatory environment and capacity of IAs. However it is important to define what minimum services there will be and what are the minimum requirements for the operators of day care centers. At the moment the services are described as 'day care' solely.
- To drive quality HCBC service standards, guidelines and indicators should be developed for HCBC

Case study 7: Standardized assessments

Hong Kong and Singapore use standardized care assessments to identify care needs and assess eligibility of the services which are subsidized by the government. This ensures that the subsidized services are being used by people who need those services.

In Hong Kong the Standardised Care Need Assessment Mechanism was introduced to ascertain the care needs of elders and match them with appropriate services. The tool was developed from InterRai's Minimum Data Set-Home Care (MDS-HC). The Mechanism has since 28 November 2003 been extended to cover eligibility screening for applications for long term care services, including admission to homes for the aged, care-and-attention homes, nursing homes, day care centers for the elderly, enhanced home and community care services, and integrated home care services (for disabled and frail cases). Assessors under the Mechanism are professionals from various disciplines such as social workers, nurses, occupational therapists and physiotherapists. They are required to go through training and accreditation on the use of the assessment tool. The five multi-disciplinary Standardised Care Need Assessment Management Offices in Hong Kong.

(http://www.swd.gov.hk/en/index/site_pubsvc/page_elderly/sub_standardis/)

Key points for Hebei EC project

- Standardized assessment for subsidized services can help target the subsidies to those with care needs
- Standardized assessment can ensure appropriate care services are used, and people are not using care services they do not need
- Standardized assessment can help create a common language amongst care professionals improving communication, understanding and a better continuum of care for older people

2. DETAILED GAP ANALYSIS

2.1 GAPS AND HOW TO ADDRESS THEM: International best practice

Lack of clear overarching vision and lack of understanding and emphasis on the following guiding principles: “Aging in Place”, “de-institutionalization” and “Active aging”. International good practices in developing elderly care systems that improve the quality of life for the elderly and significantly reduce the costs of long-term care follow three guiding principles. These include promoting: (i) aging in place by creating an enabling environment for elderly to remain at home, in their communities, supported by adequate services; (ii) “de-institutionalization” by developing systems that promote use of residential care facilities only for those in need of residential care services and (iii) active aging by supporting preventive health and social care programs that keep the elderly healthy and as contributing members of their communities. Application of these principles requires an appropriate balance of investment in residential, community and home care services.

Currently the HCBC services lack any clear preventative or promotive health and social care programs, and only minimal assistance is provided to support aging in place, with an underlying assumption that many older people need to be in institutions, including many people who are completely able to ‘self-care’ This **strongly contradicts** international best practice.

How to address this fundamental issue is addressed in a number of the points below. However much of it stems from a lack of clearly articulated vision and defining principles for the elderly care system. The recently published WHO World Report on Ageing and Health (2015) provides a useful starting point for consideration in the development of a vision and guiding principles. In summary it highlights that ‘long-term care is simply a means to ensure that older people with a significant loss of capacity can still experience Healthy Ageing’ and there are two key principles that should underlie the development of a long term care system:

‘First, even in circumstances in which older people have a significant loss of functioning, they still “have a life”. They have the right and deserve the freedom to realize their continuing aspirations to well-being, meaning and respect. Second, as with other phases of life, intrinsic capacity during a period of significant loss is not static, but rather declines in capacity are part of a continuum and in some cases may be preventable or reversible...Framing the purpose of long-term care in this way has several important implications. For example, potential recipients of long-term care include not just those who are already care-dependent but also those with significant losses of capacity and at high risk of deteriorating to this state. Implementing simple interventions may avoid the need for more intensive interventions later. Furthermore, care dependence is not considered as a fixed, all or nothing, state. For example, rehabilitation, good nutrition or physical activity might improve an older person’s capacity to the point that the need for long-term care diminishes or even disappears. Finally, making functional ability the ultimate goal of long-term care, rather than focusing simply on meeting older people’s basic needs for survival, requires caregivers to focus on other domains. These include older people’s abilities to move around; to build and maintain relationships; to learn, grow and decide; and to contribute to their communities²²⁵.

Following the development of a clear overarching vision and principle, built around a well-

²²⁵ World Report on Ageing and Health, WHO, (2015), p127-128

articulated goal for the development of care systems, there should be training on these guiding principles for policy makers and operators alike, as well as a monitoring and evaluation framework developed to collect evidence on the inputs required (cost efficiency) and outcomes (effectiveness) of these guiding principles to ensure these principles are appropriate for the local context.

Lack of appropriately skilled staff for HCBC leading to a lack of appropriate services: one of the most obvious omissions in the current system is the lack of appropriately skilled staff working in HCBC services which then limits the services that can be provided. Community centers, including rural happiness yards, are understaffed, often with no full or part time dedicated staff. This means the services provided can only reach those people with no care needs i.e. those who can self-care. This is a result of a lack of funding and lack of available staff. For example internationally day care centers are usually utilized with people classified as 'semi disabled', and therefore need some trained staff to ensure quality care. Internationally many day care centers are suitable for people with dementia, and have staff trained in dementia care.

Financially viable business models for HCBC need to be developed. Business models are likely to require public funding. Regulation and guidance on what services HCBC operators should and can provide should be reviewed, incorporating feedback from a wide range of stakeholders, such as health providers, and inclusive of the views of older people and family members. Safety of older people and the adequate legal protection of service providers are two key considerations to consider in these regulations. Develop training programmes for HCBC management, including case management (see below); care assistants including care for dementia, stroke; overcoming loneliness and disengagement. Develop HR staffing plans for community centers including rural happiness yards. These could start with limited or part time services initially until the demand for such services increases. Where it is not feasible for the private sector to deliver services, consider other options such as the social organization sector, or even the direct public provision of staff to cover rural happiness yards for example.

Lack of appropriately designed community centers: community centers need to be designed to be accessible to their target audience. This means incorporating universal design principles, and not placing community centers above the ground floor without elevators for example. There is a requirement for the revision of guidelines on the design of community centers, incorporating aspects of international best practice. Expert technical architects should be consulted in the process. Legislate the design of a community center in the construction of new residential areas, as well as principles of universal design in the construction of new residential and public buildings.

Lack of quality assurance and monitoring system for care providers: the current quality standards for home- and community-based services are related to *input/structure* standards only. This means in terms of number of beds provided, number of different rooms to be provided, number and qualification levels of staff to be provided. Whilst this is a good starting point, such standards in themselves are insufficient to assure quality. The quality standards do not apply to any processes (safety standards, record keeping and so forth) or outcome measures (quality of life, change in ability to conduct ADLs for example). These are important to ensure the services being provided are suitable, meaningful and appropriate for older people with care needs. The current monitoring system for care providers therefore also focuses on input and structural indicators. Standards of care are usually applicable to all those receiving care, without discrimination between ability to pay.

The development of applicable standards, or quality indicators is required at national or provincial level, with an appropriately staffed and resourced 'organization' to oversee. This could be within

government, as is the current arrangement, or an independent body (such as UK's Care Quality Commission). Dissemination, and if necessary explanation of, the quality assurance system is required to operators, training providers, customers and the public. Monitoring reports should be freely available in order the potential customers can review.

Lack of risk pooling in the financing of elderly care services: Currently at national and provincial level the current financing system for elderly care services, relies heavily on the individuals' ability to pay. Usually care needs are higher amongst rural, poor, lower educated and female populations this leads to an exacerbation of inequalities suffered by these populations over the life course. In addition not everyone needs care, or will incur care costs. Therefore the extent of care costs cannot be predicted by individuals, and this leads to some families experiencing very high care costs that they cannot afford, again leading to inequalities.

International best practice to overcome these financial risks, including long term care insurance or universal schemes. The consideration of such financing schemes needs to happen at the national or provincial level. In the meantime at the sub project level, government subsidies should be developed and targeted at for those older people with high care needs, and limited ability to pay.

Lack of incentives for home- and community-based care: whilst international best practice supports ageing in place, currently government financial subsidies seem to favor residential care, with residential operators receiving both construction and operational subsidies. The only indirect subsidies for HCBC operators seem to be vouchers for HBC services utilized in Shijiazhuang, with the impact both of operators and older people unclear. Since the development of HCBC will need encouragement and government facilitation, greater incentives for HCBC should be introduced. The introduction of a formal financing scheme, such as long term care insurance would facilitate the development of HCBC services. However in the meantime support could come in the form of operating grants including for salaries for staff, extension of vouchers to eligible older people, grants/loans for home modifications and so forth.

Lack of assessment and eligibility criteria: related to the issue of publicly subsidized or funded elderly care services, is the lack of assessment of care needs and related eligibility. Most countries with publicly funded schemes have assessment tools to i. assess a person's care needs ii. secondly to determine what services they are eligible for. Currently there is a simple care and income assessment used in Shijiazhuang, to determine eligibility vouchers for HBC services. Currently with the lack of government funded HCBC services the use of an assessment to identify eligibility is not such a gap. If in the project period it is assumed that public funding for care services will be increased then an assessment and eligibility criteria should be developed.

Lack of care planning and management: Regardless of funding source, HCBC care providers should be able to conduct a holistic care assessment to determine care needs of an individual. International best practice currently supports the use of **person centered** care assessments, which assess not only ADL/IADL/Cognition but also considers other factors such as psycho-social wellbeing, home environment, strength of personal networks and coping mechanisms. The care assessment is then used to develop an individual care plan, identifying what support a person needs, who will provide the different types of support, and who will coordinate and monitor the implementation of the care plan, usually a care or case manager. The case manager links with a wide range of health and social service providers. Case management is increasingly important for high risk people, to make every effort to ensure they can stay safely at home for as long as possible.

The project should include a component to test the validity of *existing* person centered care assessments, in different settings, primarily rural and urban settings. The results should lead to the formal recommendation of one or two such care assessments for care providers to use. A pilot on the use of case management as a tool to support effective HCBC should be included in the project, with the findings, if positive, disseminated to other HCBC providers.

Lack of health and social care integration: to maintain functional and capacity in old age requires both health and social interventions. This is particularly important in HCBC to promote prevention, self-care, and self-management of conditions such as NCDs, or physical impairments (vision, hearing and so forth). This does not mean the HCBC service providers necessarily need to provide clinical services themselves (such as nursing services, medication reviews). However they should work closely with the health service providers to ensure that older people do receive a *continuum of care* and have convenient access to such services, and that for complex cases requiring a case management, that the information between the various service providers is shared. To ensure the continuum of care from acute, transitional care to the elderly care system works there needs to be consideration of how the different service providers share information, organize referrals and follow up, and how older people experience these care pathways

Community centers can be a useful hub for the provision of services such as different types of therapy (physical, occupational, speech therapy), vaccinations, health monitoring and health education. Again it should be reiterated that the service providers may come from outside service providers (community health center or specialists from a rehabilitation hospital for example). In addition international best practice is increasingly supporting the delivery of some clinical services in the home, through home nurses, and increasing the tasks home nurses are trained and legally permitted to conduct in the home.

Both social and health service providers should be incentivized, either financially or through targets, to encourage prevention and promotion, to minimize the development of care needs.

The project should include one or two pilots on developing integrated health and social care for HCBC, ideally in rural and urban areas. This would require close cooperation and active support of the health providers, and strong leadership for the pilot from the respective government agencies.

Lack of vibrant social or voluntary sector: in every country with a comprehensive care system there is an important role for the voluntary/nonprofit/ social sector. This is usually a combination of nonprofit providers providing formal HCBC services contracted by the financial duty bearer (government, or long term care insurance companies), and more informal care services provided by voluntary groups, support groups who can provide a wide range of services such as befriending, accompaniment, home help, meal delivery, organization of social activities, information and education sessions for carers and people needing care. These are activities that are important for an effective HCBC system, but not necessarily ones that can be 'privatized.' The development of these kinds of activities can also add to social cohesion, and community.

To develop this sector there are a number of options

- Review definition, policies and structure of nonprofits, as in international best practice such organizations are obligated to invest any generated profits back into the organization or contribute towards the organization's objectives

- Publicize more widely the existing guidelines, and create incentives for social organizations working in EC field, to encourage new entrants or encourage existing organizations who currently do not work in EC field to expand the scope of work. Incentives should include grants, not only for activities but also for operating costs. Other incentives include public recognition of good work.
- Map existing social organizations, and provide access to training on EC if interested in developing activities or services. These could include Older People's Associations, Women's Federation, Village Health Doctors, schools, universities, resident committees, Third Age Colleges and so forth
- Encourage private providers, including IT call center operators, to develop volunteer networks. This is often effectively used by private providers as marketing mechanism.

2.2 GAPS AND HOW TO ADDRESS THEM: National and legislative and policy framework

The gap analysis presented is consistent between the provincial level and the sub project level

Residential and HCBC mix: The current project is heavily focused on the construction of residential facilities to support the target of 3% of residential beds under the government's strategy and aspiration of 90-7-3. Support to delivery services to support older people in their homes and their communities in only a very small part of the project, and as yet not well articulated.

In addition a large percentage of the residential beds are being targeted at persons with self-care ability, so providing a living facility only. Such a population should be served by HCBC. By including them in 3%, then there is a danger that persons needing residential care are unable to *access such services, and 3% target will be inadequate.*

How to address gap this gap is highlighted in the analysis above (international best practice gaps). One specific way to address this in the project, would be to request all sub projects to invest no more than 70% for example on residential care. The challenge with this is that HCBC have low capital requirements but high operating costs

Focus on urban populations: Only three sub projects are considering coverage of the rural areas, and this coverage is limited to rehabilitation of rural happiness yards, without consideration of any services. Rural happiness yards without any staff or service provision will have limited outcome on the ageing rural population.

All sub projects which aim to provide some coverage in rural areas must define an outline of services rural population are likely to receive, by whom, and most importantly from what funding modality. IAs could be strongly encouraged to provide some part time staff to support the development of HCBC services in rural communities. For example this could be in the form of utilizing the rural happiness yards to provide services for two mornings a week, organizing well designed social health promotion activities; facilitate support group for training and mutual support for family care givers; home visits for house bound older people; organizing transport to health facilities.

Definition of home and community care services: The purpose of home and community care services is to provide services to people in the homes, and accessible in their community. Some of the proposals under HCBC seem to be residential projects (such as the Xinji proposal for rural Parent Gardens), with the distinction of being placed in a community. This is not therefore HCBC. This is not to say the small residential facilities in communities should not be considered, and can be a center from which HCBC services are developed, managed and implemented. However centers where older people reside on a long term basis should be considered as residential care. All sub projects must clarify if community centers are in fact residential facilities for long term residents, or whether overnight stays are limited to a certain time period, i.e. providing respite care only.

Services to be delivered in HCBC undefined: The current sub projects FSRs, based on the

national policies and guidelines do contain clear descriptions of what home and community care services have the potential to be. However there is a lack of connection to what the FSRs state and the understanding of this description, which is currently not well understood by the local authorities and IAs. The current HCBC services proposed seem to be limited to the organization of social activities with some meal delivery. The services to be provided under HCBC need to be articulated with who the target customers, and who will provide the services, including human resources details.

Day care centers for example should have a well-developed program of activities for its target customers, who should be frail older people. Appendix 1 has a list of potential activities that can be incorporated into a day care center to meet the needs of its customers. These should be organized into a well-planned and regular daily schedule.

Rationale and services to be delivered by the IT call center unclear: All sub projects propose the development of an IT call center as a means of facilitating HCBC. This is in accordance with both national and provincial policy. However there are a number of areas in which these proposals need further consideration:

- Services to be provided. Currently it seems to be assumed that the IT call center will lead to the development of appropriate home services. This may be the case for simple services such as housekeeping and home maintenance. However for full coverage of home services, including such services as assistance with personal care, home safety assessment and modification, the provision of a IT call center solely may not be enough
- Appropriateness of technology: Based on existing IT call centers it seems they serve a purpose of facilitation between individuals and service providers. This is based on the assumption that older people with care needs can articulate exactly what they need, and will use the call buttons to do so. If the service is solely to link service providers with customers, the added value of having a call center, and related equipment over a direct telephone call needs to be articulated
- Coverage: some sub projects have assumed that such IT call centers will cover the rural populations. However even if the call center covers the rural areas, the providers to deliver services to the rural population in an economical way may not exist. Some older people with limited income and confidence with technology may not use the service
- Business model: Not one of the sub projects could fully articulate the business model behind the call center, and in fact seemed to consider the call center a revenue generator to cross subsidize other services. This needs verification. From existing call centers it is clear that not only do government subsidies for construction and operations of call centers are important in the initial years of operation, but that many of the users also receive subsidies to be used for services, thereby driving demand for services.

Suggestions for optimal utilization of IT call centers

- Preventative and promotive activities included. This could include
 - Check and warnings in times of potential hazard: extreme heat, cold, air quality
 - Regular calls to high risk older people to 'check in' with their current well being
 - Information on available services
 - Medication reminders, and medication delivery (subject to legal license)
- In addition the IT call centers can themselves become a hub of organizing social and volunteer activities

- Information proactively shared on social/ informational events in the immediate vicinity of the resident
 - Organization of volunteers to provide befriending services
 - Organization of volunteers to help with house work, meal delivery, accompaniment, delivery of shopping for those unable to purchase such services
- Helpline, manned by trained staff/volunteers for providing advice and counseling if required to older people, their families
- Referral of persons at potential of high risk to HCBC providers, or resident committees for follow up

3. Recommendation for project design

Output 1: Home- and community-based services improved

To ensure HCBC services are improved in Hebei province there will be a number of activities required under 5 key areas:

- design, construction and rehabilitation of community centers
- service development
- human resource development
- quality systems
- IT systems

Supporting these activities will be a number of pre-requisite for system development at the provincial level regarding EC financing, development of quality standards and system, care assessment, definition of care services, human resource development.

There are a number of areas of missing information at the moment, which makes it challenging to determine timelines and milestones. The major omission is that many of the activities listed below have not been agreed with the IAs and the local authorities, at provincial or sub district. This is because the activities are more detailed than the original FSRs, and the PPTA team is still waiting for the revised FSRs in which some of these activities may have been included. Therefore they are recommendations only. However as recommendations only and not agreed activities, the PPTA team is unclear as to the human resources, largely staff of the IAs and local authorities, that will be allocate to the activities within the project and when, and this will largely determine when these activities can start, in terms of capacity building and the provision of services. Agreed activities from IAs is also required for budgeting purposes, as it is unclear at the moment if all sub projects and IAs will agree to the activities, or whether activities will be conducted in one locality only, which obviously has an impact on resources required.

Once the project activities are agreed to in most part, then it is a fairly simple exercise to develop the detailed instructions for implementation and resources required.

Table 1: Suggested summary of activities for Output 1 – Home and community care services improved

Activity 1.1: Rehabilitate or construct appropriately designed XX community care centers in the six subproject areas covering a catchment population of XXXX households, providing XX services by 2022, and serving XXX unique customers by XX (construction/design)		
1.1.1	Build, rehabilitate and equip XX community care centers, providing a range of services, including sufficient space, facilities and equipment for at a minimum information services, recreational activities, day care, outreach home-based care services, support for care givers	INPUTS Procure appropriate design firm Consultation on design and equipment Procurement of engineering and construction Procurement of equipment and fittings Develop maintenance and replacement plan
1.1.2	Rehabilitate and equip XX rural happiness yards, including at a minimum information/education services, recreational activities, outreach home-based care services and support for care givers	Assessment and if required modification of existing rural happiness yards (especially accessibility) Consultation and prioritization of equipment Procure equipment Develop agreement between IA, village authorities and CA on maintenance and replacement
Activity 1.2 XX service providers develop home and community care services reaching XX		

(service development), including minimum information services, social services, care planning, outreach home-based care services, support for care givers		
1.2.1	Conduct participatory and multi stakeholder consultation process on needs, design and delivery of HCBC in 6 sub projects (8 months), resulting in the development of a road map of HCBC to be provided over the project period	Working group established Facilitator for community consultations Consultant to work with IAs to develop precise services to be offered Study tour to Beijing. Hong Kong to learn about person centered HCBC
1.2.2	Develop HCBC service specifications for each sub project (at establishment and road map for 4 years), including areas of services to be provided, and service specifications for service providers	Consultant to work with IAs to develop precise services to be offered Agreement with CAs Training of IAs
1.2.3	Develop outreach HCBC services in 20 (?) in rural locations, serving older population of 2000, with a minimum of services provided weekly	Exact details to follow on from community consultations and resource analysis Communication campaign with village leaders, local authorities Recruitment of social worker/care assistant to support rural happiness yards activities (\$) <i>Who leads? Ia/ Ca?</i>
1.2.4	Develop XX (18?) social organizations, and mobilize of approximately 1200 volunteers supporting HCBC services in 6 sub projects	Mapping of existing social organization (by whom?) Interest generating workshop CAs lobbied for financial resources for social organizations (lottery fund) Volunteer recruitment campaigns by local CAs Training and management of volunteers by IAs Exchange visit of social organizations and CAs/ Committees of Ageing to Shaanxi, Sichuan, etc.
1.2.5	Establish training/ support programme for family care givers (dementia, stroke...), run out of rural and urban community center	Support for family care givers integrated into plans for day care clients (in HCBC service specification 1.2.2) Requires national consultancy to establish systems and train IAs to implement (ADI, Bob, existing information services)
	Establish home safety assessment and modification program in 6 sub projects, reaching minimum 600 homes	Train XX in home risk assessment by XX (occupational therapists? Don't exist – who will do this?) Identify and train XX sub-contractors for home modifications by XX Communication and marketing campaign Establish pricing structure
1.2.6	Develop capacity of HCBC providers develop, implement and monitor care plans, in coordination with health service providers (or Pilot integrated H&C at community level in 1 sub project	Buy in received from Health authorities Training for Health and CA and IAs on integrated care; and care planning implementation (consultant) Allocation of health center staff (\$\$)

	(Chengde))	Working group established (with monitoring framework developed) – evidence from pilot may need international/ national consultancy to develop
Activity 1.3 Recruit and appropriately train home and community care staff (HR development)		
1.3.1	Develop and implement HR plan	Consultancy with experienced care provider: skills, career progression retention strategies, training for staff, workforce planning
1.3.2	Train XX HCBC managers	Placement (1 month?) in existing community care center and HCBC provider
1.3.3	Recruit and where necessary train staff for community centers with XX expertise by 2022	Training program developed/ modified On the job + institution
1.3.4	Upgrade XX care assistants to provide HCBC in specific conditions (dementia, stroke), (Year 4-5)	Train existing care workers by XXX HBMC? (assumes care assistant will not be providing this service at the start)
1.3.5	Collaborate with residential centers for outreach of technical experts (rehab, nurses) – increase services in Community centers	
1.3.6	Develop training/ support programme for family care givers	National consultant, develop options for training, pilots with IA, rolls outs, ToT for IAs, documentation
Activity 1.4 Develop quality systems including care assessment, HCBC quality standards and monitoring system (system development)		
1.4.1.	Test and validate care assessment tool (existing or new?) and establish mechanisms for lead on care assessment (CA, service providers, social workers – somewhat depends on funding mechanism)	International and national consultant Training of assessors Pilot
1.4.2	In collaboration with National Civil Affairs and PCA develop service standards/ quality standards for HCBC and monitoring system	Consultant to support
1.4.3	Training for IAs + other care providers on standards	Training by consultant
1.4.4	Establish monitoring system	PCA, with local CAs + consultant to mentor, annual monitoring by IAs
Activity 1.5 IT system		
	<i>IT call centers operationalized, providing wide range of prevention, promotive activities as well as facilitating service provision</i>	
Activity 1.6 Financing		
	<i>Requirements and options for public financing for HCBC explored</i>	Consultant (national and international) – not at sub district level but for whole project

Risks and assumptions

There are a number of risks and assumptions underlying the project, which are listed below. At this stage of the project development three very high risks do need to be highlighted:

C.1. Lack of experienced implementing agencies: one of the major risks in this project is the lack of experience of the proposed implementing agencies, where in all cases, except Xunhua, and to some more limited extent Li County, the IA has no experience in elderly care. This leads to be lack of conceptual understanding of the role of EC services and a lack of appreciation of the complexity of EC, specifically in HCBC on building appropriate services and linkages with other service providers, and in understanding the human resource requirements to provide effective care. This cannot be overcome in the short term, but a detailed capacity building plan for each IA needs to be developed, including commitment of staff secondments to existing HCBC service providers, training for management and care providers, collaboration with Civil Affairs on standards, monitoring and financing, and understanding how other service providers will link with them, in particularly health services. There is a danger with this suggestion though as IAs once realizing what is involved in EC may wish to withdraw.

C 1.2. Lack of involvement from Civil Affairs. Given the nascent state of EC service development in some of the sub project areas and the limited experience of the IAs, the Civil Affairs Bureau need to be fully engaged, supportive and understand the process of EC development. In the *Announcement of doing a good job in government purchasing elderly care services (2014)*, it is clearly stated that the role of government is 'leading, planning, providing policy support and funding, and monitoring and evaluation' and 'local government is required to formulate service standards for elderly care HCBC services and organize regular monitoring and evaluation activities.' The respective Civil Affairs Bureaus need to be fully committed to these responsibilities and again develop a road map as to how this will happen.

C1.3 Lack of detailed around the business model: This lack of EC experience is demonstrated in the top level business models presented with special reference to HCBC, which are not clear not only on costs, largely with the exclusion of human resource costs, but on pricing which is not clear on target customers and ability to pay. There is no clarity as to what services will be charged for and what will be freely available, such as access to the entertainment facilities in the community center. In this project there is a considerable danger, that when HCBC services are developed and found not to be immediately profitable, that the IAs withdraw these services. A 5 year business plan for HCBC services should be developed and incorporated into the overall business plan, including the residential facilities. This will require information from the Bureaus of Civil Affairs and Finance as to what, if any, services they are likely to directly purchase in the future, provision of service vouchers to older people, and what operating grants may be available.

Risk	Level of risk	Mitigating factors
Lack of experience of IAs	High	Need to broaden their understanding of what EC is and then develop a road map for building their capacity, linking with organizations with existing experience
Lack of regulatory support from Civil Affairs	Medium/High	Depends on sub projects. Appoint dedicated EC CA staff per district.
Home- and community-based care is not immediately profitable for the implementing agencies	High	Clarity from PCA on plans for development of HCBC including financing, including necessary operating grants, and subsidies
Insufficient expansion of private and nonprofit service providers services limits coverage and quality, especially	High	

coverage in rural areas		
HCBC services, as opposed to facilities, not developed	High	Service level agreements, or similar, to be defined
Information on HCBC services not adequately communicated to the elderly and their families.	Low	Use community centers as information centers, supported by outreach communication (leaflets, staff visits, announcements)
Pricing structures of HCBC run contrary to the projects social inclusiveness objectives.	High	Civil Affairs, and Finance bureaus to further define subsidies and provide guidelines on the pricing mechanisms
Lack of interest from social organizations or volunteers	Medium	Information campaigns, incentives for organizations and individuals developed
IA interest in HCBC limited and withdraw	High	Service agreements with GO to be developed
HCBC services developed not appropriate to the target population	Medium	Services to be developed slowly, in holistic manner, and based on customer feedback
Services are unaffordable to older people and their families	High	Clarity from PCA on plans for development of HCBC including financing necessary subsidies
At risk older people 'slip through the net'	Medium	Proactive outreach included throughout the HCBC components including IT call centers, use of resident committees,
Health service providers not interested in collaborating on piloting integrated care	Medium	Strong GO support a prerequisite for identification of location for pilot
Low take up on HCBC services	Low	Information campaigns held, outreach marketing work, step by step development of HCBC services

4. Detailed guidance for implementation

Activity 1.1: Rehabilitate or construct appropriately designed XX community care centers in the six subproject areas covering a catchment population of XXXX households, providing XX services by 2022, and serving XXX unique customers by XX (construction/design)

- 4.1.1 Build, rehabilitate and equip XX community care centers, providing a range of services, including sufficient space, facilities and equipment for at a minimum information services, recreational activities, day care, outreach home-based care services, support for care givers
 - Procure appropriate design firm
 - Consultation on design and equipment
 - Procurement of engineering and construction
 - Procurement of equipment and fittings
 - Develop maintenance schedule with defined responsibilities
- 4.1.2 Rehabilitate and equip XX rural happiness yards, including at a minimum information/education services, recreational activities, outreach home-based care

services and support for care givers, assessment and if required modification of existing rural happiness yards (especially accessibility)

- Consultation and prioritization of equipment
- Procure equipment
- Develop agreement between IA, village authorities and CA on maintenance and replacement

Activity 1.2 XX service providers develop home and community care services reaching XX (service development), including minimum information services, social services, care planning, outreach home-based care services, support for care givers

1.2.1 Conduct participatory and multi stakeholder consultation process on needs, design and delivery of HCBC in 6 sub projects (8 months), resulting in the development of a road map of HCBC to be provided over the project period

- Working group established
- Facilitator for community consultations
- Consultant to work with IAs to develop precise services to be offered
- Study tour to Beijing. Hong Kong to learn about person centered HCBC

1.2.2 Develop HCBC service specifications for each sub project (at establishment and road map for 4 years), including areas of services to be provided, and service specifications for service providers

- Consultant to work with IAs to develop precise services to be offered
- Agreement with CAs
- Training of IAs

1.2.3 Develop outreach HCBC services in 20 (?) in rural locations, serving older population of 2000, with a minimum of services provided weekly

- Exact details to follow on from community consultations and resource analysis
- Communication campaign with village leaders, local authorities
- Recruitment of social worker/care assistant to support rural happiness yards activities (\$)

1.2.4 Develop XX social organizations, and mobilize of approximately 1200 volunteers supporting HCBC services in 6 sub projects

- Mapping of existing social organization (by whom?)
- Interest generating workshop
- CAs lobbied for financial resources for social organizations (lottery fund)
- Volunteer recruitment campaigns by local CAs
- Training and management of volunteers by IAs
- Exchange visit of social organizations and CAs/ Committees of Ageing to Shaanxi, Sichuan, etc.

1.2.4 Establish training/ support programme for family care givers (dementia, stroke....), run out of rural and urban community center. Support for family care givers integrated into plans for day care clients (in HCBC service specification). Support services to include support groups, training, information on services and entitlements, information on long term conditions (dementia)

- Requires national consultancy to establish systems and train IA staff to implement (potential consultants: ADI, Bob, existing information services), evaluation of services. Need based on community consultations (Activity 1.2.1)

1.2.5 Establish home safety assessment and modification program in 6 sub projects, reaching minimum 600 homes

- Train XX in home risk assessment by XX (occupational therapists? Don't exist – who will do this?)
- Identify and train XX sub-contractors for home modifications by XX
- Communication and marketing campaign
- Establish pricing structure

1.2.6 Develop capacity of HCBC providers develop, implement and monitor care plans, in coordination with health service providers (or Pilot integrated H&C at community level in 1 sub project (Chengde))

- Buy in received from Health authorities
- Training for Health and CA and IAs on integrated care; and care planning implementation (consultant)
- Allocation of health center staff (\$\$)
- Working group established (with monitoring framework developed) – evidence from pilot may need international/ national consultancy to develop

Activity 1.3 Recruit and appropriately train home and community care staff (HR development)

1.3.1 Develop and implement HR plan

- Consultancy with experienced care provider: HR plan would cover
 - Skills analysis
 - Career progression
 - Retention strategies
 - Training for staff
 - Workforce planning

1.3.2 Train XX HCBC managers

- Consultancy to develop training development program
 - Placement (2 months?) in existing community care center and HCBC provider
 - Appoint mentor (could be experienced practitioner as a consultant)
 - Any formal qualifications?
 - *When will IA management be appointed?*

1.3.3 Recruit and where necessary train staff for community centers with XX expertise by 2022

- Training program developed/ modified
- On the job + institution

1.3.4 Upgrade XX care assistants to provide HCBC in specific conditions (dementia, stroke), (Year 4-5)

- Train existing care workers by XXX HUMC?
- (assumes care assistant will not be providing this service at the start)

1.3.5 Collaborate with residential centers for outreach of technical experts (rehab, nurses)

1.3.6 Develop training/ support programme for family care givers National consultant, develop

options for training, pilots with IA, rolls outs, ToT for IAs, documentation

Activity 1.4 Develop quality systems including care assessment, HCBC quality standards and monitoring system (system development)

1.4.1 Test and validate care assessment tool

International and national consultant (Year 1)

- Lead research
- Training
- Pilot; test algorithm
- Training of assessors
- Pilot

1.4.2 In collaboration with National Civil Affairs and PCA develop service standards/ quality standards for HCBC and monitoring system

- Consultant to support

1.4.3 Training for IAs + other care providers on standards

- Training by consultant

1.4.4 Establish monitoring system

5. M&E arrangements and key indicators

5.1 Home- and community-based care improved

	Current indicator and target	Modified/ proposed indicators
Outcome level	Number (or should it be percentage) of elderly receiving EC services (disaggregated by gender and level of care) increased to XX by 2022 (baseline to be determined in 2016)	<p>Number of elderly having received EC services (disaggregated by gender, age and type of care (HCBC/ residential care)) increased</p> <p><i>By IAs, in sub districts or at provincial level? At outcome level, it should be provincial, and not just an aggregate of residential and HCBC IAs)</i></p> <p>Baseline 2017: Target 2022:</p> <p>Data source: Annual provincial CA records</p>
		<p>>50% of EC users low and middle income users</p> <p>Baseline 2017 Target 2022 >50% (maybe more?)</p> <p>Data source: IA records, project mid-term and end evaluation (how to define and collect data on low and middle income users?, At IA level or provincial)</p>
	Client satisfaction with home, community, and residential care services increased to XX% by 2022 (results disaggregated by gender)	<p>90% EC service providers demonstrating year on year improvement in quality, based on</p> <p>Baseline 2017: Target 2022: 90%</p>

	(2017 baseline to be measured and target set based on this?:	Data source: Not clear yet: depends on quality standards and system – could be the IAs own monitoring system, or standardized provincial systems. Any monitoring system should include family and user feedback and satisfaction
Output level	1a. The number of elderly served by home-based services provided by the project IAs in 2022 (number of beneficiaries sex-disaggregated) (2016 baseline: XX%)	<p>The number of elderly served by home-based services provided by the project IAs increases to XX (number of users disaggregated by sex, rural, urban, age, income?)</p> <p>Baseline 2017:0 Target 2022:</p> <p>Data source: IA reporting, validated by CA monitoring system</p>
	1b. Number of community centers and rural community homes constructed or rehabilitated and resourced with equipment under the project	<p>Number of unique community members using constructed or rehabilitated community centers (sex/age disaggregation)</p> <p>Project reports, aggregated from IA reports</p> <p>Baseline - 2017 Community centers - Rural happiness yards</p> <p>Target Community centers - Rural happiness yards -</p>
	1c. Percentage of elderly aged over 70 formally assessed for HCBC	<p>1c. Percentage of elderly aged over 60 formally assessed for HCBC at sub project district level</p> <p>Baseline 2017 - 0 Target 2022: suggest target <i>for somewhere between 8-10% of population over 60, as this tends to be the population that required care services. If the indicator is from 70 years up, then the % may need to be higher, say 15 – 20%.</i></p> <p>Data source: district CA records, collated from XX,(depends who will conduct the assessment)</p>
	1d Percentage of elderly assessed as needing HCBC who actually receive the services they need (disaggregate by age, gender and rural/urban)	<p>An indicator about coverage should be at outcome level</p> <p>Percentage of elderly assessed for requiring care who are unable to access care (Assumes that care assessment is done on needs not other factors)</p> <p>Data source: project baseline, mid-term and end of project evaluations, street office records</p>
	1e. XX users (elderly and their	XX of unique registrations (aggregated by age.

	family members) of IT services support networks by 2022 (2016 baseline: 0)	<p>Gender. Urban. Rural) for IT services support networks by 2022, and XX regular users, defined as using service monthly (?)</p> <p>Baseline: 0 Target: No of OP in the service area *10% for registration, and 5% for regular users</p> <p>Data source: Annual IT center reports, and CA population report</p>
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Appendix 1: Elements of day care

Matching customers' needs with activities

Customers' Needs	Related Activities
Emotional expression	Singing Writing Art
Health promotion	Group work with therapist Education
Intellectual stimulation	Reading and discussing newspapers Card games
Physical stimulation: gross motor skills	Walking Armchair exercise Dancing
Physical stimulation: fine motor skills	Cards games Cooking Crafts
Sensory stimulation	Dancing Gardening Music Pet visits
Social stimulation	Discussion groups Intergenerational activities Special events

Hebei Elderly Care Development Project

Final Report

Volume Two

Document 2-C

Technical Report on Residential Care

HEBEI, PRC

PPTA

HEBEI ELDERLY CARE DEVELOPMENT PROJECT:

TECHNICAL REPORT

Technical Report
(originally submitted on Jun 15, 2016, revised on August 15, 2016)

Residential Care

ABBREVIATIONS

ADB	—	Asian Development Bank
ADL	—	activities of daily living
DMF	—	design and monitoring framework
CAB	—	Civil Affairs Bureau
CNY	—	Chinese Yuan
EC	—	Elderly care
FSR	—	feasibility study report
HC	—	home care
HCBC	—	home- and community-based care
HPG	—	Hebei Provincial Government
HPMO	—	Hebei Project Management Office
HRD	—	human resources development
IA	—	implementing agency
ICT	—	information and communication technology
IT	—	information technology
KM	—	kilometer
LTC	—	long-term care
OR	—	occupancy rate
PPTA	—	project preparatory technical assistance
RC	—	residential care (institutional care)
SA	—	sector assessment
SSA	—	summary sector assessment
TA	—	technical assistance
TR	—	technical report
USD (\$)	—	US dollars
12FYP	—	12th Five-Year Plan (2011–2015)
13FYP	—	13th Five-Year Plan (2016–2020)

NOTE

In this report, 1USD = 6.1CNY (Yuan)

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1.0 INTRODUCTION, SCOPE OF WORK AND PROPOSED OUTPUTS

1.1 INTRODUCTION

1. The most significant demographic challenge facing the People's Republic of China (PRC) today is aging of the population. The proportion of people aged 60+ across the PRC is expected to grow from roughly 12% in 2010 to 34% by 2050. Combined with fast urbanization, internal migration with youth moving away from rural areas, and the one child policy, traditional family support systems are stressed and increasingly unable to meet the elderly care (EC) needs. These demographic, social and economic challenges will require increased involvement from Government, the private sector and voluntary sector efforts and other social organizations in order to build a socially inclusive EC system able to meet the care needs of China's aging population.
2. The proposed project supports development of the EC system in Hebei province through improving the quality and coverage of residential (RC), community and home-based (HCBC) EC services and facilities. The project will improve quality and service delivery in collaboration with government and will include the participation of the private sector in most of the proposed subprojects. The project constitutes a major capacity building effort in the development of the EC system in Hebei province.
3. The project supports the PRC's 13th Five-Year Plan (13YFP) (2016–2020) and the Hebei Provincial 13FYP (2016–2020), which will support developing and strengthening the EC system in PRC by developing a three-tiered system of services, stimulating investment in the sector, define roles and responsibilities for government, the private sector, civil society organizations and the public. The project is aligned with ADB's country partnership strategy (2016–2020) which prioritizes the development of the EC sector, the midterm review of Strategy 2020 which supports social protection and health, and the Operational Plan for Health (2015–2020), which has EC as a focus area.
4. The project will have a demonstration effect on other provinces in the PRC and has the following special features:
 - a) Development of an integrated elderly care system linking home-based, community, and residential care (including medical rehabilitation hospital) that provides services for both urban and rural project areas through the collaboration of the public sector, private sector and social organizations.
 - b) Promotion of seamless links in how the elderly access different elderly service components and between the EC and healthcare systems.
 - c) Improvement of EC planning and service delivery capacity for provincial and local government and the EC industry, including systems for the assessment of individual care needs, monitoring and evaluation of the performance of all licensed providers of EC services, regulation of pricing, and ensuring inclusiveness in service access.

- d) Support of an enabling human resources development program for the EC industry in Hebei Province, including coordination across the new Hebei-Beijing-Tianjin region.
5. The impact of the project is aligned with the government's goal that a three-tiered EC system (home, community, and residential) is established. The expected outcome is that the quality of EC services in Hebei Province is improved. The project will support selected cities and counties initiatives to improve the quality and coverage of the elderly care systems. The project is to help create a platform from which other elderly care services can grow in the future.

1.2 SCOPE OF WORK

6. The scope of work of this report is on Residential Care (RC) or Institutional Services as stipulated in the TOR of ADB. Both the national and international consultants are to:
- a) Analyze the RC services currently provided in the locality (capacity, services, quality, facilities, human resources, medical services, etc.).
 - b) Describe the different care level that will be provided through RC of each subproject and estimate the demand and willingness and ability to pay of the target population.
 - c) Detail the type, quality standards, and quantity of services that will be provided in RC, including social, medical, psychological, and rehabilitation and other support services given the target population.
 - d) In collaboration with the civil engineer, propose quality (e.g., universal design) and safety features for the construction of the EC facilities.
 - e) Analyze and discuss arrangements with medical facilities for health care needs, including transitioning elderly to home-based care - exceeding in-house service capacity.
 - f) Describe quality assurance measures that will be implemented in-house to ensure quality services and safety of the elderly.
 - g) Detail human resources recruitment strategies, continuous development programs, and quality monitoring for the different professional categories of personnel (social, management, caregivers, medical [doctors, nurses, physiotherapists, psychologists] and support staff).
 - h) Describe information technology support systems that will be implemented in the facilities to promote high performance of services and efficiency of operations.
 - i) In cooperation with the financial specialist, analyze the business model, project investment and operations cost over 20 years, and match with potential revenues (fee schedule and government subsidies) to assess financial viability of the operation.
 - j) Provide capacity building to local government officials, private sector operators and non-governmental organizations to understand the recommendations for institutional EC under the technical assistance.

- k) Reformulate each subproject to ensure a need based and commercially viable operation. Provide information on costing, activities, human resource requirements, timing, outputs and monitoring indicators.

1.3 SUB-PROJECTS

- 7. Out of the 6 sub-projects, 5 have RC as part of their proposals. These 5 sub-project sites are:

- g) She County – a part of Handan Municipality
- h) Xinji County, reports direct to Hebei PG
- i) Li County – in Baoding Municipality
- j) Shuanglan District – in Chengde Municipality
- k) Julu County – in Xingtai Municipality

In general, each sub-project proposed to construct (1) medium to large scale RC facilities that will provide in the range 300 to 600 beds; and (2) a medical rehabilitation unit (geriatric hospital) of typically 100 beds.

2.0 SITUATIONAL ANALYSIS

2.1 EARLY ASSESSMENT OF EC/RC IN HEBEI

2.1.1 The Challenges of EC in China

8. China's growing elderly population and the need to provide EC to them is a very complex social issue: with the one-child policy, the "empty nest", phenomena and the plight of rural elderly, China getting old before getting rich, etc., as complicating factors. So much so that President Xi Jinping in a recent learning session of the Political Bureau of the CPC Central Committee, used three superlatives to describe China's elderly population: (1) largest, (2) fastest growing, and (3) toughest to cope with²²⁶. Population ageing in Hebei is no exception. The elderly population is increasing in size and rapidly so. Government EC policies are many but resources are limited. The government hopes to cope with the toughest EC issue by placing increased reliance on private capital/providers.

2.1.2 Elderly Population is increasing Hebei

9. In 2013, people aged 60+ reached 15% (10,742,300) of the total population (73,326,300). It is expected to reach 17% (13,300,000) by 2020.²²⁷ Among the 5 municipalities where the sub projects are located, proportion of elderly population will increase from 20% in 2015 to 24% in 2020 in Tangshan (Zunhua); 17% to 21% in Chengde (Shuangluan); 16% to 20% in Shijiazhuang (Xinji); 17% to 19% in Boading (Lixian) and 14% to 17% in Handan (Shexian). Based on international practice, a community will be an aging community when the proportion of people aged 65+ exceeds 10 – 12% of its total population. In China however, the age when people are classified as elderly is >60+. In general, there are more elderly in rural than in urban area. The ratios of urban and rural elderly in the five sub project areas are: Lixian (1:2.34); Xinji (1:2.32); Zhuhua (1:1.72); Shexian (1:1.65) and Shuangluan – Chengde (1:0.46). Even though Chengde is one of the rapidly ageing municipalities, there are more urban than rural elderly.²²⁸

2.1.3 Elderly Population Density and Service Utilization

10. Elderly population density affects service utilization. In a more populated area, service utilization will likely be higher. Elderly persons by Sq. Km are as follows: Xinji (104); Lixian (103); Zhuhua (64); Shuangluan – Chengde (39) and Shexian (29). Elderly population density is the highest in Xinji and the lowest in Shexian²²⁹.

²²⁶ http://news.xinhuanet.com/politics/2016-05/28/c_1118948763.htm

²²⁷ Xinji FSR, 2016. p. 5

²²⁸ Wang Xiaobo (2015). Hebei Elderly Care System Development. A report prepared for ADB (SC 104708). Section 3.1

²²⁹ Wang Xiaobo (2015). Hebei Elderly Care System Development. A report prepared for ADB (SC 104708). Section 3.2

2.1.4 Supply of RC beds in Hebei

11. In 2014, there were 675 public (131,000 beds) and 500 private (80,000 beds) RC facilities in Hebei. Public RC is mainly for the 5-guarantees with an occupancy rate of about 50%. Poor quality of care, low staffing level, strict admission criteria (for five-guarantees and three-nos only), inflexibilities, etc. are just some of the reasons leading to low occupancy. Most of these beds were not well designed and are not staffed to the care for people with complex care needs²³⁰.

2.1.5 Local Government Finance Performance²³¹

12. Many elderly and EC providers depend on government subsidy. Thus, the financial capacity of local governments affects their spending in EC. Almost all the municipal governments in which the sub projects are located, ran a deficit budget, their expenses were more than their income. The reported deficits for 2013 were: Lixian (41%); Chengde²³² (25%); Zhuhua (24%); Shexian (9%) and Xinji (6%). The higher fiscal deficit does not necessarily prevent local government from EC spending, but does make the policymakers take a wait-and-see attitude or more cautious approach towards implementing new EC policies and increased expenditure commitments.

2.1.6 People's Income & Price of Services²³³

13. People's income affects their ability and willingness to purchase EC services. Presumably, people with higher income are likely to purchase services when needed. In 2013, annual disposable income per capita of urban residents in Tangshan (Zunhua)²³⁴ was 27,000 CNY; Xinji - 23,000 CNY; Shuangluan – 22,000 CNY; Boading (Lixian)²³⁵ – 21,181 CNY and Shexian – 13,000 CNY. Per capita disposable income of rural residents in Tangshan (Zunhua)²³⁶ were 12,000 CNY; Xinji - 11,000 CNY; Boading (Lixian)²³⁷ – 8,700 CNY; Shuangluan and Shexian – 7,600 CNY.
14. Overall, the average price of semi and total dependent RC beds was higher than the average income of urban and rural residents. It was lower in Tangshan (Zunhua), on par in Handan (Shexian) but higher in other three municipalities. However, the price of semi and total dependent RC beds was higher than rural residents' average income in all sub project area. On the other hand, the average price of independent RC beds was more affordable as it was lower than people average income in the urban area. However, the price, except for those seeking the lowest level of care, was still above the average income of rural residents.

²³⁰ Hebei provincial DRC, Department of Finance and Civil Affairs Bureau. (2015). ADB Financed Hebei Elderly Care Service System Development Project (July 16th, 2015)

²³¹ Wang Xiaobo (2015). Hebei Elderly Care System Development. A report prepared for ADB (SC 104708). Section 3.3

²³² Shuangluan's information was unavailable, based on Chengde which consists of Shuangluan and Luanping

²³³ Wang Xiaobo (2015). Hebei Elderly Care System Development. A report prepared for ADB (SC 104708). Section 3.3

²³⁴ Zunhua's information was unavailable, based on Tangshan

²³⁵ Lixian's information was unavailable, based on Boading

²³⁶ Zunhua's information was unavailable, based on Tangshan

²³⁷ Lixian's information was unavailable, based on Boading

2.1.7 Medical support

15. Medical support is vital in EC. Hospitals in China are grouped under different levels in terms of specialties and resources. Level III hospitals have the most specialties and resources. This is then followed by level II and level I. None of the municipality where the sub projects are located has a Level III hospital. For level II, there are 6 in Zunhua, 5 in Xinji, 4 in Shuangluan, 2 in Lixian and 1 in Shexian. Having said that, Baoding and Handan where Lixian and Shexian are located, have 8 Level III hospitals each. Shijiazhuang, which is the capital of Hebei and where Xinji is located, has 23 Level III hospitals.

2.1.8 Nursing Training Schools

16. Local nursing schools train EC staff. Most of the nursing training schools are located in the provincial capital; there are 23 schools in Shijiazhuang (Xinji); 3 in Baoding (Lixian); 2 each in Chengde (Shuangluan), Handan (Shexian) and Tangshan (Lixian).

2.2 POVERTY, GENDER AND SOCIAL ANALYSIS

17. A poverty and social assessment, including a questionnaire survey, community and focus group discussions, and key informant interviews was conducted during project preparation (see **volume 3** for the full assessment report). Based on a survey of 354 questionnaires and 35 focus group discussions, it was found that regarding preferences for care, 58.8% of elderly respondents chose to be taken care of by their children, 19.3% chose the community and home-based EC services, and 15.6% chose the EC institutions as their preferred means of care. Individual EC decisions were said to be influenced by a variety of factors, including an older person's health condition, economic status, age, education level, number of children, traditional EC concepts, and social networks. These factors will also influence willingness-to-pay. However, obviously, the limited income of poor elderly restricts their expectation of enjoying EC services. Without government subsidies or assistance, it will be difficult for poor elderly to live in an EC residential care with good quality. Thus, there is a need for provincial and local governments to assess the options for subsidizing the semi-disabled or disabled and poor elderly and if possible, expand coverage and amounts. The HCBC to be established and improved under the project will expand coverage, access and affordability of EC services for the low and middle income elderly.

18. The project will benefit residents of the five subproject sites through the development of integrated residential, community, and home-based EC services, facilities, and ICT systems. The construction of EC facilities and their operation will create new job opportunities for about 2,200 persons. The project will benefit a total of about 300,000 persons in the six project areas when the services are operational and 4,400 students will have been certified by YSU at project completion. The project targets low- and middle-income elderly who comprise approximately 40% of the total elderly population, and will promote improved care assessment systems to allow care to be directed to those most in need. The project will directly benefit local EC services providers, caregivers, and local officials through capacity building. The project targets low and middle income elderly who comprise approximately 40% of the total elderly population.

Gender

19. The project is classified as "effective gender mainstreaming" (EGM). Analysis of the survey and focus group discussion data revealed gendered differences in elderly needs and

circumstances. Among the elderly population, women typically outnumber, live longer, and suffer from more diseases than men. Especially among the “empty nest” elderly, fully independent elderly, and those 80 and above, women significantly outnumber men, but their income levels are typically lower than those of men. Family contributions often play a significant role in access to care services for both women and men, but to what degree varies among individuals and circumstances. Development of EC will help relieve family caregivers and give unsupported elderly better access to care. Benefits will include reduced time burdens for family caregivers and improved job opportunities from training in a service industry traditionally female dominated.

20. A social and gender action plan (SGAP) has been prepared to be carried out by the implementing agencies during project implementation, under the overall oversight of the HPMO. Social inclusiveness and gender mainstreaming is the objective of the SGAP actions. All the actions, indicators, responsible institutions, timeframe, and budget have been discussed with the HPMO, implementing agencies, and relevant local government departments and agreement reached on the actions included. The SGAP is included as Appendix 8 to Volume 1 of this report.

2.3 NATIONAL LEGISLATION AND POLICIES

21. China is not short of EC laws and policies. The central government has issued many of EC legal framework and policies, which can be found in Annex A. These EC laws and policies are by no mean to be inclusive and can be largely grouped under the following themes:

- i. Rights and interests of the elderly
- ii. A three-tier EC system
- iii. Impaired and/or financially difficult elderly are the priority of publicly funded EC services
- iv. Engagement of social organizations (NGOs)/private sector in EC
- v. Quality and human resources requirements of EC
- vi. Clinical and nonclinical services and management support of RC and role of government in RC monitoring
- vii. Health and EC integration.
- viii. EC facility construction standards and guidance – they are:
 - a. Code for the planning of city and town facilities for the aged. (Annex A:14)
 - b. Code for construction of community adult day care for the aged. (Annex A:1)
 - c. Code for design of a residential building for the aged. (Annex A: 2)
 - d. Code for design residential care home for the aged. (Annex A: 3)

2.3.1 Rights and interests of the elderly

22. The Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly²³⁸ provides an overarching legal framework to protect the rights of the elderly in the PRC, including the rights to receive care and supports from their families²³⁹ and from the government. Sections of the law that are particularly pertaining EC/RC are:

²³⁸ 中 国 人 民 共 和 国 老 年 人 权 益 保 障 法 (2013)
<http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201302/20130200418213.shtml>

²³⁹ It states that children or others with legal obligations of care to provide the elderly with financial, practical, and

- i. Section #30: developing *long term care* to address elderly with nursing care needs and providing a subsidy to those who are semi and totally dependent, and/or in financial destitute.
- ii. Section #37: developing community care to address the care need of activities of daily living (ADL), emergency assistance, medical and nursing care, mental health and counseling, etc.
- iii. Section #38: incorporating community care in town planning and developing services to meet the needs of elderly in their vicinity including ADL, cultural and recreational activities, day care, disease management and rehabilitation.
- iv. Section #41: priority of Government's EC services – widows, disabled and people in advanced age.
- v. Section #42: developing services standards for EC facility construction, service quality, manpower requirements, classification of EC facilities, service monitoring, and fee charging

2.3.2 A three-tier EC system

23. The way how EC should be organized has been clearly covered by (1) 12FYP (2011), (2) 13FYP (2016), (3) "A development plan for EC system (2011)." (4) "Plan for the construction of the EC System" (issued by the General Office of State Council in 2011), and (5) "Opinions on speeding up the development of EC industry (2013)." Basically, these policies require all levels of government to set up a three-tier EC system with *"home-care as the foundation, community services as backbones, and residential care facilities as supplements."* All levels of government will have to meet the planning ratio of 9073 (or 9064) of the three-tier EC system that assumes 90% of elderly would have their needs been met with in-home services, 7% with community services and the other 3% with residential care service.

2.3.3 Impaired and/or financially difficult elderly are priority of publicly funded EC services

24. The law and government policies require the provision of EC services, especially those publicly funded to be prioritized and provided to those requiring *long term care: nursing and ADL, and/or with financial difficulties* such as the three-no, etc. This priority has been reiterated in 13FYP and the intended usage of publicly funded EC services is reflected in (1) "The Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly (2013)", and the (2) "Directives on good practice of government EC services purchasing (2014)" and (3) "Directives on the establishment of subsidizing system for impaired and old people with financial difficulties (2014)."

2.3.4 Engagement of social organizations (NGOs)/private sector in EC

25. Government policies strongly encourage the involvement of social organizations such as NGOs and the private sector in the development of EC industry. The documents on (1)

spiritual support. It also requires children to take care of the medical, practical and housing needs of the elderly.

“A development plan for EC system (2011)” and (2) “Opinions on government purchasing services from social organizations (2013)” made the outsourcing of EC services to social organizations through service purchasing and contracts easier. The government will retain the role of service monitoring through the establishment of a clear and transparent performance management system. These policies also mandate all levels of government to develop a service purchasing system by 2020. The (1) State Council (Circular No. 35) re “Opinions on promoting the development of EC Industry, 2013”, and (2) Civil Affairs (2016) directives on the promotion of active involvement of private capital in the development of EC industry²⁴⁰ encouraged the engagement of private sector in EC industry through a fair market mechanism such as private public partnership (PPP).

26. A number of preferential policies have been in place to attract the involvement of private sector including social organizations (NGO):

Tax reliefs

27. “The opinions on the implementation of private capital involvement in the development of EC industry(2015 [33]0²⁴¹”, include tax exemptions in the following areas:

- i sales tax;
- ii capital gain
- iii corporate income tax
- iv property tax and urban land use tax on the lands or buildings used by the facility;
- v 100% reduction of administration fee for nonprofit and 50% for profit making organizations

Supports on land supply

28. The Ministry of Land and Resources’ opinions on land use for EC facility (2014)²⁴², provides the following supports on land use by EC organizations:

- i For nonprofit EC organizations, they could obtain the right of use of land by allocation at no cost and pay a difference in land cost should they decide to become a profit organization with the approval of the county government.
- ii For-profit EC organizations, they could obtain the right of use of land by leasing and/or auction if there are more than one competitor for land use.
- iii Land for RC should not exceed 3 acres whereas land for integrated RC, medical and health, rehabilitation should not exceed 5 acres
- iv There will be no charge for land cost differences for 5 years should an existing land or facility (e.g., school) be converted into an EC use land or facility

²⁴⁰

http://mp.weixin.qq.com/s?__biz=MjM5MjE0OTU5OA==&mid=2666147514&idx=1&sn=0b710c62f42832e3177bb9dfe990beb9&scene=5&srcid=0530H1v2HTqwPtcl1TRoxxie#rd

²⁴¹ <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201502/20150200777798.shtml>

²⁴² http://www.mlr.gov.cn/xwdt/jrxw/201404/t20140424_1313743.htm

2.3.5 Quality and human resources requirements of EC

29. “The Law on elderly rights protection of PRC (2013)” mandates the State Council to establish standards for EC facility construction, services and manpower, including EC facility ranking (e.g., star). EC standardization is further operationalized by a joint directive issued by the Ministry of Civil Affairs, Standardization Committee of China (SAC), Ministry of Commerce, General Administration of Quality Supervision, Inspection and Quarantine of the People’s Republic of China (AQSIQ) and The National Working Committee on Ageing: “Opinions on strengthening the standardization of elderly care (2014)”²⁴³ The directive is set to achieve an universal standard for all EC services, management and products covering HCBC and RC (Section #3.1). The opinions suggest the establishment of EC quality management and ranking (e.g., star) systems through accreditation and certification by an independent 3rd party (Section 3.4). Another important aspect of these opinions is the standardization of human resources training in EC especially for professional and managerial staff; as well as standardization of EC information sharing through the use information technology (Section #4.3). All these will first be proven through pilot and/or demonstration projects before a national roll out.
30. “The opinions on the implementation of private capital involvement in the development of EC industry the Ministry of Civil Affairs (2015)[33]” has also made the following suggestions to support the training of EC workers:
- i. To designate vocational training schools and EC organizations to develop EC workforce and to issue subsidy to those who complete the training and attain the license to practice.
 - ii. To provide social insurance subsidy to those EC organizations offering employment to those who have difficulties in job finding.
 - iii. To allow physicians and social workers to work in EC organizations.
 - iv. To provide credentialing, registration and monitoring of professionals working in EC organizations, similar to that of public organizations.
31. “The Ministry of Civil Affairs’ opinions on introducing liability insurance to EC organizations(2014)”²⁴⁴ requests better collaboration between insurance and EC sectors so that EC organizations will acquire liability insurance with government subsidy in insurance premium.

²⁴³ <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201402/20140200585735>

²⁴⁴ <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201403/20140300600030.shtml>

2.3.6 Clinical and nonclinical services, management support and service monitoring in RC

32. Under the policy on the management of residential care (RC) (2013),²⁴⁵ all RC operators are required to provide:
- i. clinical and nonclinical services: ADL/IADL, nursing, rehabilitation, mental health and social recreational activities (Section #9); ADL/IADL including eating, dressing, toileting, bathing, in and outdoor activities (Section #12); preventive health care including periodical functional and health assessment (Section #13); emergent health care and infection control (Section #14)
 - ii. management support: risk and safety management (Section #17, 21, 22, 23 and 24); professional staffing requirements and qualifications (Section #19); privacy (Section #25) and periodical collection of users' feedback (Section #26).
33. The law also requires local Civil Affairs Departments to:
- i. conduct a periodical comprehensive evaluation of RC operation: staffing, facilities, service, management and reputation (Section #29);
 - ii. receive statistical reports by RC operators (Section # 30);
 - iii. conduct on the spot inspection and make the inspection reports public (Section #28); and
 - iv. handle service users' complaints (Section #31).

2.3.7 Health and EC integration

34. The Ministry of Health and Family Planning's opinions on health and social care integration (State Council, 2015 [84])²⁴⁶, along with other government directives such as "The opinions on the implementation of private capital involvement in the development of the EC industry, 2015 [33], support closer health and EC collaboration by forming formal collaboration agreement. Health care services offered in EC setting may be covered by health insurance and vice versa. The government will also provide a subsidy for EC organization focusing on nursing care. Skills certification and the monitoring of health care employees in elderly care will be similar to those in health care setting.

²⁴⁵ 养老机构管理办法 (2013)<http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201306/20130600480076.shtml>

²⁴⁶ http://www.gov.cn/zhengce/content/2015-11/20/content_10328.htm

2.4 PROVINCIAL LEGISLATION AND POLICIES

35. HPG follows the EC legal framework and policies of the central government, and faces the challenges of finding effective ways to operationalize them by giving practical advice and guidance to city and county governments within Hebei. For instance, preferential policies to promote private sector/capital involvement, are spelled out in far more details. Some of these policies can be found in Annex A. These EC laws and policies, which are by no mean to be inclusive, can be largely grouped under the following themes:
- i. Plan to realize the three-tier EC system
 - ii. Government's role in EC
 - iii. Engagement of private sector through preferential policies
 - iv. Training of EC workers
 - v. Health and EC integration
 - vi. Subsidy for people in advanced age.

2.4.1 Plans to realize the three-tier EC system

36. HPG follows the national plan of "9073." According to (1) "the Hebei's 12FYP for EC-" and (2) "Opinions about accelerating the promotion of building an EC system by HPG", it was the HPG plan to meet the target of 9073 by the end of the 12th Five-Years Plan (from 2011 to 2015).
37. For in-home services, these include: housework, daily care, nursing, counseling, and etc. The intention was that the elderly can simply dial for services from home when they need. The community services mainly refer to daycare, and also include community dining-room/canteen. In the urban area, day care and community canteen were to be integrated into the in-home services center or station in the community with the support of calling center. In the rural area, in-home and daycare services were to be provided through "Xingfu" (means happiness) Yard".
38. To achieve the targeted 3% RC rate, more beds are therefore needed at the district or county levels). As most existing RC facilities are public and primarily serve the vulnerable elderly, it was the government's plan to raise the proportion of private operated RC beds to 50% by the end of the 12th Five-Years Plan.
39. The focus of government has always been on the public RC and vulnerable elderly. Other EC services and the involvement of private sector have been largely ignored. The projects "care-with-love" and "integrating various types of institutions to one" are two most important RC projects in recent years. The former tries to expand RC services to cover the general elderly and promote the development of private RC facilities by building a brand name and setting standards of RC for the elderly. The latter intends to make the public RC run more efficiently by integrating publicly operated RC for children, disabled and elderly.

Plans by 2020

40. In Jun. 2014, Hebei government issued another plan: “Opinions on accelerating the development EC.” The new goals included: by 2020, (a) to develop in-home services centers/stations covering of all urban communities and > 90% of townships; and Xingfu Yards in all villages with; (b) to increase the proportion of RC beds by as much as 3.5% of the elderly population, (c) to increase the proportion of EC managers (100%) and workers (>90%) with license to practice; (c) to make the private sector become the major EC provider.
41. Under the plan, a number of new initiatives pertaining to RC are:
 - i. lowering the thresholds required to launch an EC facility such as registered capital, land, and staff, so as to enable more private capital to participate in EC development;
 - ii. helping EC institutions to get finance by guaranteeing, interest subsidizing, and extending the scope of collaterals, expanding the credit supply for elderly services;
 - iii. encouraging the insurers to offer the third party liability insurance for RC and long-term care insurance, and subsidizing premiums for insured institutions;
 - iv. piloting reverse mortgage for elderly;
 - v. trying various types of public-private-partnership (PPP) by separating finance, construction and operation, such as management contracts, transfer-operate-transfer (TOT), build-operate-own (BOO), etc.

2.4.2 Government’s role in EC

42. EC has transitioned from a welfare to an industry concept. The former focuses on the vulnerable elderly whereas the latter implies participation of the private sectors in the delivery of EC services. Such a shift of conception can be reflected in the provincial plans and the following policies.
43. Firstly, that public fund should be used to mainly support the most vulnerable elderly, while other elderly should meet their needs by using private EC services and/or paying for their services. Accordingly, the public EC facility must give priority to “three-no” elderly (no ability to work, no income and no supporters), low-income elderly and impaired elderly, though they are allowed to admit others as well.
44. Secondly, the government will continue to focus on building EC infrastructure and standards, while more direct services and management work will be contracted out to private sectors or existing public EC operators, instead of being managed directly by government departments.
45. Finally, the government will use the leverage of various policies to get more private funds involved in the development and operation of EC, such as tax reliefs, fees remissions on public utilities, and support on land supply and subsidies to reduce the startup and running costs of the EC. The government also adopts the principle of “value creation for EC investor and operators”, and a non-discriminative policy by welcoming all sorts of

investment: sole, joint or partnership, regardless of whether they are domestic or overseas organizations.

2.4.3 Engagement of private sector through preferential policies

Tax reliefs

46. According to the “Notice of implementing tax reliefs for promoting the development of EC organization” by the HPG, to be eligible for the tax reliefs, the organization should be
- i. welfare or nonprofit in nature;
 - ii. registered with local Bureau of Civil Affair and licensed;
 - iii. providing EC including activities of daily living, nursing, cultural and recreation activities.
 - iv. registered with the local tax offices within 30 days after licensed.
47. The exemptions include the following items:
- i sales tax on the charge for accommodation, catering, nursing and medical services;
 - ii property tax and urban land use tax on the lands or buildings used by the facility;
 - iii corporate income tax on donation income, subsidies from the government (excluding the government’s purchase), and interest accrued from the exempted income;
 - iv agriculture usage tax if the organization needs to be built on farmland;
 - v deed tax if the organization needs to lease buildings from public sectors.
48. In addition, any corporations, organizations or people who donate to the EC institutions can also receive a tax exemption for income donated. The amount can be deducted from the taxable income before taxation. The amount of donation cannot exceed 12% of the donor’s income.

Fees remission on public utilities

49. According to the document “Notice about Implementing the Policies on Price Charged to Elderly Service Institutions” issued by provincial bureau of price (2011), the rate of public utilities charges including water, gas, heating, telephone, television and internet, charged to welfare or nonprofit EC organizations, should be similar to that of other community residents. If the current rate charged to the EC organizations is lower than the rate of the residents, the current rate remains unchanged. In addition, the rate of water, electricity, gas and heating charges to in-home services providers, should be similar to the rate of the residents as well.

Rewards and subsidies

50. According to the “Opinions on implementing the rewards and subsidies for EC organizations” issued by the Department of Civil Affairs (2012[81]) and the Department of Finance, the government will subsidize the EC organizations in the form of rewards if

they meet certain conditions. There are two types of subsidy that the organizations can quality for.

51. The first type is called “one-off construction subsidy”. If an EC facility is built by using owned capital and meeting certain conditions, the institution can apply for this subsidy. The subsidy will be no less than 1,500 CNY per bed, and no more than 1 million CNY for each facility. The conditions for applying this subsidy include:
 - i. built after Jan. 1, 2012 and has been in use;
 - ii. in operation for >1 year and passing the annual check;
 - iii. having >50 beds and meeting the building standards for EC facility issued by the Ministry of Civil Affairs;
 - iv. registered with the Department of Civil Affairs; and
 - v. having not receiving this subsidy before.
52. The second type is “subsidy for bed in operation”. If an EC organization has been in operation for >1 year continuously and meet certain conditions, the organization can apply for this subsidy. The subsidy for each bed should be <50 CNY per month, and the total amount should be based on the number of beds occupied by elderly whose *hukou* are registered in Hebei Province. The conditions for receiving this subsidy include:
 - i in operation for >1 year and passing the annual check;
 - ii having no grave safety concern or serious disputes with service users within the past year;
 - iii >30 elderly living in the facility each month;
 - iv >90% service users satisfied with the service within the past year; and
 - v using the EC MIS of Hebei Province and updating users’ information monthly.
53. It is the provincial Department of Civil Affairs and Finance that will jointly decide whether to provide a subsidy to the applicants. However, the subsidy funding is shared by provincial, municipal and county-level finance. The local governments can provide a subsidy to a facility with <50 beds, provided that they come up with their policy and own funding.
54. The subsidies can only be used to improve the living conditions of the facility and/or to purchase equipment. The government may withdraw the subsidy if the subsidy is not used for the purposes designated. It is the responsibility of local Bureaus of Civil Affairs and Finance to monitor the use of subsidy.

Support on land supply

55. The “Notice of land supply for the construction of EC facility” issued by the Department of Land and Resources (2011[40]) and the Department of Civil Affairs provides supporting policies on land supply for EC organizations in Hebei Province. The key measures of the notice are:

- i the land for building EC facilities should be listed in the annual supply plan as a priority;
- ii the approval of an application for building elderly service facilities should be expedited;
- iii for new nonprofit EC organizations, they could obtain the right of use of land by allocation at no cost;
- iv for profit EC organizations, they could obtain the right of use of land by auction at market rate; and
- v the village committees could use the lands owned to build EC facilities at no cost if they got the permit.

Liability insurance

56. To comply with the central government directive on “introducing liability insurance to EC organizations”²⁴⁷, all EC organizations including public organizations have to obtain liability insurance to cover (1) accidental injury or death, (2) litigation expenses and (3) 3rd party liability insurance. The premiums of liability insurance are based on an agreed flat rate per bed.

2.4.4 Health and EC integration

57. According to “the methods of establishing health care services in EC setting as proposed by Hebei’s Department of Health and Family Planning and Department of Civil Affairs²⁴⁸ (2014 [62]), health and EC integration takes place through the following methods:
- i To develop nursing, rehabilitation and end of life care in RC of >500 bed
 - ii To allow county’s Health Authority to approve the establishment of health care services in EC setting
 - iii Health Authority to assist the development of health care services with EC setting and to encourage physicians to visit and to give a talk, health care trainees to practice and graduates to seek employment in EC setting.
 - iv To encourage EC to form a strategic alliance with health care sector.
 - v To develop a green pathway between RC and Level II hospital so that residents can be transferred back and forth between health and EC sector seamlessly.

2.5 INTERNATIONAL GOOD PRACTICE IN RC

58. International good practice in RC can be broadly summarized into four major trends in EC in the past decade.

²⁴⁷ The Ministry of Civil Affairs’ opinions on introducing liability insurance to EC organizations - 推进养老机构责任保险工作的指导意见 (2014) <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201403/20140300600030.shtml>

²⁴⁸ http://blog.sina.com.cn/s/blog_48e79ec30102wc8b.html

2.5.1 Ageing in place

59. Older persons wish to remain in their own homes as they age. Undoubtedly, demand in EC service volume, i.e., the number of places in HCBC and/or RC beds will increase resulting from an ageing population. However, demand increase due to increasing impairment rate could be debatable. Firstly, old does not imply impaired. There are a significant number of people who live healthily and actively aged 60+, 70+ and even 80+. Secondly, due to improved health care, better environmental design, rehabilitation aids and better lifestyle, the impairment rate of elderly has been decreasing or stabilizing during the last two decades. The age at which care is needed is later on average. It has been said that today 80s are the 70s in 2000. The general consensus among OECD health policy analysts has been that increasing longevity linked to the expansion of “light” (or low) but a reduction of severe disability (equilibrium theory) and a much shorter period of disability in older age (compression theory). Because of light disability, their care need can be addressed by better housing design and technology, with in home care and community support. Without strong evidence to suggest otherwise, future older people in China will likely be very similar to this trend. Not only will ageing in place be good for the overall wellbeing and longevity of the elderly, it is also more cost effective. RC is 2 – 3 times more expensive than HCBC. Two significant EC service trends to support ageing in place in developed countries are (1) development of various types of housing project e.g., independent and assisted living, for the elderly and (2) the significant expansion of HCBC.
60. In Canada, independent and assisted livings are considered as part of community care and not residential care because residents in these accommodations are able to live freely without the rules and regulations of a RC facility and to use all the HCBC services as those living in their own homes. There are many elderly friendly services and amenities available in independent and assisted living. The most popular services and amenities are: 24 hour call bell (95%), a nurse on site (50%), transportation (45%), exercise facilities (44%), movie theatre (34%), swimming pool (11%) and pharmacy (11%) (Canada Mortgage and Housing Corporation, 2014b). The take-up rate of independent and assisted livings has generally increased year-on-year in British Columbia, Alberta, Manitoba, Quebec, and Newfoundland and Labrador (Canada Mortgage and Housing Corporation, 2014b). In 2014, independent and assisted living accounted for 77% of senior housing in Canada whereas the other 23% were non-standard spaces. Ontario regulates its independent living communities through licensing by the Retirement Homes Regulatory Authority. Assisted living communities are regulated in Ontario and British Columbia.
61. In Hong Kong, the government objective is to support “aging in place” through enhancement of community-based care by setting up HCBC. Community-based service included 67 Day Care Centers/Units for the Elderly while home-based services include 24 EHCCS teams (Enhanced Home and Community Care Services), 60 IHCS teams (Integrated Home Care Services) and Home Help and Care Teams. Personal care,

nursing care, rehabilitation training, social activities, day respite services and caregiver support services, are offered to frail elders and/or elders in need of services within their homes or communities.

62. To support frail elderly to continue to live in the community, the Hong Kong Department of Health (DH) provides health services such as health assessment, health education and promotion, and primary care, through its 18 Elderly Health Centers (EHCs), 9 nongovernment organizations (NGOs) under the Elderly Health Assessment Pilot Programme (EHAPP), 18 Visiting Health Teams (VHTs) and the Elderly Healthcare Voucher Scheme (EHCVS). For EHCVS, every elderly resident aged 70+ are eligible, which aims to subsidize elderly in the use of primary healthcare. The annual voucher amount was USD260 (HKD 2,000) for 2014. As at 31 March 2014, 556,000 elderly enrolled in the Scheme, representing a take-up rate of 75% with a settling voucher claims amounting to USD109 Million (HKD846 million).

2.5.2 Deinstitutionalization

63. Deinstitutionalization is a clear direction of all developed countries and this trend will continue. Deinstitutionalization may take different forms: (1) less RC, more HCBC, (2) smaller RC facility, and (3) home like RC. In 2000, out of the 8.7% of the elderly requiring care in Japan, 63% receiving HCBC vs. 37% receiving RC. In Australia, the ratio between home and community vs. residential care was 73% vs. 27%. In UK, it was 80% vs. 20%.²⁴⁹ The demand for more RC beds is not there. Out of the 8 OECD countries studied, 7 showed an age-specific decline in residential care usage. In addition, older people are more affluent and living in far better designed housing where care can be delivered in situ rather than requiring a move elsewhere. Elderly who chose RC as their accommodations are likely those who are older, more disabled and closer to the end of life²⁵⁰. Projections of future need for RC beds based on past trend and current usage can be misleading.²⁵¹ Due to the reasons mentioned above, most of the newly built RC facilities in these countries are within the range of 100-150 beds so as to make them manageable both physically and financially. The days when large RC facilities with >300 beds were the norm have gone. To make RC home like, there have been a number of movements in US, such as the Eden Alternative.²⁵² One of their goals is to make RC facility home-like by creating an ambience that will eliminate helplessness, boredom and loneliness – the three drivers of depression and increased mortality in RC.
64. In USA, some of the states are experimenting new approaches to (1) help elderly returning home from RC and (2) reduce elderly dependence on RC (institution). Minnesota is a good example. Its “return to Community Initiative” targets private pay RC residents, assigns HCBC specialists to determine reasons for continued stay in RC and to provide assistance to move back into their homes if they would like to do so. Programs

²⁴⁹ OECD (2005), P41.

²⁵⁰ <http://www.statcan.gc.ca/pub/82-003-x/2010004/article/11390-eng.pdf>

²⁵¹ OECD (2005), P42.

²⁵² <http://www.edenalt.org/>

to reduce dependence on RC includes (a) information and assistance linkage lines (b) requiring long term care consultant recommendations for admitting to RC and assisted living, both private and public (Alper, Domnitz, et.al., 2016. P. 21).

2.5.3 Mainstreaming ageing²⁵³

65. This was one of the key products of the Madrid International Plan of Action on Ageing 2002²⁵⁴. Since then, European countries have been taking the lead and are at the stage of developing indicators to monitor its progress in Europe. The focus of mainstream ageing is the creation of “a society for all,” and viewing population ageing as a positive dynamic rather than a threat/burden of society²⁵⁵. This is to promote intergenerational harmony and fits well with the Chinese policy on creating and maintaining a harmonious society.
66. Home, community and residential care are not just for elderly only, they will benefit people of all ages and social groups with care needs.²⁵⁶ This is one of the reasons why these services: HCBC and RC, are called long term care and not the elderly care in other countries. People of any age group may need long term care if they have a condition(s) that require care on a long term basis: cerebral palsy, stroke, mentally handicapped, mental illnesses, etc. Elderly who need care are one of them. Universal design (vs. barrier free) is another example. Universal design includes barrier-free which supports people with impairment, both temporarily and permanently. It is a design concept to accommodate people of all ages and social groups with care need: people with disability, pregnant women, a football player with temporarily sprained or fractured ankle. Elderly who need care may be one of the beneficiaries of universal design. It also makes caring for people with care need less strain on staff, gives frail and disabled people more independence and requires less supervision, thus enhance the effectiveness of care.

2.5.4 Active (Healthy) ageing

67. The process of optimizing opportunities for health, participation and security in order to enhance the quality of life as people age. Older people who retire from work, ill or live with disabilities can remain active contributors to their families, peers, communities and nations. Active ageing aims to extend healthy life expectancy and quality of life for all people as they age (WHO).²⁵⁷ Not only those who are healthy, but also people with care need can continue to pursue a health ageing lifestyle.

²⁵³ The Madrid Second World Assembly 2002 called for mainstreaming ageing by better integration of the needs of all age groups into the policymaking process. Sources

http://undesadspd.org/LinkClick.aspx?fileticket=JwOZhy1g_4%3D&tabid=502

²⁵⁴ <http://www.monitoringris.org/index.php?id=1>

²⁵⁵ International HelpAge, 2012

²⁵⁶ The Madrid Second World Assembly 2002 called for mainstreaming ageing by better integration of the needs of all age groups into the policymaking process. Sources

http://undesadspd.org/LinkClick.aspx?fileticket=JwOZhy1g_4%3D&tabid=502

²⁵⁷ WHO. Sources: http://www.who.int/ageing/active_ageing/en/

68. Active or healthy ageing is an international ageing agenda, it has also become an integral of all ageing policies in developed countries. Almost all developed countries have an active ageing policy framework in addition to their long term care policy framework. For instance, in the Australian Government's "National Strategy for an Ageing Australia – an older Australia, Challenges and Opportunities for all. (2001), many ageing issues were discussed in the report and healthy ageing was the key theme²⁵⁸. A similar report can be found for the European Union²⁵⁹ and in different levels of the Canadian government.²⁶⁰ In practice, this translates into programs: healthy eating, injury prevention, physical activity, tobacco cessation, social connectivity etc. organized by the government and nongovernment agencies for the general public including the elderly. They are not just for the abled elderly, these programs are equally important for those who are impaired and requiring care. These programs are an integral part of HCBC and RC services.

2.6 NATIONAL GOOD PRACTICE IN RC

2.6.1 A brief review of RC in China

69. Residential care in China is a very convoluted concept, which encompasses nursing homes, senior apartments (senior centers) and charity houses, etc., with funding support by the government, relatives of the elderly or the old people themselves. It consists of senior housing and care facility for the elderly in need of long term care. What's more, RC facilities also include recovery clinics and geriatric hospitals specialized in chronic diseases. By the end of 2013, there were 42,475 residential care facilities with 4.937 million beds. 72% of them are publicly owned.
70. The operation of these RC facilities falls into four types (1) publicly-owned and operated, (2) publicly-owned and privately-operated, (3) privately-owned and publicly aided and (4) profitmaking.
- (1). Publicly-owned and publicly-operated model
71. Publicly owned and publicly operated institutions are a model sponsored totally by the government with all the staff belonging to the government-affiliated institutions. Most institutions of this type are welfare institutions targeting urban seniors without income, labor ability, and legal providers, as well as rural seniors receiving governmental guarantees of food, clothing, housing, medical care and burial, though some of them offer services to the society as well. Most of these RC facilities are for people with three-nos. Their quality has been low except those designated for senior retired officials such as Beijing's First Welfare Home. The government ultimate plan is to outsource these facilities to private operators,

²⁵⁸ http://www.ifa-fiv.org/wp-content/uploads/2012/11/062_Australia-2001-National-Strategy-for-an-Ageing-Australia.pdf

²⁵⁹ <http://www.healthyageing.eu/sites/www.healthyageing.eu/files/featured/Healthy%20and%20Active%20Ageing.pdf>

²⁶⁰ http://www.swsd.gov.nl.ca/publications/pdf/seniors/vision_rpt_e.pdf

Publicly-owned and privately-operated model

72. Publicly owned and privately operated institutions refer to the ones established and mainly sponsored by the government and operated by civil organizations through contract. They are different from publicly-owned and publicly-operated institutions in that their ownership and operating rights are separated so that the country and the collectives no longer take charge of everything but permit intermediaries or civil service organizations to conduct concrete management. Jingrongjie Senior Apartment in Beijing and Elderly Homes in Shanghai are just two good examples. Not only do they offer high quality of care, their operation is also financially sustainable. Jingrongjie Senior Apartment has proved to be profitable. Further deliberation of these two EC operations can be found below.

(2). Privately-owned and publicly-aided model

73. Privately-owned and publicly-aided model means that such institutions are founded by civil organizations, who register as “private non-enterprise units” at Civil Affairs Bureaus and aim at providing nonprofit senior service to the aged. Their operating costs mainly come from fees paid by the lodgers. They may also receive some subsidies for construction and operation from the government as well as a few amounts of social donations. This model is rare and mostly through the donation of cash or land for the construction of EC facility, which is then operated by the public organization.

(3). Privately-owned profitmaking model

74. Privately owned profitmaking RC are sponsored by private investors to make profits through profitable services offered to the elderly. They are required to register as “private enterprise units” at administrations for industry and commerce. In the past, there were very few institutions of this type due to restrictions in policy. In recent years, however, it has achieved certain development. Cuncaochunhui Nursing Home in Beijing is a good example, which offers high quality of RC service and has been proved to be financially sustainable. Further deliberation of this EC operation can be found below.

2.6.2 Cuncaochunhui Nursing Home

75. It is a privately owned senior service institution and was founded in 2011. It was converted from a small hotel with 100 beds. Its basic business is to offer services to seniors taken care of at home. And at the same time, it accepts semi and total dependent elderly in need of long-term care with an average monthly charge of USD640 to USD960 (CNY4,000 to CNY6,000) per person. Due to its quality of service and reasonable price, the number of people waiting for beds is five times the number of beds offered by the Home.

76. Cuncaochunhui has created an integration of RC and HCBC. Compared with traditional nursing homes and home-based care companies, Cuncaochunhui has extended its services to its vicinity areas through its RC facility in order to provide multiple levels of senior services to meet different demands. It does not simply regard itself as a nursing home. It builds itself into a professional and comprehensive platform to realize the seniors' wish of ageing in place. The core is the establishment of a professional and comprehensive senior service system based on home-based care, supported by a professional residential care service and relying on communities. It requires less investment, provides more efficient and effective services, extends its services from a center to the nearby neighborhoods in a radial pattern, and has the ability to integrate scattered senior service resources. It possesses the following features: small in size, community-based, multi-functional, wide in coverage, and professional. At the end, more old people will enjoy elderly care near their homes.
77. This model of EC is a perfect match to that Chinese national situation, especially for areas with limited land resources. If a small community EC center can be established in each neighborhood or community, and develop into chain centers with its own brand name and service criteria, it will help to stimulate the development of the whole EC industry and thus realize the old people's wish of ageing in place.

2.6.3 Jingrongjie Senior Apartment (JTJ-Care Senior Center Co., Ltd)

78. Jingrongjie Senior Apartment is a publicly-owned and privately-operated residential care sponsored by the Street-Level government of Jingrongjie, which invested ¥0.33 billion for the construction and furnishing of the apartment. The apartment is operated by JTJ-Care Senior Care Co., LTD, which also operates 4 other RC facilities for the elderly, two day care centers and 1 home care center (no drop in but simply office space for the outreaching service). The number of beds originally designated for Jingrongjie Senior Apartment was 102, but only 92 are in operation due to building modification required to facilitate nursing care. 2/3 of the beds are for people requiring semi and total care. 1/3 of the beds are for people who have no care needs but have been considered high risk (e.g., fall) or are lonely at home. On average, residents with no care need pay US490 (or 3,000 CNY) per month whereas residents with care need pay US656 (or 4,000 CNY) per month. The government regulates the monthly fee. The apartment has been in operation since 2013 with a monthly income of US65,600 (or 400,000 CNY²⁶¹) and monthly expenses of US54,100 (330,000 CNY) with a net profit of US11,500 (or 70,000 CNY) per month. In addition to operating subsidy of US5,000 (or 30,000 CNY), the government subsidizes rent, utility charges and facility maintenance.
79. Out of the 92 beds in operation, 5 beds have been designated as day care, which receives community residents who may require care. These residents will come in the morning and return home in the evening, normally after dinner. The majority of them will

²⁶¹ 370,000 CNY from fee and 30,000 CNY from the government operating subsidy

return home by cabs. They will come to the center 7 days a week. Current income from day care and home care service is about US\$5,000 (or 30,000 CNY) per month. The apartment is adjacent to a community health center, which is operated by the Health Bureau of the City of Beijing. The center provides primary care to the residents of the apartments and residents in the nearby community. The co-location of EC and health care center offers a unique advantage for users of Jingrongjie Senior Apartment. They can have access to a number of primary care services through the health care center.

2.6.4 Elderly Home in Shanghai²⁶²

80. A model that is very similar to Jingrongjie Senior Apartment are the Elderly Homes in Shanghai. It is a one-shop community-based service facility and offers three-tiers of EC services:
- i. residential care to dependent seniors whose care need is above level three according to Shanghai's Unified Care Needs Appraisal Standards;
 - ii. short-term accommodation for seniors who might retrieve from the hospital and need rehabilitation service or families who need respite care; and
 - iii. home visiting and care services to seniors in the community. At the meantime, services can be extended to other senior related areas, such as training for family caregivers, etc.
81. Almost all Elderly Homes in Shanghai are constructed by the government, placed under the Civil Affairs system, and commissioned to private operators who have experience either in institutional care or in home health care to operate. The private operators involve themselves as early as possible at the stage of a project with their support and expertise input to the design, marketing and operation of the facility. This is one of the initiatives of getting private capital and/or operators involved in EC industry - "government build, private operate" or also known as Public Private Partnership (PPP). The minimum size of an Elderly Home is around 300m², containing 10 to 49 beds. Construction standard for Elderly Home is lower than what nursing homes are normally required. However, requirements as to staffing, service standard, security, among many others are almost as same as those applied to the nursing home. Similarly, construction and operation subsidies from the government are also available for newly constructed Elderly Home, subject to a series of conditions being met with. There were 22 Elderly Homes by the end of 2015 in Shanghai and an increment of 50 is planned for 2016. By the end of 2017, it is expected to realize a substantial coverage of Elderly Homes in downtown and suburban areas in Shanghai.
82. The only drawback is that many for-profit operators view the "Elderly Homes" as "welfare" by nature and the government has set restrictive guidelines on service pricing. As a result, profit that private operator can obtain by operating an Elderly Home has been minimal (Qu, 2016).

3.0 DETAILED GAP ANALYSIS

3.1 GENERAL GAPS

3.1.1 More data are needed to support the demand of RC and Medical Rehabilitation beds

83. Almost all FSR started with need projection based on an increasing ageing population. Undoubtedly, the demand of EC including medical rehabilitation, residential care (RC) and home and community-based care (HCBC) will increase due to an ageing population. However, such an assumption needs to be supported by data. Experience from developed countries suggested otherwise. In “more aged” OECD countries, there is no demographic imperative whereby RC beds will be needed at the same rate for each age group in future as today. Unless there is strong evidence to suggest otherwise, future older people in China will be similar to this trend. The second justification of EC demand is by using 9073 or three-tier EC system. Broadly speaking, this projection is generally correct. However, the ratio of 9073 was roughly based on “the 11th Five-Year Plan for Elderly Care in Shanghai” (issued in 2006). Whether or not the figure of 9073 was based on care need study of the elderly in Shanghai, is unclear.
84. The proportion of RC beds unoccupied in PRC should not be underestimated. It was known that out of the 131,000 public RC beds, 50% were empty or unoccupied in 2014. Despite low occupancy rate, the province of Hebei added another 26,000 public RC beds between 2011 and 2014.²⁶³ Occupancy RC bed rate in the private sector is not better off. There are different reasons leading to the low RC occupancy rate including quality of RC environment and services, one person taking up a 2-bed room, Chinese culture of considering admission to RC as being abandoned by family, etc. It does not make sense to build more RC beds when a significant proportion of existing RC beds are unoccupied. The argument of replacing currently low with the future high quality of beds with the support of ADB loan does not stand up. There is no guarantee that the so-called “new high-quality RC beds with loan supported by ADB” will not be replaced by even higher quality beds in future.
85. Finally, let’s not forget the issue of oversupply and/or overproduction. With the encouragement of the government to expedite the development of EC industry, many private investors and developers have already jumped on the bandwagon, and many more will come. It is expected that the EC industry will be expanded exponentially in the next decade. China is well known for its “over production fiascos.” Real estate, steel, etc. are just a few examples. It is all because of government encouragement and investors/developers’ zealously. Without proper study and analysis of current demand and supply, the supply of EC beds can easily be turned into another overproduction fiasco.

²⁶³ Hebei provincial DRC, Department of Finance and Civil Affairs Bureau. (2015). ADB Financed Hebei Elderly Care Service System Development Project (July 16th, 2015)

3.1.2 Core values and principles in guiding the development of EC are needed

86. EC is about the care of the vulnerable population of our society, who are old, frail and likely disabled and many of them may be lonely as well. Thus, EC should start with a few guiding principles on the protection of the right and wellbeing of the elderly. Internationally, UN proposed a set of EC principles under the headings of independence, participation, care, self-fulfillment and dignity.²⁶⁴ In 2015, WHO issued the World Report on Ageing and Health, which upholds two principles in EC (long term care). Firstly, older people have the right and deserve the freedom to realize their continuing aspirations to well-being, meaning and respect, even in circumstances in which they have a significant loss of functioning. Secondly, EC should optimize capacity and to reduce the deficits of the elderly.²⁶⁵ China, as a member of UN and WHO, is committed to upholding the spirit and intent of these principles by integrating them into its laws such as The Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly.²⁶⁶ It provides an overarching legal framework to protect the rights of the elderly in the PRC from the government. The law upholds the principles of “respect, concern and care” for the elderly. These core EC values and principles, which are important in guiding EC service and construction design need to be reiterated in the FSRs through the realization of project design, management and services proposed.

3.1.3 An overarching EC system plan is needed

87. EC is more than a project for the construction of RC beds and HCBC sites. It is also about building an EC system so that the EC beds and HCBC sites will be put to good use when they are completed, and the elderly in need can have access to safe service along a comprehensive EC service continuum. Despite the national government making HCBC as the foundation of EC and RC as a supplement, there is no clear direction how these three tiers of service, i.e., RC and HCBC are to be integrated, both in urban and rural areas. It is very unclear how the medical rehabilitation center, RC, and HCBC can be better integrated to support ageing in place, deinstitutionalization, mainstreaming ageing and active ageing. There should be a roadmap showing the relationships of all system components: human resources, management, direct services (medical rehabilitation center, HCBC, and RC), and outcome etc., and a plan on how these components and linkage can be built over time. The project stakeholders, IAs, service providers, and governments, are short in communicating such a roadmap.
88. Many developed countries have spent the last few decades in identifying a more effective integrated model of care: collaborative geriatric care model, On-Lok model (PACE), CHOICES, etc. and are still searching. The good news is that the Chinese government begins to promote health and social (elder) care integration. However, there are at least three more issues that need to be addressed before integration works. Firstly, integration

²⁶⁴ United Nations, Convention on the Rights of Persons with Disabilities, 13 December 2006, Article 3.

²⁶⁵ WHO, World Report on Ageing and Health. 2015, p 89

²⁶⁶ 中 国 人 民 共 和 国 老 年 人 权 益 保 障 法 (2013)
<http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201302/20130200418213.shtml>

needs to occur inside (vertical integration) and outside (horizontal integration) EC. Secondly, a number of enabling factors need to be in place: case management, shared client records, practice guidelines, service re-alignment, etc., for integration optimization. For instance, case management is needed to help the service users to navigate in a complex health and social care environment. Finally, integration implies the involvement of more expertise and disciplines. The recruitment and retention of expertise in these new disciplines will be a challenge to all IAs.

3.1.4 Capacity in handling complex care needs to be shown

89. Section #30: of The Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly²⁶⁷ requires all levels of government to..... develop *long term care* (长期护理保障工作) to address elderly with nursing care needs The policy on the management of residential care (RC), (2013)²⁶⁸, requires all RC operators to provide clinical and nonclinical recreational activities (Section #9); ADL/IADL including eating, dressing, toileting, bathing, in and outdoor activities (Section #12); preventive health care including periodical functional and health assessment (Section #13); emergent health care and infection control (Section #14) However, many of these important complex care needs and ways to deal with these issues, due to whatever reasons, have not been deliberated in the FSR.
90. The EC industry including all IAs of this project is expected to handle more complex cases as (1) the government is pushing for better integration of health and EC and (2) each IA's plan to develop a medical rehabilitation center. Better integration of health and EC may imply the transfer of higher level of care responsibilities such as rehabilitation, end of life care, tube feeding, ostomy care, dialysis etc., from health to RC. This is exactly what happened in most developed countries, Even though such a transfer may not occur right away, the scope of care of EC/RC will inevitably become more complex in the next 5 years when the project facilities are ready for operation.

3.1.5 Capacity in providing EC management support needs to be shown

91. The quality of RC in Hebei and China is a major concern, which has been admitted by the government.²⁶⁹ Based on the RC facilities visited, poor safety and service standards are evidenced. Except a few, most of the RC services provided are sub-standard both in terms of physical design, service delivered and staffing levels. In one RC facility run by Civil Affairs, the building is old and poorly lit. Due to a poor quality of RC, the general public perception of EC and RC in particular has been poor. This compounds the issue of HR because people do not want to enter an industry with a poor reputation.

²⁶⁷ 中 国 人 民 共 和 国 老 年 人 权 益 保 障 法 (2013)
<http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201302/20130200418213.shtml>

²⁶⁸ 养老机构管理办法 (2013)<http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201306/20130600480076.shtml>

²⁶⁹ Hebei provincial DRC, Department of Finance and Civil Affairs Bureau. (2015). ADB Financed Hebei Elderly Care Service System Development Project (July 16th, 2015)

92. Quality EC services require management support, which includes management of risk, quality, utilization, finance, human resources, and strategic alliance and networking. The policy on the management of residential care (RC), (2013)²⁷⁰, requires all RC operators to provide management support: risk and safety management (Section #17, 21, 22, 23 and 24); professional staffing requirements and skills certification (Section #19); privacy (Section #25) and periodical collection of users' feedback (Section #26). Essential components of EC management are missing e.g., quality and utilization management. At least, they are still not part of the FSRs.

3.1.6 Target population of private and public EC needs to be established

93. For public funded EC services including those supported by means of EC subsidy and preferential tax policies, the target is people with care need and financial difficulties. This has been reflected in Section #30: of The Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly²⁷¹ to address elderly with nursing care needs and to provide a subsidy to those who are semi and totally dependent, and/or in financial destitute. The target population is further affirmed by "Directives on good practice of government EC services purchasing (2014)", "Directives on the establishment of a subsidizing system for impaired and old people with financial difficulties (2014)" and the 13FYP. Thus, it is very clear that public funds should be used to mainly support the most vulnerable elderly: impaired and financially destitute, while other elderly should meet their needs by using private EC services and/or paying for their services.
94. Despite clear legal requirements and policy directives, in practice, there are two major issues. Firstly, there is no centralized assessment system to determine service eligibility. Thus, older people are occupying many RC beds in Hebei with no obvious caring need. Secondly, subsidies for EC services are not well-targeted, they are made to the service providers rather than the elderly, and they are not given based on need. There is no significant difference in government subsidy between people with and without care need. Thus, the EC providers may incline to offering low rather than high care level service. There is no incentive for RC operators to offer complex EC services.
95. The good news is that the recently announced LTC insurance pilot project clearly stipulated target population of EC, which is to cover people requiring care in activities of daily living²⁷². Two of the IAs: Shuangluan (Chengde) and Julu have been selected as pilot sites in Hebei. Julu's LTC insurance covers those with severe Parkinson's disease and dementia, late stage rheumatoid arthritis, comatose, end stage cancer, permanent catheterization (gastro feeding, tracheostomy tube, etc.), unhealed fracture, paralysis,

²⁷⁰ 养老机构管理办法 (2013)<http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201306/20130600480076.shtml>

²⁷¹ 中 国 人 民 共 和 国 老 年 人 权 益 保 障 法 (2013)
<http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201302/20130200418213.shtml>

²⁷² file:///Users/peterchan/Dropbox/ADB_Hebei/EC%20Sector%20Assessment/%E4%B8%AD%E5%8D%8E%E4%BA%BA%E6%B0%91%E5%85%B1%E5%92%8C%E5%9B%BD%E4%BA%BA%E5%8A%9B%E8%B5%84%E6%BA%90%E5%92%8C%E7%A4%BE%E4%BC%9A%E4%BF%9D%E9%9A%9C%E9%83%A8.html

etc. (Section 7). LTC insurance eligibility will mainly be based on the results of ADL assessment by specialists designated by the County's Human Resources and Social Security Department (Section 8).²⁷³ The introduction of LTC insurance will eventually shift the focus of EC from a general to a more targeted elderly population. Eligibility of EC will be focused on frail and disabled elderly.

3.1.7 Capacity building in EC for local Civil Affairs is needed

96. The policy on the management of residential care(RC) (2013)²⁷⁴, requires local Civil Affairs Departments to:

- i. conduct a periodical comprehensive evaluation of RC operation: staffing, facilities, service, management and reputation (Section #29);
- ii. receive statistical reports by RC operators (Section # 30);
- iii. conduct on spot inspection and make the inspection reports public (Section #28); and
- iv. handle service users' complaints (Section #31).

97. This may be the reason why the Civil Affairs appears to be more reactive than proactive at provincial and municipal levels. Many local Civil Affairs are quite contented with the status quo. They may get involved and react when there is public EC concern and/or unusual EC incident. In general, staff of Civil Affairs lacks the needed knowledge and skills to deal with elderly with complex care needs. It may be that Civil Affairs consider the care of elderly with complex health care need as a jurisdiction of Health and tend to relinquish the responsibility to Health. However, elderly with complex care needs are exactly the elderly who require EC and are stipulated in various EC's policy and legal framework issued by various levels of Civil Affairs. If EC is confined to providing lodging and food to those elderly who need to be sheltered and fed, the current capacity of Civil Affairs may be sufficient to cope with the charged responsibility. However, if they are to lead EC development in China as stipulated in the grand EC plan of China, more capacity in terms of EC knowledge, planning and management of Civil Affairs will be needed.

3.1.8 Expecting making profit in EC/RC industry needs to be managed.

98. The Chinese Government is very supportive of involving private sector including the NGOs in EC industry. Its support can be reflected by different policies and directives mentioned under 2.3.4 along with a number of preferential policies and tax, as well as all kinds of subsidies. The goal is to make the EC market profitable so that private capital and operators will be lured to the industry. This needs to proceed with cautions. Firstly, if EC a profitable market places is quite debatable. Shall we make profit out of people's misfortune is an ethical issue, which requires more discussion. Except a few who are

²⁷³ The opinion on establishing LTC insurance (pilot), Julu's People Government (July 12, 2016).

²⁷⁴ 养老机构管理办法 (2013)<http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201306/20130600480076.shtml>

very wealthy, not too many people can afford EC on a long term basis. This is the reason why insurance has been in place to pool the risk of care on a long term basis, and government involvement continue to be vital in many countries including USA. Secondly, NGOs, which are presumably, part of the private sector, have been largely left out or unheard of in this project. It may be because the NGO are less well developed in China and are therefore not well mobilized and organized.

99. There has been evidence showing the difference in quality of care especially in terms of residents and staff ratio. In the United States, studies showed that not-for-profit EC operators were associated with higher staffing levels, lower staff turnover, and better outcomes on a range of measures, compared with for-profit EC operators. Three Canadian studies have quantitatively examined associations between staffing levels and facility ownership. Analyses in Ontario and British Columbia found that for-profit facilities employed fewer nursing staff than did not-for-profit facilities. By contrast, a Manitoba study reported no apparent differences in nursing staff levels between for-profit and not-for-profit facilities²⁷⁵. While the results of American and Canadian analyses are intriguing, differences in the market mix may limit the generalizability of such findings to China.

3.1.9 Scope of technology use in EC needs to be expanded

100. All IAs proposed to develop call center, in support of government policy on the application of information and communication technology (ICT) in EC. However, what ICT can do in EC is more than just call center. It can be used to increase service accessibility (e.g., call center), to promote health and well-being (e.g., electronic health record that can be shared by all service providers) and to supporting independence (e.g., lifeline). The scope of ICT needs to be expanded to take into what the ICT can do (1) today and (2) in the near future. Many ICT may change in 5 years. For instance, what the “internet of things” can do today in EC may be very limited. In 5 years, the technology will advance and EC need to take advantages of this development.

3.2 GAPS PERTAINING TO MEDICAL REHABILITATION CENTERS

3.2.1 Watch for increase EC cost resulting from health and EC integration

101. Health and EC integration, at least in most developed countries, is driven by two factors: (1) client care excellence and (2) system efficiency. Users achieve client care excellence through access to a better health and social service continuum after integration. System excellence is through system efficiencies and improved service levels. Service users, who do not need medical care should be able to shift from a more expensive, e.g., hospital to a less expensive form of care, e.g., RC setting or medical rehabilitation center. Thus, health and social integration are also about cost saving for service users, EC providers and the government. If, however, the integration of health e.g., medical rehabilitation center, end of life care, with EC does not come with resource transferring

²⁷⁵ <http://www.statcan.gc.ca/pub/82-003-x/2010004/article/11390/findings-resultats-eng.htm>

from health to EC, the health and social care integration may imply an increase in EC cost. This issue has not been explicitly acknowledged in the FSR, and if acknowledged, measures to contain costs are unclear.

3.2.2 “Geriatric” focus of the medical rehabilitation center may be lost

102. There are certain advantages of support to the medical rehabilitation center by the local general hospital. However, most of the local hospitals and/or medical clinics may not have the experience in dealing with EC. There is a significant difference between hospital/ medical care and EC. Hospital/ medical care is for disease curing. Hospital/medical care has two foci: diagnosis and treatment. Thus, it is episodic and short term. EC is for the purpose of maintenance and deterioration postponement. It is ongoing and long term, which is not the forte of acute medical care. Many medical and health care professionals are often not keen to work in EC setting, as EC users are less likely to recover completely from their chronic conditions, and if they do recover, their progress can be very slow. Without proper positioning, the medical rehabilitation center can simply be an extension of existing hospital and medical clinics in dealing with the health care need of the general public. The need of the elderly may, therefore, be oversighted.

3.2.3 Functions of the geriatric hospital are missing

103. Apart from the size of the medical rehabilitation center, i.e., 100 beds, little is known about the clinical services to be delivered. Based on the government document on health and social (elder) care integration, the government does expect social (elder) care to pick up more complex cases with the support of the local health care providers such as hospital or medical clinics: sub-acute care (tube feeding, dialysis, etc.), post-acute care (transitional care), end of life care, rehabilitation, etc. These are care and services found in the RC in developed countries but not common in RC of PRC. What are the other functions that the medical rehabilitation center can perform is either largely unclear or yet to be decided.

3.3 GAPS PERTAINING TO RESIDENTIAL CARE

3.3.1 Large number of the RC beds proposed can be risky

104. Except Shuanglan, which made a significant reduction of RC beds to 268. All other IAs, even after repeated discussion, continue to construct RC with >400 beds. Not only has the size of the proposed RC beds not been supported by an adequate study, the large size of beds also presents a management challenge. Management of large RC with complex cases is highly risky especially when most of the IAs have no and/or limited RC operation and management experience. Large RC also goes against the international good practice of deinstitutionalization.

3.3.2 RC is a convoluted concept in China

105. Despite it is government's policy to give EC priority to those with (1) care needs and (2) in financial destitute and that the government recognizes the need to build more RC to address the care need of the older people²⁷⁶, many of the RC beds proposed in this project intend to take elderly people with no care needs. If the choice of RC is a personal lifestyle and is fully supported by personal resources, this is entirely a personal and free market behavior. However, if this is to be supported by public resources such as that all IAs in this project receiving free land or land at low/no cost, bed subsidy both for construction and operation, etc., this is another matter.
106. Mixing the abled and disabled people under one roof is not always a good idea. Firstly, this can be demoralizing for the abled people as RC, inevitably reinforce dependency, helplessness and boredom instead of active ageing. Research findings showed that those who are helpless, bored and lonely tend to have a higher mortality rate, heart disease rate, etc. than those who are not. Secondly, provision of RC for those with no caring need appears to counteract the international good practice of ageing in place and deinstitutionalization. Finally, RC is expensive and can be a waste of public resources if it is delivered to people with no care need. Chinese government policy is to give RC priority to those with care needs and in destitution such as the three-nos and five-guarantees. For those people with no care need but are fiscally destitute, the Chinese government may consider other housing options such as offering low cost or subsidized housing.

3.3.3 RC has not been designed with care in mind

107. RC is not simply a housing design, it is also a design for care. At least, there are three design issues that were omitted or significantly attenuated in current FSRs. Firstly it is about design for with people with cognitive impairment (dementia). For instance, a design that will prevent wandering residents from leaving the facility will significantly enhance resident safety and save staff time in locating the residents wandering away. Secondly, infection control is another design issue. RC residents are frail and weak and are susceptible to infections. Residents themselves are also sources of bio hazardous waste. Improper infection control design is a risk management issue. Finally, design to fit workflow is vital in RC. One of the most exhausted and time consuming activities for staff and residents in RC setting is transportation: moving from one spot e.g., resident room, to another e.g., nursing station within the facility multiple times in a shift. A good understanding of work flows: care and other key activities (e.g., dining, resident transport inside facility), etc. help to create a user and staff friendly living and working environment. These three important design issues need to be deliberated clearly in the FSR

²⁷⁶ Hebei provincial DRC, Department of Finance and Civil Affairs Bureau. (2015). ADB Financed Hebei Elderly Care Service System Development Project (July 16th, 2015)

3.3.4 Affordability and WTP by elderly with lower middle income

108. The project is designed with low to middle income elderly in mind, which is also reiterated in the document: “ADB-financed Hebei EC service system development,”²⁷⁷ assuming that these groups of older people are affluent enough to do so in the private market. However, even in countries where the private EC market is significant such as the USA, private funding only accounts for 35% of EC spending. Public funding is still the major payer, which accounts for 65% of total EC spending. One of the reasons for this is that the fees of EC or long term care, especially in RC setting, can be catastrophic and not too many people can afford the cost on a long term basis without the bailing out of the government. One of the biggest assumptions that many EC investors and operators are making is that the middle class to wealthy Chinese will want to exit their primary residence and move into a senior care facility. The answer to this question is unclear even for a senior care expert in China like Ben Shubert. What Ben is sure is that given Chinese culture, there will be a massive market for aging in place technologies and approaches to how care is delivered.²⁷⁸
109. All IAs provided a fee schedule. However, it is not clear if the fee schedule is affordable by older people with low to middle income - people whose income are not affluent enough to purchase quality RC service in the open market but are not destitute enough to be covered by government welfare program for the three-nos and five-guarantees. Based on the RC fee schedules provided by RC providers visited, the schedule proposed by IAs appears to be high. It becomes doubtful if the low to middle income elderly can afford the price and are willing to purchase the service.

Table: Fee Schedule of RC sites visited

IA sites	Type of RC facility	Price range (CNY)
Chengde	private	1,200 – 2,500
Zunhua	public	900 – 1,500
	private	1,500 – 2,350
Xinji	private	900 – 2,400
Xuanhua	private	900 – 2,400

²⁷⁷ Hebei provincial DRC, Department of Finance and Civil Affairs Bureau. (2015). ADB Financed Hebei Elderly Care Service System Development Project (July 16th, 2015)

²⁷⁸ <http://wachinawatchdigest.us/wachinawatchspecial-shobert.html>

3.4 GAP ANALYSIS AT SUB PROJECT LEVEL

3.4.1 She County – a part of Handan Municipality

	Issues	Observations	Rooms for improvement
a)	Current EC provision (capacity, services, quality, facilities, human resources, medical services, etc.).	<ul style="list-style-type: none"> Public: 6 RC with 860 beds (OR²⁷⁹ = 89%) Fee: unknown Private: 2 RC with 148 beds (OR = 95%) Fee: 1200 – 1800 CNY # of EC employees: 48 out of 70 are licensed 	
b)	Care level to be provided, estimate demand and willingness and ability to pay	<ul style="list-style-type: none"> Population: Total: 464,000 Elderly: 60,586 (13%) Medical rehabilitation RC with 500 beds RC Fee to be charged by the project: Independent: 1,000 – 1,500 CNY Semi-dependent: 2,000 – 2,500 CNY Dependent: 3,000 – 3,500 CNY RC demand, willingness and ability to pay are unknown 	<ol style="list-style-type: none"> To conduct a study on RC demand, willingness and ability to pay. To reduce the number of RC beds to 200 – 300.
c)	Type, quality standards, and quantity of RC services to be provided	Service specifications are in Chapter 11, which require further enhancement including hospice care, rehabilitation, and handling of the emergency.	<ol style="list-style-type: none"> To enhance service specifications according to Annex G, and enlist the help of external consultant(s) if required.
d)	Quality (e.g., universal design) and safety features of construction with civil engineer	Need to include design for care especially in (1) care of people with cognitive impairment and (2) infection control issues	<ol style="list-style-type: none"> To ensure the need of people with cognitive impairment, e.g., dementia, and infection control issues are properly addressed in RC design.
e)	Arrangements with medical facilities re health care needs	Only informal agreement has been made with the health care sector.	<ol style="list-style-type: none"> To ensure health services provided by the project will be covered by health insurance through formal agreement To develop a collaborative working relationship with health care sector
f)	Quality assurance measures	This is largely unknown especially in relation to clinical care issues	<ol style="list-style-type: none"> To enhance service specifications especially in relation to Section 6 & 7 of Annex G: quality and risk, performance management; and to enlist the help of external consultant(s), if required.
g)	Human resources recruitment strategies, continuous development programs, and quality monitoring	<ul style="list-style-type: none"> The project has a total workforce of 383 employees, of which 100 in RC, 100 in HC and 40 in Day Care. There is a shortage of EC workers and high-skilled EC workers, 	<ol style="list-style-type: none"> To develop recruitment plan to ensure sufficient supply of licensed EC workers for the project To develop training plan to retrain existing non-licensed workers

²⁷⁹ OR = Occupancy rate

Issues		Observations	Rooms for improvement
h)	Information technology (IT) support systems	Other than the call center which is a very limited application of information technology, no other use of IT was mentioned	10. To develop staff retention plan so as to reduce the outflow of EC workers.
			11. To explore the use of ICT in EC including electronic medical records, care planning, and monitoring, use of clinical and service guidelines, call center, etc.
			12. To enlist the help of external consultant(s) if required.
			13. To enlist the help of external consultant(s) if required.
i)	Analyze the financial viability with the financial specialist	Unclear business plan including financial viability and plan to repay loan	14. To develop sustainable and viable financial plan including a realistic projection of income and repayment plan.
j)	Capacity building need for government, operators and NGOs	Other than EC policies and directives, government involvement has been generally limited	15. To build government capacity in EC especially in developing a strategic EC plan for the next 5 years
			16. To enhance government role in EC eligibility assessment and service monitoring
K)	Demonstration/pilot project	The IA revamped its FSR with a new perspective of providing a high quality of EC services. This provides a climate for a formalized quality assurance system.	17. To pilot a quality assurance system ²⁸⁰ before the construction of RC is completed. The pilot is to be funded through TA funding.

²⁸⁰ Quality assurance (QA) is a planned and systematic activity for monitoring and evaluating the quality of care and services of an EC organization. It involves the establishment of quality policy and quality objectives, quality planning, and quality control and quality improvement. One key element of a generic quality assurance is the development of a risk management system for the detection, evaluation and resolution of EC risks, which is defined as losses by an organization due to injury to people and property.

3.4.2 Xinji County, reports direct to Hebei Provincial Government.

	Issues	Observations	Rooms for improvement
a)	Current EC provision (capacity, services, quality, facilities, human resources, medical services, etc.).	<ul style="list-style-type: none"> RC – Public vs. Private = 12 vs. 8 Total RC beds: 2,037 OR = 31% Fee: <ul style="list-style-type: none"> Single room: 4800 – 5100s Double occupancy: 4500 – 4800CNY Multiple occupancy: 3000 – 3300 CNY # of EC employees: unknown 	
b)	Care level to be provided, estimate demand and willingness and ability to pay	<ul style="list-style-type: none"> Population: <ul style="list-style-type: none"> Total: 635,000 Elderly: 129,000 (20%) Medical rehabilitation center RC with 540 beds (+HCBC: 180 beds) <ul style="list-style-type: none"> Independent: 120 Semi-dependent: 270 Totally dependent: 150 RC Fee to be charged by the project: 2000 – 3500 CNY RC demand of 740 beds (RC - 560 and HCBC - 180 beds) needs to be verified esp. when the current OR is only 31% In addition, willingness and ability to pay are unknown 	<ol style="list-style-type: none"> To conduct a study on RC demand, willingness and ability to pay. To reduce 50% of the beds proposed by eliminating the 14-18 floors of the multipurpose building, reducing selfcare buildings from 2 to 1, reducing # of beds both in semi-dependent and totally dependent care. To adopt a phase in approach in RC construction and management.
c)	Type, quality standards, and quantity of RC services to be provided	Service specifications for Medical Rehabilitation and RC are generally unclear and oversimplified, making no mention of fall prevention, infection control management, etc.	<ol style="list-style-type: none"> To enhance service specifications according to Annex G; and to enlist the help of external consultant(s) if required
d)	Quality (e.g., universal design) and safety features of construction with civil engineer	Need to include design for care especially in (1) care of people with cognitive impairment and (2) infection control issues	<ol style="list-style-type: none"> To ensure the need of people with cognitive impairment, e.g., dementia, and infection control issues are properly addressed in RC design.
e)	Arrangements with medical facilities re health care needs	Only informal agreement has been made with the health care sector.	<ol style="list-style-type: none"> To ensure health services provided by the project will be covered by health insurance through formal agreement To develop a collaborative working relationship with health care sector
f)	Quality assurance measures	This is largely unknown especially in relation to clinical care issues	<ol style="list-style-type: none"> To enhance service specifications especially in relation to Section 6 & 7 of Annex G: quality and risk, performance management; and to enlist the help of external consultant(s) if required.
g)	Human resources recruitment strategies, continuous development programs, and quality monitoring	<ul style="list-style-type: none"> The project has a total workforce of 403 employees, of which 153 in RC, and 8 in Day Care. 	<ol style="list-style-type: none"> To agree with the First Hospital formally for the deployment of their staff in this project

Issues	Observations	Rooms for improvement
h)	Information technology (IT) support systems	<ul style="list-style-type: none"> Plan to deploy staff of the First Hospital to this project is unclear even though it was mentioned in FSR. The readiness of Hebei Medical School to supply the 240 nurses and care aides (RC & HCBC) required by this project is unclear Plan to convert existing garment manufacturing staff to EC care aides is unclear. Whether or not existing staff wants to be converted is unclear.
	Other than the call center, which is a very limited application of information technology, no other use of IT was mentioned.	10. To agree with Hebei Medical School formally to ensure supply of graduates to meet the demand of professionals and care aides for this project 11. To identify existing manufacturing staffs that want to be converted to EC workers and to develop a retaining plan. 12. To develop staff retention plan so as to reduce the outflow of EC workers. 13. To explore the use of ICT in EC including electronic medical records, care planning, and monitoring, use of clinical and service guidelines, call center, etc. 14. To enlist the help of external consultant(s) if required.
i)	Analyze the financial viability with the financial specialist	Unclear financial viability – needs to consider the slow uptake of service utilization in all areas: medical rehabilitation center, RC, and HCBC,
j)	Capacity building need for government, operators and NGOs	Other than EC policies and directives, government involvement has been generally limited
K)	Demonstration/pilot project	The project has some initial agreement with the local hospital. This will enable a better integration through collaboration between the medical rehabilitation center proposed and the local hospital,
		15. To develop sustainable and viable financial plan including a realistic projection of income and repayment plan. 16. To build government capacity in EC especially in developing a strategic EC plan for the next 5 years 17. To enhance government role in EC eligibility assessment and service monitoring 18. To pilot medical and health integration – horizontal ²⁸¹ . The pilot is to be funded through TA funding.

²⁸¹ A better collaboration between medical (hospitals) and health/social (rehabilitation center or RC) care enables elderly (1) to access medical care (e.g., to a hospital, should a complex medical condition arise); and (2) to transit from a hospital to a rehabilitation center and RC seamlessly. In addition, it will also allow the transfer of low level care activities such as oxygen therapy, tub feeding etc. from hospital to a rehabilitation center or RC, and at the same time, enable social care to recover their costs from the medical insurance scheme. A formal collaboration framework between medical and health/social, in terms of (1) sharing of users' medical and health/social records, (2) care management through the use of practice pathway and guidelines, (3) care coordination through case management, and (4) revamping medical and health/social service arrangements, is needed. This can be enforced using contractual arrangement, if necessary. Involvement of respective authorities e.g., Health, Civil Affairs may be required.

3.4.3 Li County – in Baoding Municipality

	Issues	Observations	Rooms for improvement
a)	Current EC provision (capacity, services, quality, facilities, human resources, medical services, etc.).	<ul style="list-style-type: none"> RC – Public 1 with 110 beds OR = 60%²⁸² Fee: Independent: 1200 – 1600 CNY Dependent: 1800 – 2300 CNY # of EC employees: 20 with 15 care aides 	
b)	Care level to be provided, estimate demand and willingness and ability to pay	<ul style="list-style-type: none"> Population: Total: 542,000 Elderly: 82,600 (15%) RC with 400 beds (+HCBC: 400 beds in 10 different locations) RC Fee to be charged by the project: <u>Independent</u> – single room: 2700 CNY – double occupancy: 2300 CNY <u>Semi-dependent</u> – single room: 3500 CNY – double occupancy: 3200 CNY <u>Dependent</u> – double occupancy: 3500 CNY Need to verify demand of health checks, rehabilitation services and day care. 	1. To conduct a study on RC demand, willingness and ability to pay.
c)	Type, quality standards, and quantity of RC services to be provided	Service specifications for Medical Rehabilitation and RC have been significantly improved	
d)	Quality (e.g., universal design) and safety features of construction with civil engineer	Need to include design for care especially in (1) care of people with cognitive impairment and (2) infection control issues	2. To ensure the need of people with cognitive impairment, e.g., dementia, and infection control issues are properly addressed in RC design.
e)	Arrangements with medical facilities re health care needs		
f)	Quality assurance measures	This may require further development	3. To enhance service specifications especially in relation to Section 6 & 7 of Annex G: quality and risk, performance management; and to enlist the help of external consultant(s) if required.
g)	Human resources recruitment strategies, continuous development programs, and quality monitoring	<ul style="list-style-type: none"> The project has a total workforce of 383 employees, of which 100 in RC, 40 in Day Care and 100 Home Care. Clearer human resources plan Clearer plan of collaboration with Hebei Medical School to ensure the supply of sufficient staff required for this project. 	4. To agree with Hebei Medical School formally to ensure supply of graduates to meet the demand of professionals and care aides for this project 5. To develop staff retention plan so as to reduce the outflow of EC workers.
h)	Information technology (IT) support systems	Other than the call center which is a very limited application of information technology, no other use of IT was mentioned	6. To explore the use of ICT in EC including electronic medical records, care planning, and monitoring,

²⁸² This information is based on one of the two public RCs

Issues		Observations	Rooms for improvement
			use of clinical and service guidelines, call center, etc.
			7. To enlist the help of external consultant(s) if required.
i)	Analyze the financial viability with the financial specialist	Financial viability – needs to consider the income especially the demand of day care, health checks, and rehabilitation services	8. To realistically estimate the income from day care, health checks and rehabilitation services
j)	Capacity building need for government, operators and NGOs	<ul style="list-style-type: none"> Apart from issuing EC policies and directives, governmental role in EC, in general, is still unclear. Civil Affairs Bureau's involvement has been high. IA is an NGO set up by the Civil Affairs Bureau. 	9. To build government capacity in EC especially in developing a strategic EC plan for the next 5 years 10. To enhance government role in EC eligibility assessment and service monitoring.
K)	Demonstration/pilot project	The IA has a close relationship with the local Civil Affairs Bureau, which creates a climate conducive to an overall EC system development and planning ²⁸³ .	11. To pilot EC system planning (see also #9). The pilot is to be funded through TA funding.

²⁸³ This is a process of establishing a formalized, ongoing, long-range EC plan to define and achieve the goals of EC. The plan provides an overarching picture of the future (vision) that all stakeholders seek to create and guides all EC activities at the municipal, county and organizational levels. Specifically, the plan should include the key service strategy such as major EC services to be established in the next 5 years; and a number of enabling strategies to support the realization of the key strategy: finance sustainability, quality assurance, human resources requirements and public expectation management. A typical EC service and system plan also includes a basic set of beliefs which communicate what is important to the general public, the government and the EC organization, what these stakeholders stand for and how they operate on a day to day basis in pursuit of their vision.

3.4.4 Shuanglan District – in Chengde Municipality

Issues		Observations	Rooms for improvement
a)	Current EC provision (capacity, services, quality, facilities, human resources, medical services, etc.).	<ul style="list-style-type: none"> • # of RC facility b. Public vs. Private = 55 vs. 32 c. Publicly owned and privately operated: 3 • OR = 65% • Fee: <ul style="list-style-type: none"> Dependent: 3000 CNY Semi-dependent: 2000 CNY Independent: 1200 CNY • # of EC employees: unknown 	
b)	Care level to be provided, estimate demand and willingness and ability to pay	<ul style="list-style-type: none"> • Population: <ul style="list-style-type: none"> Total: 3,780,000 Elderly: 583,000 (15%) • Medical rehabilitation center: 100 beds • RC with 268 beds: 100 (semi- dependent); 100 (dependent) and 68 three nos. • RC Fee to be charged by the project: 2500 – 3500 CNY 	
c)	Type, quality standards, and quantity of RC services to be provided	Service specifications for Medical Rehabilitation and RC are either unclear or oversimplified.	1. To enhance service specifications according to Annex G, and to enlist the help of external consultant(s) if required
d)	Quality (e.g., universal design) and safety features of construction with civil engineer	Need to include design for care especially in (1) care of people with cognitive impairment and (2) infection control issues	2. To ensure the need of people with cognitive impairment, e.g., dementia, and infection control issues are properly addressed in RC design.
e)	Arrangements with medical facilities re health care needs	Agreement with the health care sector re the operation of medical rehabilitation center is unclear.	3. To develop collaborative working relationship with the health care sector
f)	Quality assurance measures	This is largely unknown especially in relation to clinical care issues	4. To enhance service specifications especially in relation to Section 6 & 7 of Annex G: quality and risk, performance management; and to enlist the help of external consultant(s) if required.
g)	Human resources recruitment strategies, continuous development programs, and quality monitoring	<ul style="list-style-type: none"> • The project requires a workforce of 383 employees, of which 173 nursing and care aides. • Unclear plan to work with local vocational training institute to address staffing need of the project. • Unclear plan to ensure the staff of the project to receive training accredited by Hebei Medical School. 	5. To formulate a formal agreement with local vocational training institute for addressing staffing need of the project. 6. To develop plan to ensure staff trained are in accordance to the standards set by the Hebei Medical School 7. To develop staff retention plan so as to reduce the outflow of EC workers.
h)	Information technology (IT) support systems	Other than the call center, which is a very limited application of information technology, no other use of IT was mentioned.	8. To explore the use of ICT in EC including electronic medical records, care planning, and monitoring,

Issues	Observations	Rooms for improvement
i) Analyze the financial viability with the financial specialist	Unclear financial viability – RC fee charge rates appear to be low whereas income from call center, day care, telemedicine, distant monitoring, and rehabilitation medical center appears to be high.	<p>use of clinical and service guidelines, call center, etc.</p> <p>9. To enlist the help of external consultant(s) if required.</p> <p>10. To realistically assess the fee schedules of RC, call center, day care, telemedicine, distant monitoring and rehabilitation medical center.</p>
j) Capacity building need for government, operators, and NGOs	<ul style="list-style-type: none"> • Other than EC policies and directives, government's role in EC is generally limited. • The government has been participative in the planning process and is supportive to the IA. 	<p>11. To build government capacity in EC especially in developing a strategic EC plan for the next 5 years</p> <p>12. To enhance government role in EC legibility assessment and service monitoring</p>
K) Demonstration/pilot project	Local Civil Affairs Bureau has been conducive to develop an EC assessment and monitoring system along with the IA. This makes the successful establishment of an EC assessment and monitoring system possible.	13. To pilot an EC assessment and monitoring system ²⁸⁴ with Civil Affairs Bureau. The pilot is to be funded through TA funding.

²⁸⁴ Assessment is the use of a systematic tool or process to collect information on the needs of EC users. Typically, the assessor (usually a case manager) uses the tool to evaluate the physical, cognitive and functional needs of the LTC users and ranks their levels of impairment. The purpose of assessment is to determine service eligibility, especially for publicly funded services, and to enable service matching, planning and monitoring. Monitoring is a systematic approach to monitor the quality of EC according to care and service standards either set by external authority or internal quality monitoring system. It involves standards setting, data collection and reporting, and plan for follow-up, if quality improvement is required.

3.4.5 Zunhua County - in Tangshan Municipality

Issues	Observations	Rooms for improvement
a) Current EC provision (capacity, services, quality, facilities, human resources, medical services, etc.).	<ul style="list-style-type: none"> Public: 8 RCs with 900 beds with OR unknown Fee: unknown Private: 13 RCs with 857 beds with OR unknown Fee: unknown # of EC employees: unknown 	<ol style="list-style-type: none"> To collect information on RC bed utilization in Tangshan municipality and fee charging schedule. To collect information on current employees working in EC industry in Tangshan and Zunhua.
b) Care level to be provided, estimate demand and willingness and ability to pay	<ul style="list-style-type: none"> Population (Tangshan): Total: 7,352,200 Elderly: 1,090,000 (15%) Medical rehabilitation center (International Hospital) RC with 400 beds RC Fee to be charged by the project²⁸⁵: <ul style="list-style-type: none"> - high-income bed: 3000 CNY - medium income bed: 2000 CNY - low -income bed: 1500 CNY Willingness and ability to pay are unknown. Higher income does not imply a willingness to pay for EC. 	<ol style="list-style-type: none"> To conduct a study on willingness and ability to pay.
c) Type, quality standards, and quantity of RC services to be provided	Other than those shown in Diagram 3.6 of FSR, service specifications for Medical Rehabilitation and RC are generally unclear and oversimplified.	<ol style="list-style-type: none"> To enhance service specifications according to Annex G. and to enlist the help of external consultant(s) if required
d) Quality (e.g., universal design) and safety features of construction with civil engineer	Need to include design for care especially in (1) care of people with cognitive impairment and (2) infection control issues	<ol style="list-style-type: none"> To ensure the need of people with cognitive impairment, e.g., dementia, and infection control issues are properly addressed in RC design.
e) Arrangements with medical facilities re health care needs	The project plans to outsource the management of its medical rehabilitation center and possibly the RC to a German company (FIAP), details of outsourcing is lacking.	<ol style="list-style-type: none"> To ensure a collaboration agreement is in place with the potential outsourcing service-management partner.
f) Quality assurance measures	This is largely unknown.	<ol style="list-style-type: none"> To enhance service specifications especially in relation to Section 6 & 7 of Annex G: quality and risk, performance management; and to enlist the help of external consultant(s) if required.
g) Human resources recruitment strategies, continuous development programs, and quality monitoring	<ul style="list-style-type: none"> The project has a total workforce of 390 employees.²⁸⁶ It is unclear how many of them will be direct service employees such as nursing and care aides. Plan to recruit, train and retain staffing sufficient to meet the need of the project is unclear 	<ol style="list-style-type: none"> To develop staff recruitment, training, and retention plan so as to address the staff need of the project.

²⁸⁵ Based on Zunhua's FSR, p.106.

²⁸⁶ Based on Zunhua's FSR, p.107.

	Issues	Observations	Rooms for improvement
h)	Information technology (IT) support systems	Other than the call center, which is a very limited application of information technology, no other use of IT was mentioned.	<p>9. To explore the use of ICT in EC including electronic medical records, care planning, and monitoring, use of clinical and service guidelines, call center, etc.</p> <p>10. To enlist the help of external consultant(s) if required.</p>
i)	Analyze the financial viability with the financial specialist	Further economic analysis is needed	
j)	Capacity building need for government, operators and NGOs	Other than EC policies and directives, government involvement has been generally limited	<p>11. To build government capacity in EC especially in developing a strategic EC plan for the next 5 years</p> <p>12. To enhance government role in EC eligibility assessment and service monitoring</p>
K)	Demonstration/pilot project	The IA is planning to introduce a German based medical rehabilitation center (International hospital), which potentially can evolve into a full scale chronic care hospital for the elderly.	<p>13. To pilot a full scale medical rehabilitation (chronic care) including an end of life care. The pilot is to be funded through TA funding.</p>

4.0 RECOMMENDED/AGREED PROJECT DESIGN

4.1 CONDUCT MARKET RESEARCH TO DETERMINE BED DEMAND AND PRICING STRATEGY

110. In light of a large number of RC beds proposed, ***the project IAs should conduct market research EC bed demand – both RC and Medical Rehabilitation Center***. The study, preferably conducted by an independent body such as academic institute to ensure impartiality, has two objectives. Firstly, it is to ascertain the demand of EC especially in relation to the proportion of older people who require care at home/community, in residential care and medical rehabilitation center. Secondly, it is to determine the affordability and “willingness to purchase” of the elderly and their family members. Even people who can afford to buy the service, may not be willing to spend their resources to do so. EC demand should be back up by affordability and willingness to purchase study. This is to help formulating pricing strategy and fee schedule of the IAs. More specifically, the study should cover the following areas:

- Complex care need of older persons: transitional care, rehabilitation, dementia, end of life care, etc.
- Need of care in nursing, ADL and IADL
- Affordability and willingness to purchase

111. In addition, a utilization analysis of current RC beds is needed to determine the magnitude and causes of under occupancy. Preferably, an independent party should conduct this study.

4.2 SET A REASONABLE SIZE OF RC

112. Regardless the result of the market study, the size of RC will continue to be an issue when a significant number of beds are concentrated in one geographical area, both from the perspectives of deinstitutionalization and RC management. Smaller size RC, i.e., 100+ beds, along with onsite HCBC appears to be an ideal model in EC delivery. Elderly Home in Shanghai (2.6.4), Jingrongjie Senior Apartments (2.6.3) and Cuncachunhui Nursing Home (2.6.2) in Beijing, are just a few good RC practice to follow. In light of the land acquired, smaller size RC may not, and 300 – 400 beds may be economically viable. In view of this, ***the IAs may take a phase-in approach***. For instance, the IA only builds half of the RC beds i.e., 150 – 200 beds initially so as to gain the experience of RC operation and to complete the construction of the rest of RC beds only when further demand is proven.

4.3 UNDERSTAND THE CHARACTERISTICS AND CLINICAL ISSUES OF THE ELDERLY POPULATION

113. To address the issue of insufficient knowledge and expertise in caring for elderly with complex care needs, ***all project stakeholders should receive training in understanding the characteristics of the target population to be served***. In

general, characteristics of older persons in need of RC, include, not limited to, the followings:

- Need specialized mechanical aids for transfer.
- Are mobile with mechanical aids such as walkers, canes, crutches, etc.
- Need considerable supervision and skilled assistance with activities of daily living, such as bathing, getting dressed, grooming, and attending to personal hygiene, etc.
- Present staff with difficulties or require extra staff time due to impaired comprehension and/or resistance to care.
- Cause management problems due to wandering.
- Disturb others with socially inappropriate/disruptive behaviors.
- Be incontinent of bladder and/or bowel.
- Need different and/or extensive professional services, e.g. nursing, rehabilitation, dietary and social services, etc.
- Have multiple disability/health problems.
- Require supervision of medication.
- Require change of dressing, including surgical dressing.
- Require treatment of pressure sore.
- Require supervision of catheter and osmotic apparatus.
- Require supervision of oxygen therapy.
- Require therapeutic diet.

114. Annex E is the admission criteria for home/community and residential care used by the government of Alberta, Canada. It could serve as a good reference about the nature of EC.

115. Due to their complexity, there are a number of clinical issues to be addressed by EC, which include, but not limited to, the following:

- fall
- skin integrity;
- wounds and pressure sores;
- incontinence;
- constipation;
- supervision of medications including the use of psychotropic medication, administration of injectable medication and selective intravenous therapy;
- nutritional and dietary management including special diet and tube feeding;
- infection control;
- chronic pain;
- special nursing procedure: e.g. tracheotomy care, oxygen therapy;
- oral care
- depression;

- cognitive impairment;
- agitated and aggressive behavior; and
- maintenance and restorative rehabilitation.

116. Annex D is a list of examples of clinical issues that most likely addressed in EC and especially in RC setting. These services and clinical issues are not necessarily the specialty of the hospital or medical care. Most of the hospitals and medical care tend to consult EC (or long term care) when dealing with these clinical issues.

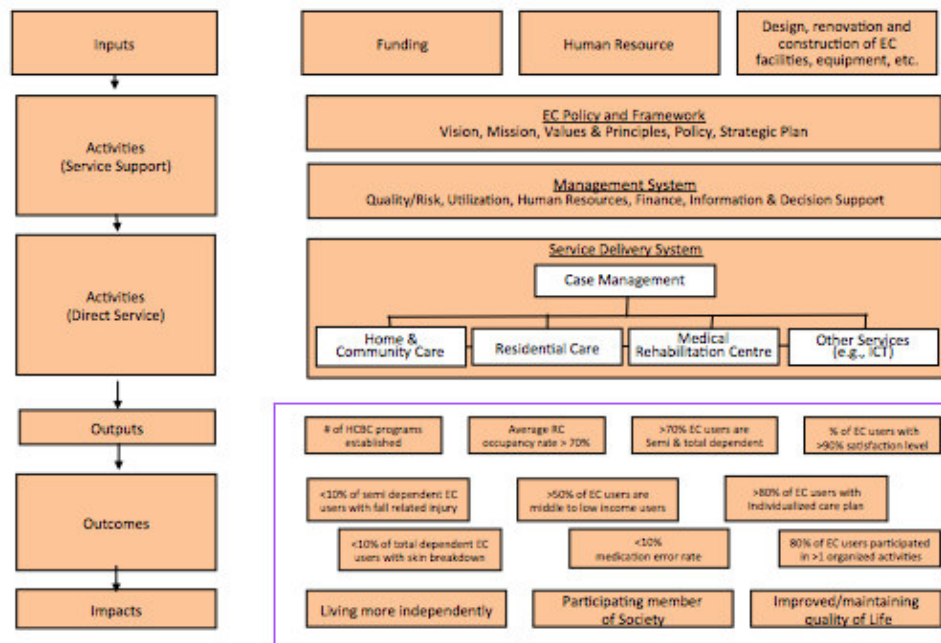
4.4 AGREE AN EC SYSTEM AND STRATEGIC DIRECTION FOR THE NEXT 5 YEARS

117. EC is more than physical construction; it is about building an EC system. Hebei government fully realizes the importance of system building. The Hebei government intends to revamp the EC system especially in improving the functions and building the software capacity of EC through this project.²⁸⁷ One simple way of depicting the EC system is by using the logic model or decision making framework (DMF), which includes a logical relationship between resources, key activities, outputs, and outcomes

118. The logic model of an EC system starts with the end in mind: project outputs and outcomes (and impact). The measures of EC outputs and outcomes should always be on the wellbeing of the elderly concerned, and not on the completion of infrastructure. Despite client care outcomes and matrices are hard to define and measure, client care outcomes should always take precedence. The logic model diagram provides a big picture and enables project stakeholders: government, IAs and service providers to think outside the boundary of resources: funding, human resources, building, etc. and to search for what need to be done and changed for the achievement of EC outputs and outcomes. “What need to be done and changed” are the key activities of the EC system, which include, but not limited to (1) EC policy and framework, (2) management support and (3) direct service delivery.

²⁸⁷ Hebei provincial DRC, Department of Finance and Civil Affairs Bureau. (2015). ADB Financed Hebei Elderly Care Service System Development Project (July 16th, 2015)

DIAGRAM 2: EC system as depicted by logic model (DMF)



119. Along with the EC system model, there should be a strategic plan (or development plan if the term “strategic plan” is too sensitive) developed both at provincial and municipal levels. The plan will stipulate what the EC sector, both government and nongovernment, will do in the next 5-10 years, which will include EC services to be delivered and other enabling strategies: (1) financial sustainability such as government subsidy, user fees, long term care insurance etc.; (2) risk and service quality management; (3) human resource plan and (4) intra and inter sector collaboration including (a) health and social (elder) care integration and (b) management of public expectation. Presumably, the EC system and development plan should be developed and agreed by all stakeholders concerned at the very beginning of the project so that **governments, IAs and service providers will have a clear roadmap on how the EC system shall evolve**. However, it is never too late to reach such an agreement prior to the approval of the loan.
120. The EC development (or strategic) plan does not mean to replace central and/or provincial FYP. It is to support the realization of FYP in a more concrete manner, which will include strategies/tactics, deliverables, milestones, champions, etc. If the FYP is a national and provincial vision for the forthcoming five years, the strategic or development plan will be a roadmap to reach the vision.
- 4.5 IDENTIFY CORE VALUES AND OPERATING PRINCIPLES, AND PURPOSE OF EC**
121. EC is driven by “core EC values and principles.” The project stakeholders may adopt principles suggested by UN and WHO, in addition to those mentioned in the national EC policy and laws of the PRC. Annex E is some EC principles and values.

122. In addition, EC should have a clear purpose in mind. The overarching purpose of EC should include, but not limited to, the following key elements, to

- (e) stay healthy and fit (health promotion),
- (f) prevent people with impairment from getting worse (health prevention - chronic disease management),
- (g) ensure a smooth path between hospital and home (transitional care) when hospitalization is needed; and
- (h) slow the progression of increasing dependence (e.g., long term care) including care at the end stage of life (e.g., hospice and palliative care facilities).

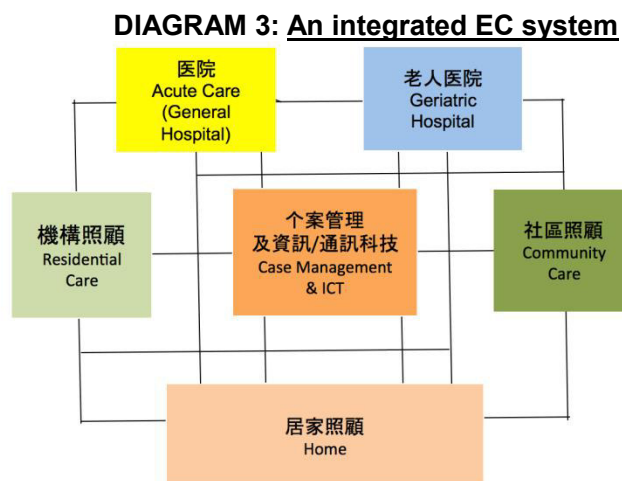
4.6 DEVELOP MEDICAL REHABILITATION CENTER WITH GERIATRIC FOCUS

123. To ensure the proposed geriatric hospital or medical rehabilitation center has a “geriatric” focus, ***a clinical services inventory for the geriatric hospital needs to be clearly stipulated.*** The government, under the policy on health and social (elder) care integration, does suggest some clinical services to be delivered in a geriatric hospital: sub-acute care, post-acute care, rehabilitation, end of life care, etc. Annex F is a list of clinical services that may be included as part of services of the proposed medical rehabilitation center.

4.7 INITIATE A DELIBERATED CARE INTEGRATION

124. Integration occurs within and outside current EC system. Within the EC, it is the integration of home, community, residential care and medical rehabilitation. The elderly will gradually move from home to community care and may end up in residential care and medical rehabilitation as their conditions deteriorate and their age advances. Thus, the current bundle of HCBC, RC and medical rehabilitation under one service provider is a better arrangement than standalone services. In many countries, this is called bundled care when the operator is asked to deliver residential, community and home care as a bundle. There are at least two advantages of so doing: economy of scale and economy of scope. In economy of scale, for instance, the same kitchen preparing meals for RC residents, can also be used to prepare meals for community residents through community canteen and meal on wheel. In economy of scope, RC offers far more clinical services than HCBC, HCBC users may benefit from, for instance, the rehabilitation programs of RC. On the other hand, RC users may benefit from the social recreational programs of HCBC. Outside EC, there is a need to better integrate health, housing, transportation, social recreation, etc. Elderly's needs are far more than HCBC, RC, and medical rehabilitation. They, at times, will need primary and acute care support, housing, transportation and social recreation. Inter-sector collaboration is far more complex than integration within EC. This may require government leadership and support. ***A formal agreement should be reached between authorities concerned such as Health and Civil Affairs*** so that users may claim medical insurance benefits even when the health service is delivered in the social care setting.

125. Diagram 3 is an integrated EC system - all related components in EC are linked to form a holistic EC delivery system. Diagram 3 has two important features. Firstly, all lines are bi-directional. All components are interlinked for back and forth movement. Secondly, case management and an integrated electronic health record system through ICT coordinate the movement of elderly along the integrated EC system.



126. An elderly residing at home, when encounters an acute condition such as fracture hip, may be admitted to an acute hospital for diagnosis and treatment including surgery. The elderly may take time to become fully mobile and the process can be slow. Assuming this process takes 5-6 months, the elderly can first be transferred to a medical rehabilitation center for further rehabilitation. After 2 months of stay in a medical rehabilitation center, the elderly will be discharged home with home and community support to continue to rehabilitation for another 4 months. In case fully recovery is impossible, elderly can either continue to receive home and community care and continue to stay at home. Only when the elderly fail to thrive after home and community care, the elderly can then be considered for RC if RC is the elderly's preferred option.

4.8 ENHANCE MANAGEMENT SUPPORT IN EC

127. To ensure there is management support in EC, ***the IAs should ensure that an organizational and leadership's commitment to service excellence is there through well-documented organizational vision, mission, values and operational plans for their EC.*** The management support includes the development of a manual of procedures (the Manual), which should be ready at the time of operation. Besides procedures/protocols covering the daily operation, there should be procedures covering the management of clinical and service issues. The Manual should also have procedures for the provision of personal care services. The Manual should be made available to all staff, service users, and their caregivers, and to the Government Representative on request.

128. There will be a quality management system that ensures adequate risk management including protocol in dealing with emergency and accident, and aims at achieving continuous improvement to the quality of the services. The quality management system should include, but not limited to, the following:
- ii the establishment of mechanism to solicit service users and their families' feedback on the services, and to promote families of service users to participate in the care of service users;
 - iii the establishment of policy and procedure in relation to the handling of suggestions and complaints from service users, their caregivers, staff, the government representative and other concerned parties;
 - iv the establishment of a mechanism to conduct user satisfaction survey at intervals not less than once every year; and
 - v the establishment of a mechanism to initiate regular review and improvements pertaining to the major clinical, personal care and other non-clinical issues of EC: skin care, falls, psycho-geriatric problems, polymedication, and food and laundry services etc. Clinical Practice Guidelines should be developed as a result of this process to assist multi-disciplinary staff in providing appropriate care for clinical conditions pertaining to EC.
129. There is a utilization management system in place. This is to keep track of RC bed utilization by increasing the occupancy rate. An unoccupied or under-utilized RC bed implies wastage of organization resources. Remedial measures are thus required to stop wastage.
130. There is a financial management system in place. It should include but not limited to budget planning and projection, accounting, auditing and a plan to deal with budget variation. Proper procedures should be established to safeguard against misuse of funds.
131. There is a human resource management system in place. It should include the recruitment and retention of appropriate staff mix with suitable qualifications and adequate training and experience to deal with the complexity and acuity of the residents.
132. There are strategies to promote collaboration and networking, including the forming of partnership with other organizations in the community such as volunteers. It may include forming alliances with other sectors such as health, housing, transportation and other NGOs in order to promote better service integration.

4.9 DESIGN WITH CARE IN MIND

133. To address the issue of design for care, three design issues need to be deliberated by the IAs in its FSR. Firstly, it is about design for dementia care. Dementia will be one of the greatest challenges facing our society today with rates of dementia expecting to increase significantly over the next 10 years. Care of people with cognitive impairment

may be far more challenging than people with physical impairment. Designing and building RC with better way finding and lighting, and reduced noises are important to support people with memory loss and dementia. Specific RC design and construction guidelines or standards for the caring of people with dementia are needed. ***IAs should ensure the architect hired to do their design work would have a good background and experience in this regard.***

134. The second design issue is infection control. Medical rehabilitation center, RC, and HCBC produces a large amount of medical and biohazardous waste. There must be provision to support waste management including designated and separated areas for soiled and clean materials, areas for waste storage and disposal. RC construction standards should include issues such as cleansing and decontamination. The standard should also specify the establishment of soiled and clean rooms and the paths of transporting soiled and clean materials, which should never cross. ***These good infection control practices should be clearly stipulated as part of the FSR.***
135. Workflow analysis is the 3rd care-design issue, which should be part of the functional plan of the facility architectural plan. A functional plan is a pre-design document describing the functions of each functional component (or areas) in the RC and medical rehabilitation center. The plan illustrates the relationship between different functional areas in terms of proximity and functions. Workflow, which is resident or staff moving from one area to another area, is a typical relationship between two areas. Studying workflow in details will enable the creation of a resident/patient friendly living and staff friendly working environment. A functional plan should be developed in such details to enable the initiation of an architectural plan. ***It is the responsibility of IA to initiate a functional planning before an architectural plan is ready.*** This should be mentioned in the revised FSR.
136. Annex H is a checklist of things that are essential and necessary in designing a physical environment in the care of the elderly. This list is not meant to be exhausted. Other factors may need to include, when appropriate.

4.10 REFRAME ROLE AND RESPONSIBILITY OF CIVIL AFFAIRS IN EC

137. According to the “Announcement of good practice in government purchasing of elderly care services (2014)”, it is clearly stated that the role of government is ‘leading, planning, providing policy support and funding, and monitoring and evaluation’ and ‘local government is required to formulate service standards for EC and organize regular monitoring and evaluation activities.’ Regardless the other responsibilities that the Civil Affairs must take on, there are two unique roles that local Civil Affairs must play in EC: assessment and service monitoring. For RC monitoring, it is very again clearly stated in the policy on the management of residential care (RC), (2013).²⁸⁸ The local Civil Affairs may take a more proactive role in monitoring EC quality. Instead of reacting to quality

²⁸⁸ 养老机构管理办法 (2013)<http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201306/20130600480076.shtml>

concerns raised by the users and/or the general public, the local Civil Affairs may take a proactive approach by establishing service standards and other quality assurance systems.

138. For assessment especially in terms of the determination of eligibility of publicly funded/subsidized EC services, the local Civil Affairs may consider the gatekeeping role of similar authorities in other countries/regions. Japan, Singapore, Hong Kong and Taiwan have effective assessment mechanism for assessing the actual EC needs of elderly. This is to ensure that those with more care needs: level of impairment, low income and/or no family member taking care of them; can enjoy public resources such as public nursing homes with high quality of facilities and services. Service assessment is one of the issues of EC software capacity building as proposed by the Hebei Government.²⁸⁹
139. The provincial and municipal governments should strengthen the capacity of their respective Civil Affairs, both in terms of EC expertise development and staffing requirement to man the EC office. There should be knowledgeable staff in Civil Affairs Office to develop the gatekeeping mechanism including a service matching and a waitlist management systems, and to monitor EC quality including maintaining ongoing liaison with service providers and addressing service users concerns and complaints. The number of staff of Civil Affairs should be adjusted to reflect increased workload.

4.11 DEVELOP HOUSING OPTIONS FOR ELDERLY WITH NO CARE NEED

140. Mixing elderly with no care need with those with care need can be demoralizing and costly. Many developed countries have separated housing from care. For instance, In Canada and Japan, there are two types of facilities for the elderly: (1) nursing homes, chronic care, or long-term care hospitals (2) residences or collective residences for senior citizens. Category (1) facility is for people with care need (after being assessed) and is subsidized by public funding and social insurance e.g., both Canada and Japan. Majority of category (2) is for people with no care needs, who move into these facilities entirely based on individual lifestyle choices. The Hong Kong government operated compassionate housing for those elderly with housing but no care need. In the long run, it will be less costly for ***the Chinese government to develop other housing options for people with no care need*** rather than mixing them with people with care needs.

²⁸⁹ Hebei provincial DRC, Department of Finance and Civil Affairs Bureau. (2015). ADB Financed Hebei Elderly Care Service System Development Project (July 16th, 2015) - #4

5.0 RISKS AND ASSUMPTIONS

141. All the gaps identified under 3.1, 3.2 and 3.3 are all potentials risk for causing project failures: harms to the well-being of users and potential users, financial and time loss to the IAs, harms to the credibility and support of the government and its officials, social harmony etc. These risks need to be addressed or mitigated by considering the recommendations under 4.0. In particular, three very high risks do need to be highlighted:

5.1 LACK OF EXPERIENCED IMPLEMENTING AGENCIES

142. Out of 5 local IAs, including the design companies hired to prepare the FSR, 3 have no EC experience – they do not even understand the complexity of EC including all clinical and management issues required in dealing with elderly in need of care. Thus, even when given the service specifications to supplement the FSR, most of them have failed to develop and elaborate. This leads to being a lack of conceptual understanding of the role of EC services and a lack of appreciation of the complexity of EC, specifically in medical rehabilitation and RC, and on building appropriate services and linkages with other service providers, and in understanding the human resource requirements to provide effective care. This cannot be overcome right away, and detailed capacity building plan for each IA needs to be developed, including training for management and care providers, collaboration with Civil Affairs on standards, monitoring and financing, and understanding how other service providers will link with them, in particularly health services. There is a danger with this suggestion though as IAs once realizing what is involved in EC may wish to withdraw.

5.2 LACK OF ENGAGEMENT IN SOME OF THE LOCAL CIVIL AFFAIRS

143. Given the nascent state of EC service development in some of the sub project areas and the limited experience of the IAs, the Civil Affairs Bureau need to be fully engaged, supportive and understand the process of EC development. Civil Affairs' general roles and responsibilities of EC are clearly stated in the "Announcement of good practice in government purchasing of elderly care services (2014)" and specific roles in RC are stated in "the policy on the management of residential care (RC),(2013)".²⁹⁰ The respective Civil Affairs Bureaus need to be fully committed to these responsibilities and again develop a plan as to how this will happen. The low engagement of Civil Affairs tends to blow in projects that IAs are with least experience. The lack of engagement of Civil Affairs compounding with the lack of experience of IAs creates a formula for project failure. Different levels of Civil Affairs may have to increase their engagement through the directives from their respective reporting supervisors.

5.3 LACK OF SOUND BUSINESS MODEL

144. The lack of sound business model can be illustrated by the (1) the large number of RC beds proposed, (2) the revenue collected through fee charging and (3) costing about human resources requirements. Only a few of the IAs have conducted market research

²⁹⁰ 养老机构管理办法 (2013)<http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201306/20130600480076.shtml>

to determine EC/RC demands. The revenue projected has not been based on affordability and “WTP” study. Thus, it turns out that both demand and supply of RC appeared to be overestimated. Staffing cost accounts for 80% of EC operating budget. Without a clear picture of human resources in RC, i.e., number and types of staff (both professional and nonprofessional), costing of human resources will be inaccurate. The IAs need to conduct a study on service demand and supply, including affordability and WTP. They also need to benchmark other similar operations abroad and within China to determine the level and quantity of staff required. Only by so doing, a sound business model can be established.

5.4 OTHER RISK ISSUES PERTAINING TO EC/RC

Risk	Level of risk	Mitigating strategies
Mismatch of EC service - elderly with care need do not whereas elderly with no care need get EC. This can be a social inequity and unrest issue.	High	Need to develop provincial wide EC/RC standardized assessment.
Poor public image of EC which discourages people from using EC and joining EC industry	Medium to high	Launch public expectation management including public education
IAs may not fully understand government policy direction, which may undermine the effort to build the EC system than individual EC project	Medium	Clearly communicating government policy and directives.
IA may not be interested in pilot and/or demonstration project	High	Provide incentives such as government and funding support

6.0 DETAILED GUIDANCE FOR IMPLEMENTATION

6.1 TO AGREE ON PROJECT ROADMAP FOR THE NEXT 3 YEARS

145. The Project cannot deal with all EC issues and therefore should not attempt to. It should complement EC system improvement initiatives as identified by the Hebei Government.²⁹¹ The detailed steps of 6.0 needs to be agreed by all parties concerned including all demonstration and pilot projects. This may take the following steps:

Step	Activities	Timelines	Resources
1.	All stakeholders gather to agree on 6.0 and get a big picture of who do what.	Oct 31, 2016	5,000
2.	All stakeholders agree on plan for capacity building	Nov 15, 2016	5,000
3.	All stakeholders make an explicit commitment to capacity building by participating in workshop and completing assignments, sending relevant staff to the workshop, etc.	Nov 30, 2016	5,000
Total			15,000

146. HPMO should be prepared to discuss with the respective authority concerned, should any of the stakeholders fails to agree and/or commit.

6.2 TO BUILD THE CAPACITY OF CAB AND IAs

147. Some common background knowledge i.e., characteristics and clinical issues of EC users along with a number of demonstration projects have been identified that are pertaining to CAB and all IAs:
- 1) Characteristics and clinical issues of EC users
 - 2) Dementia care
 - 3) Medical rehabilitation center
 - 4) Generic Quality Assurance system
 - 5) EC management training
148. Adopting a capacity building collaborative in which all stakeholders will work intensely for 18 months to build capacity on the above themes. During that time, participants will participate in five two-day learning sessions, each session is dedicated to one of the 5 themes listed above. The participants will maintain continuous contact with each other, their coaches, the Collaborative faculty (i.e., external consultants) through email, wechat, videoconference, and 10-15 on-site learning sessions. This may take the following steps:

Step	Activities	Timelines	Resources
1.	Topic selection, learning objective and outcomes. Topic: Characteristics and clinical issues of EC users	Jan 1, 2017	
1.1	Recruitment of consultant(s) and workshop instructor(s)	Jan 7, 2017	62,000
1.2	Determination of workshop venue and schedule	Feb 1, 2017	
1.3	Recruitment of workshop participants and site specific instructors		

²⁹¹ Hebei provincial DRC, Department of Finance and Civil Affairs Bureau. (2015). ADB Financed Hebei Elderly Care Service System Development Project (July 16th, 2015) - #4 included four specific areas of improvements: (1) human resources; (2) EC development plan; (3) EC system development (e.g., assessment), horizontal (with health, etc.) and vertical (HCBC, RC, Medical Rehabilitation Center) integration, use of IT/ICT and NGOs networking; and (4) PPP and creating incentives for involving private sector.

Step	Activities	Timelines	Resources
1.4	Workshop and PDSA cycle (2 days)	April, 1 -2 2017	10,000
1.5	On-site learning session 1 – Plan (1 day)	June 1, 2017	7,000
1.6	On-site learning session 2 – Do (1 day)	Sept 1, 2017	7,000
1.7	On-site learning session 3 – Study (1 day)	Dec 1, 2017	7,000
1.8	On-site learning session 4 – Action (1 day)	Mar 1, 2018	7,000
1.9	Evaluation and celebration	Jun 1, 2018	10,000
2.	Topic selection, learning objective and outcomes. Topic: Dementia care	June 1, 2017	
2.1 - 2.9	Same as 1.1 – 1.9	Jun 7, 2017 – Dec 1, 2018	100,000
3.	Topic selection, learning objective and outcomes. Topic: Medical Rehabilitation Center	Dec 1, 2017	
3.1 - 3.9	Same as 1.1 – 1.9	Dec 7, 2017 – Jun 1, 2019	100,000
4.	Topic selection, learning objective and outcomes. Topic: Generic Quality Assurance system	June 1, 2018	
4.1 - 4.9	Same as 1.1 – 1.9	Jun 7, 2018 – Dec 1, 2019	100,000
5.	Topic selection, learning objective and outcomes. Topic: EC management training	Dec 1, 2018	
5.1 - 5.9	Same as 1.1 – 1.9	Dec 7, 2018 – Jun 1, 2020	100,000
Contingency (20%)			100,000
Total			600,000

6.3 TO VERIFY EC/RC DEMAND AND SUPPLY

149. Each IA with the support of their respective local Civil Affairs is to sponsor an independent study to assess (1) current EC/RC utilization, and (2) EC/RC demand and affordability and (3) current RC utilization. This is important to substantiate a realistic demand and supply of EC/RC with affordable fee schedules. The study is to be completed by 2017. This may take the following steps:

Step	Activities	Timelines	Resources
1.	Identifying funding sources and independent party for the study	Jan 1, 2017	240,000 = 6*40,000
2.	Forming the Study Steering Group with representatives from ADB, local CAB, IA and principal investigator.	Feb 1, 2017	
3.	Agreeing on the study plan	Mar 1, 2017	
4.	Conducting the study and producing the report	Apr 1 – Aug 31, 2017	
5.	Refining the business plan including pricing strategy realistically according to the findings of the study	Sept 1 – Nov 1, 2017	
6.	Sharing the results with other project teams	Dec 1, 2017	10,000
Contingency (10%)			25,000
Total			275,000

6.4 TO PILOT THE FORMULATION OF EC DEVELOPMENT PLAN IN LIXIAN & JULU

150. Since a project-wide approach to developing an EC development (or strategic) plan may not be feasible at this point of time, it is suggested to work with IA and Lixian's CAB and Julu's County Government to formulate an EC development plan by 2017 in Lixian and Julu respectively. Lixian and Julu are suggested as the IAs, Lixian's CAB and Julu's County government are fairly open to change and improvement. The formulation of an EC development plan may take the following steps:

Step	Activities	Timelines	Resources
1.	ADB explores funding support (e.g., TA) to pilot the formulation of an EC development plan (ECDP) in Lixian and Julu.	Jan 1, 2017	200,000 = 2*100,000
2.	ADB, with the help of HPMO, agrees with the IA, Lixian's CAB and Julu's County Government on the formulation of an EC development plan and its process	Feb 1, 2017	
3.	An EC Development Plan Working Group (ECDPWG) is formed in Lixian and Julu respectively with representatives from ADB, CAB, IA and other government departments e.g., health, social security and human resources, etc.	Feb 1, 2017	
4.	ADB assists the search of external consultant(s), both international and national, to help the planning process.	Feb 15, 2017	
5.	The consultants work with the ECDPWG to identify key stakeholders to formulate an ECDP.	Mar, 15, 2017	
6.	The consultants and ECDPWG agree on the pilot's evaluation framework.	Apr 15, 2017	
7.	ECSPWG, other stakeholders, and consultants work to complete the plan.	May 1 – Sept 30, 2017	60,000 = 2*30,000
8.	The plan is shared with all stakeholders, government and community leaders, and other IAs.	Oct 1, 2017	40,000 = 2*20,000
9.	An EC Development Plan Response Team (ECDPRT) with representatives from CAB, IA and other stakeholders, e.g., Health, will be formed to implement the plan right after the Plan is shared. Preferably, 50% of the team members are from the ECDPWG and 50% are new members. ECDPRT makes the progress report to the ECDPWG on a regular basis.	Oct 7, 2017	
10.	The consultants evaluate the planning process and recommend the room for improvement to the ECDPWG.	Nov 1, 2017	
11.	ECDPWG may suggest the roll out of the pilot project to other sub projects if it proves to be successful (e.g., developing big picture view; improving intra and inter sectors collaboration, etc.).	Dec 1, 2017	
12.	Roll out of the pilot to other sub-projects between 2018 – 2019.	Jan 1, 2018 – Dec 31, 2019	
Contingency (10%)			30,000
Total			330,000

6.5 TO PILOT EC ASSESSMENT AND MONITORING SYSTEM IN SHUANGLUAN - CHENGDE & JULU

151. Since a project-wide approach to developing a provincial wide EC assessment and monitoring system may not be viable at this point of time, it is suggested to work with the CAB and IA of Shuangluan, and county government and IA of Julu respectively to pilot an EC assessment and monitoring system by mid-2018. Shuangluan – Chengde and Julu are suggested as the CAB of Shuangluan, Chengde and Julu's county government have demonstrated significant interest in this area and their leaders are very amicable to new ideas. The development of an EC assessment and monitoring system may take the following steps:

Step	Activities	Timelines	Resources
1.	ADB explores funding support (TA) to pilot the development of an EC assessment and monitoring system in Shuangluan – Chengde and Julu respectively	Mar 1, 2017	300,000 = 2*150,000
2.	ADB, with the help of HPMO, agrees with the CAB, IA and other EC providers in Shuangluan – Chengde and Julu respectively re the development of an EC assessment and monitoring system, its major components and process. For instance, the assessment system should include, but not limited to: assessment, levels of impairment, service matching, etc. The monitoring system should	Apr 1, 2017	

	include, but not limited to: care plan, care coordination, monitoring, and evaluation.		
3.	An EC Assessment and Monitoring System Working Group (ECAMWG) is formed with representatives from ADB, CAB, IA, other EC providers and other government in Shuanglun – Chengde and Julu respectively.	Apr 1, 2017	
4.	ADB assists the search of an external consultant(s) to help the developing process.	Apr 15, 2017	
5.	The consultants work with the ECAMWG to identify key stakeholders to formulate an ECAM system.	May, 15, 2017	
6.	The consultants and ECAMWG agree on the pilot's evaluation framework.	Jun, 15, 2017	
7.	ECAMWG, other stakeholders, and consultants work to complete the development of the systems.	July 1 – Dec 31, 2017	60,000 = 2 * 30,000
8.	The CAB and ECAMWG identify EC providers including sub-project IA, for a trial of the ECAM system.	Jan 1, 2018	
9.	The ECAM system is put on a trial by using existing EC providers for 6 – 9 months.	Jan 1 – Sept 30, 2018	80,000 = 4 * 20,000
10.	The ECAM system and the results of the trial are shared with all stakeholders, government (e.g., all levels of CAB and Health), community leaders, and other IAs.	Nov 1, 2018	
11.	The consultants evaluate the ECAM developing and the trial process and recommend the rooms for improvement to the ECAMWG.	Dec 1, 2018	
12.	ECAMWG may suggest the roll out of the pilot project to other sub projects if it proves to be successful (e.g., sensitivity and specificity in identifying elderly in need of care; quality reporting in place, etc.)	Dec 1, 2018	
13.	Roll out of the pilot to other sub-projects between mid-2018 – 2020.	Jan 1, 2019 – Dec 31, 2020	
Contingency (10%)			44,000
Total			484,000

6.6 TO PILOT QUALITY MANAGEMENT SYSTEM WITHIN EC/RC IN SHEXIAN

152. This is to develop a quality management system within an IA's EC environment, it is suggested to work with the IA of Shexian to pilot the development of a EC quality management system (ECQM) by 2018. The IA of Shexian is suggested because the IA has a strong medical background and appreciates the importance of quality in EC. The development of an ECQM system may take the following steps:

Step	Activities	Timelines	Resources
1.	ADB explores funding support (TA) to pilot the development of an ECQM system for the EC project in Shexian	Jun 1, 2017	200,000
2.	ADB agrees with the IA, preferably with the support of local CAB re the development of an ECQM system, its major components, and process. For instance, the QA system should include, but not limited to, quality monitoring, quality improvement and quality planning, etc.	Jun 1, 2017	
3.	An ECQM Working Group (ECQMWG) is formed with representatives from ADB, IA, CAB, other government departments e.g., Health, etc.	Jun 1, 2017	
4.	ADB assists the search of an external consultant(s) to help the developing process.	July 15, 2017	
5.	The consultants and ECQMWG agree on the pilot's evaluation framework.	Aug, 15, 2017	
6.	ECQMWG, IA, and the consultants work to complete the system.	Sept 1, 2017 – Mar 31, 2018	20,000
7.	The IA and ECQMWG, with the help of local CAB, identify EC providers including IA, for trial of the ECQA system.	Apr 1, 2018	
8.	The ECQM system is put on trial by using existing EC providers for 6 – 9 months.	Apr 1 – Sept 30, 2018	80,000 = 4 * 20,000
9.	The ECQM system and the results of the trial are shared with all stakeholders, government, community leaders, and other IAs.	Nov 1, 2018	

10.	The consultants evaluate the ECQM developing and the trial process and recommend the rooms for improvement to the ECQMWG.	Dec 1, 2018	
11	ECQMWG may suggest the roll out of the pilot project to other sub projects if it proves to be successful (e.g., quality management system is in place and service is properly monitored, etc.)	Dec 1, 2018	
12.	Roll out of the pilot to other sub-projects between 2019 – 2020.	Jan 1, 2019 – Dec 31, 2020	
Contingency (10%)			30,000
Total			330,000

6.7 TO PILOT MEDICAL AND HEALTH INTEGRATION – HORIZON (XINJI)

153. This is to identify the enabling factors for a better integration between health and elderly care. The pilot will then try to build a collaborative relationship between the medical rehabilitation center, RC (and HCBC) and one of the local hospitals by using the enabling factors identified. This is to ensure that the EC users and elderly patients will have access to a seamless health and social care continuum. The IA suggested for this pilot is Xinji as the IA has already developed a strong relationship with the First Hospital in Xinji. The pilot of medical and health integration is to be completed by 2018 and may take the following steps:

Step	Activities	Timelines	Resources
1.	ADB explores funding support (TA) to pilot the development of a horizontal integration between health and elder care in Xinji.	Jun 1, 2017	120,000
2.	ADB agrees with the IA and Xinji First Hospital (or another hospital as proposed by IA), with the support of local CAB and Health on the application of the framework for horizontal integration. For instance, the enabling factors for horizontal integration may include: but not limited to, case management, clinical practice guidelines, electronic health records, EC and health services revamp, etc.	Jun 1, 2017	
3.	A Health and Elder Care Integration Working Group (HEIWG) is formed with representatives from ADB, IA, Xinji First Hospital (or other), CAB, Health Bureau, etc.	Jun 1, 2017	
4.	HEIWG works with the Health Authority to identify types of health services occurred in an elderly care setting to be covered by health insurance.	Jun 15, 2017	
5.	IA, with the assistance of HEIWG, signed an agreement with the authority concerned regarding payment for health care services occurred in the elder care setting before mid-2018.	Aug, 15, 2017	
6.	ADB assists the search of an external consultant(s) to help build an integrated health and elder care system.	Aug 1, 2017	
7.	The consultants and HEIWG agree on the pilot's evaluation framework.	Sept 15, 2017	
8.	HEIWG, IA, and the consultants work to build the HEI system.	Oct 1, 2017 – Mar 31, 2018	
9.	The HEI system is put on trial for 6 – 9 months.	Apr 1 – Sept 30 2018	30,000
10.	The HEI system and the results of the trial are shared with all stakeholders, government, community leaders, and other IAs.	Oct 1, 2018	
11.	The consultants evaluate the building of HEI and the trial process and recommend the rooms for improvement to the HEIWG.	Nov 1, 2018	
12.	HEIWG may suggest the roll out of the pilot project to other sub projects if it proves to be successful (e.g., seamless access to health and social care, etc.)	Dec 1, 2018	
13.	Roll out of the pilot to other sub-projects between mid-2018 – 2020	Jan 1, 2019 – Dec 31, 2020	
Contingency (10%)			15,000
Total			165,000

6.8 TO PILOT A FUNCTIONAL PLAN FOR THE MEDICAL REHABILITATION CENTER (ZUNHUA)

154. This is to develop a functional plan for the Medical Rehabilitation Center (MRC) by identifying its key elements and ensuring a geriatric focus. The functional plan will then be used to help the design of the MRC. The IA suggested for this pilot is Zunhua because the IA is new to EC and will require significant capacity building both in EC and medical rehabilitation. The MRC functional plan is to be completed by 2017. The pilot may take the following steps:

Step	Activities	Timelines	Resources
1.	ADB explores funding support (TA) to pilot the development of a functional plan for Medical Rehabilitation Center in Zunhua.	Jun 1, 2017	120,000
2.	ADB agrees with the IA, with the support of local CAB, Health and local hospital re major services to be delivered by the MRC. For instance, services may include post-acute (e.g., transitional care); sub-acute (e.g., tube feeding, oxygen therapy, ostomy management), rehabilitation, end of life care, chronic disease management, primary care, etc.	Jun 1, 2017	
3.	A Medical Rehabilitation Working Group (MRWG) is formed with representatives from ADB, IA, CAB, Health Bureau, local hospital., etc.	Jun 1, 2017	
4.	MRWG works with the Health Authority to identify and to agree on the types of health services delivered in MRC, which will be covered by health insurance.	Jun 15, 2017	
5.	ADB assists the search of an external consultant to help the development of a MRC plan.	Aug 1, 2017	
6.	IA, with the assistance of MRWG, signed an agreement with the authority concerned regarding payment for health care services delivered by the MRC before 2017.	Aug, 15, 2017	
7.	The consultants and MRWG agree on the pilot's evaluation framework.	Sept 15, 2017	
8.	MRWG, IA, and the consultants work to complete the MRC functional plan.	Oct 1, 2017 – Mar 31, 2018	
9.	The MRC functional plan is shared with all stakeholders, government: Health and CABs, community leaders, and other IAs.	Apr 1, 2018	
10.	The consultants evaluate the MRC functional plan development process and recommend the rooms for improvement to the MRWG.	May 1, 2018	
11.	MRWG may suggest the roll out of the pilot project to other sub projects if it proves to be useful (e.g., a consistent approach, etc.)	May 1, 2018	
12.	Roll out of the pilot to other sub-projects between mid 2018 – 2020.	Jun 1, 2018 – Dec 31, 2020	
Contingency (10%)			12,000
Total			132,000

6.9 TO DESIGN EC WITH CARE IN MIND

155. That IAs and their designing team should work closely with the Project Design Consultation Team to ensure essential elements of care as mentioned under 4.9 and Annex H is included in their respective FSR.

6.10 TO DEVELOP HOUSING OPTIONS FOR THE ELDERLY IN HEBEI

156. That Hebei Government may want to consider the split of housing need from RC. The biggest private market for elderly in developed countries is housing that is designed to meet the lifestyle need of the elderly. This may be one of the areas that PPP may do well too.

7.0 M&E ARRANGEMENTS AND KEY INDICATORS

7.1 OUTPUT 2

157. It is expected that at the end of the project, RC service capacity will be increased and quality of RC services will be improved. In specific, there are four sub-outputs

- a) Number of RC bed places created by the project IAs by 2022 (2016 baseline: XXX total, XX female, X male)
- b) Average occupancy of RC beds provided under the project reaches XX% by 2022 (2016 baseline: 0%) Occupancy to be disaggregated by gender and social status
- c) X% of caregivers and other technical staff with certification increased to XX% by 2022 (2016 baseline: XX%)
- d) All residential facilities constructed under the project implement agreed staffing plans and 75% of staff are appropriately certified.

Results Chain	Performance Indicators with Targets & Baselines	Data Sources & Reporting	Risks
Residential EC service capacity increased and quality improved	Number of residential elderly care bed places created by the project IAs by 2022 (2016 baseline: XXX total, XX female, X male)	HPMO Project monitoring reports, semiannual	Demand assumptions are all supply side based and real demand for residential beds is hard to ascertain.
	Average occupancy of residential care beds provided under the project reaches XX% by 2022 (2016 baseline: 0%) Occupancy to be disaggregated by gender and social status		Potential conflict of interest arises between the project objective of targeting low to middle income elderly and the IAs natural desire to maximize revenue by targeting higher income elderly with higher discretionary spending power.
	X% of caregivers and other technical staff with certification increased to XX% by 2022 (2016 baseline: XX%)		Regulatory staffing requirements are no enforced.
	All residential facilities constructed under the project implement agreed staffing plans and 75% of staff are appropriately certified.		

7.2 OUTPUT 4

158. It is expected that at the end of the project, EC sector capacity will be improved. In specific, there are four sub-outputs that will be addressed by this Section 6.0 off this technical report:

- a) All project city governments to have comprehensive EC sector development plans approved (including financing section) by 2020 (2016 baseline: 0), – see Section 6.4
- b) At least two health/EC integration pilots implemented by 2020 - see Section 6.7
- c) All project cities introduce formal assessment systems for EC services by 2020 – see Section 6.5
- d) Development of a pilot integrated EC/health service support IT system by 2019, with rollout to all project cities by 2022. See Section 6.5

Results Chain	Performance Indicators with Targets & Baselines	Data Sources & Reporting	Risks
Capacity of the EC Sector Organizations Improved.	All project city governments to have comprehensive EC sector plans approved (including financing section) by 2020 (2016 baseline: 0) – see 6.4	ADB review missions to assess	Lack of “buy-in” from HCAD and local CABs Sector barriers for improved health EC integration remain in place
	At least two health/EC integration pilots implemented by 2020 - see 6.7		
	All project cities introduce formal assessment systems for EC services by 2020 – see 6.5		
	Development of a pilot integrated EC/health service support IT system by 2019, with rollout to all project cities by 2022. See 6.5		

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9.0 ANNEXES

A. Policies and Legal Framework of EC industry in China and Hebei

People Republic of China (中华人民共和国)

[主席令]中华人民共和国老年人权益保障法 (2012/12/28)

State Department (国务院及各部委)

(52) [住建部]老年人居住建筑设计标准(2003/5/28)

(53) [民政部]社区老年人日间照料中心建设标准(2011/3/1)

(54) [民政部]老年人养护建设标准(2011/3/1)

(55) [老龄办]关于进一步加强老年人优待工作的意见(2013/12/30)

(56) [国务院]关于促进健康服务业发展的若干意见(2013/09/28)

(57) [国务院]关于加快发展养老服务业的若干意见(2013/09/06)

(58) [国务院]关于创新重点领域投融资机制鼓励社会投资的指导意见(2014/11/26)

(59) [民政部]关于贯彻落实《养老机构设立许可办法》和《养老机构管理办法》的通知
2013/07/08)

(60) [民政部]《养老机构设立许可办法》(2013/06/28)

(61) [民政部]《养老机构管理办法》(2013/06/28)

(62) [民政部]关于推进养老服务评估工作的指导意见(2013/07/30)

(63) [民政部]关于开展公办养老机构改革试点工作的通知(2013/12/13)

(64) [民政部]关于开展国家智能养老物联网应用示范工程的通知(2014/06/20)

(65) [民政部等联合发布]关于推进城镇养老服务设施建设工作的通知(2014/05/28)

(66) [民政部等联合发布]关于加强养老服务标准化工作的指导意见(2014/01/26)

(67) [民政部等联合发布]关于开展养老服务业综合改革试点工作的通知(2013/12/27)

(68) [民政部等联合发布]关于做好养老服务业综合改革试点工作的通知 (含清单)
(2014/07/30)

(69) [民政部等联合发布]关于开展养老服务业统计工作的通知 (2014/12/8)

(70) [住建部等联合发布]关于加强养老服务设施规划建设工作的通知(2014/01/28)

(71) [住建部等联合发布]关于加强老年人家庭及居住区公共设施无障碍改造工作的通知
(2014/07/08)

(72) [住建部]关于发布国家标准《养老设施建筑设计规范》的公告

(73) [国土部]关于印发《养老服务设施用地指导意见》的通知(2014/04/17)

(74) [发改委等联合发布]关于加快推进健康与养老服务工程建设的通知(2014/09/12)

(75) [发改委等联合发布]关于组织开展面向养老机构的远程医疗政策试点工作的通知
(2014/06/16)

- (76) [发改委]关于开展政府和社会资本合作的指导意见(2014/12/2)
- (77) [教育部等联合发布]关于加快推进养老服务业人才培养的意见(2014/06/10)
- (78) [财政部等联合发布]关于减免养老和医疗机构行政事业性收费有关问题的通知
- (79) [财政部等联合发布]关于做好政府购买养老服务工作的通知(2014/08/26)
- (80) [财政部等联合发布]关于建立健全经济困难的高龄、失能等老年人补贴制度的通知(2014/09/10)
- (81) [财政部]关于推广运用政府和社会资本合作模式有关问题的通知(2014/09/23)
- (82) [财政部]关于印发政府和社会资本合作模式操作指南（试行）的通知(2014/11/29)
- (83) [保监会]关于开展老年人住房反向抵押养老保险试点的指导意见(2014/06/17)
- (84) [保监会等联合发布]关于推进养老机构责任保险工作的指导意见(2014/02/28)
- (85) [国家新闻出版局等联合发布]关于公布首届向全国老年人推荐优秀出版物的通知(2014/09/28)
- (86) [卫计委]关于加快发展社会办医的若干意见(2013/12/30)
- (87) [卫计委]关于成立卫生计生老龄工作领导小组的通知(2014/03/14)
- (88) [卫计委]关于开展计划生育家庭养老照护试点工作的通知(2014/09/17)
- (89) [卫计委]关于印发老年健康核心信息的通知(2014/10/07)
- (90) [卫计委]关于印发《养老机构医务室基本标准（试行）》和《养老机构照护站基本标准（试行）》的通知(2014/10/31)
- (91) [人社部等联合发布]关于进一步做好基本医疗保险异地就医医疗费用结算工作的指导意见(2014/11/18)
- (92) [商务部]关于推动养老服务产业发展的指导意见(2014/11/14)
- (93) [商务部等联合发布]关于外商投资设立营利性养老机构有关事项的公告(2014/11/24)
- (94) [商务部等联合发布]关于香港、澳门服务提供者在内地举办营利性养老机构和残疾人机构服有关事项(2013/2/17)

Hebei

- 9. "The 12th Five-Years Plan for EC in Hebei Province"
河北省老龄事业发展“十二五”规划
- 10. "Opinions on speeding up the building of an EC System" (2014/6/24)"
河北省人民政府《关于加快推进养老服务体系建设的意见》
- 11. "Opinions on speeding up the development of EC", was issued by the provincial government (2014)".
河北省人民政府《关于加快发展养老服务业的实施意见》
- 12. "Notice about implementing tax reliefs to support the development of EC organizations (2011)"
河北省民政厅《关于落实国家支持老年服务机构发展税费减免政策的通知》

13. "Opinions on the implementation of rewards and subsidies for EC organizations (2012)"
河北省民政厅财政厅《关于对养老服务机构实行奖补的意见（试行）》
14. "Notice about land supply for the building of EC organizations" issued by the Department of Land and Resources and the Department of Civil Affairs (2011).
河北省民政厅国土资源厅《关于做好建设养老机构用地工作的通知》
15. "Notice about providing free training and accreditation for current EC workers" (2011).
河北省人保厅财政厅民政厅《关于对在岗养老护理员开展免费职业培训和技能鉴定工作的通知》
16. "Guiding opinions on speeding up the implementation of subsidy for elderly in advanced age" was issued by the Department of Civil Affairs (2012)"
河北省民政厅《关于加快建立高龄老人生活补贴制度的指导意见》

B. National legislation and policies

1. The Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly (2013)²⁹²

This legislation is an overarching framework, which outlines the rights of the elderly of PRC. It includes rights of elderly to receive:

- i. Care and supports from their families
- ii. Social security such as people requiring long term care as target population of EC (#30)
- iii. Social services including EC: services (#37 & 38); priority for the widows disabled and advanced age (#41); services standards for EC facility construction, service and manpower, classification of EC facilities, assessment, service monitoring and fee charging (#42).
- iv. Priorities of service and social benefits such as housing, legal aids etc.
- v. Livable environment
- vi. Social participation and development
- vii. Legal protection and responsibility

2. A development plan for elderly care system (2011)

This document operationalizes the 12th Five Year plan by providing a definition of the elderly care system and its components, which is issued by State Council.

- ii. The elderly care system is defined as: home-based care as the base, community care as backbones, and residential care as supports. Among them, home-based care is defined as to include personal care, home care, rehabilitation, medical and nursing care, and psychological comforting. Community care includes day care and supports for home-based care. Residential care includes all residential facilities such as nursing home and other forms where old people are supported in their daily living and activities.
- iii. Multiple sources of funding are proposed such as land, taxation and government purchase of services. Welfare lotteries funds are required to prioritize the development of elderly care facilities. Local government is required to design policies to attract social organizations to provide services.

3. Opinions on government purchasing services from social organizations (2013)

This is the major document governing government purchasing services from social organizations, which was issued by State Council in September 2013. It was expected that by 2020 a well-developed system of government purchasing services from social organizations will be in place all over the country.

²⁹² <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201302/20130200418213.shtml>

- i. Definition of the contractual parties: Government, institutions with public administrative responsibilities and public funded mass organizations are all allowed to purchase services from social organizations. All social organizations that are registered through civil affairs, and enterprises and other social entities registered in the industry and commerce department are eligible for entering contract with government for providing services.
- ii. What can be purchased? All public services deemed suitable for provision through the market, and which social organizations have the capacity to provide, can be provided through purchasing services. The scope of government purchasing service should gradually expand in such basic public services as education, employment, social security, culture and physical education activities, and services for people with disabilities; other public services should be provided as much as possible through social organizations; and those services that should be provided by the government directly should not be provided through purchasing services. Local government is required to make a list of service items suitable to be purchased from social organizations.
- iii. Methods of government purchasing services: Government purchasing services should be conducted transparently. Providers can be selected through different methods such as open bidding, inviting providers, competitive negotiation, selecting a single provider, or through price comparison.
- iv. Funds used by government purchasing services are part of government budget.
- v. Performance management: Comprehensive performance evaluation mechanism should be established with participation of government, the service provider, and service users. The results of the evaluation should be disseminated to the society.

4. **State Council (Circular No. 35). Opinions on Promoting the Development of Elderly Care Service Industry, 2013.** ²⁹³

This document provides the overarching guidelines for the development of the elderly care system in China, which was issued by State Council. It reaffirmed the principle of home-based care as the base, community care as the backbone, and residential care as support, and it called for the setting up of such a system all over the country by 2020. By then, all urban communities should have established a day care center and an activity center for old people with defined quality standards; over 90% of townships and 60% of rural communities should have a comprehensive community service center in place, which include the provision of elderly care services. The development of EC service industry will be based on four principles:

- v. System reform by simplifying administrative interference, strengthening policy support and monitoring, enhancing quality and efficiency.
- vi. Protecting the basic needs of the elderly especially the 3 “Nos” and elderly in rural areas.

²⁹³ <http://jnjd.mca.gov.cn/article/zyjd/zcwj/201310/20131000534003.shtml>

- vii. Coordinated development so as to realize the effects of integrated care and services.
- viii. Perfecting the market system.

This document comes with an annex, which provided further deliberation about human resources development and planning. This includes means for attracting more people to enter the EC industry through professional/vocational training, credentialing and employment subsidy.

5. Announcement of good practice in government purchasing of elderly care services (2014)

This is the major policy guideline for government purchasing elderly care services. It was jointly issued by the Ministry of Finance, National Development and Reforms, Ministry of Civil Affairs, and National Aging Committee in 2014.

- ii. Target population: government purchasing elderly care services should be demand-based, focusing on needs of the elderly for daily living activities and rehabilitation. Priority should be given to the needs of widows, impaired old people and those of advanced age, who have financial difficulties.
- iii. The role of the government: leading, planning, providing policy support and funding, and monitoring and evaluation.
- iv. The types of HCBC services to be purchased: 1) home care services include meal services, personal care, health services, and nursing care for old people eligible for government subsidies; 2) community care include day care, rehabilitation, and cultural and physical education activities; 3) residential care include residential care and nursing care for “three no’s” and dependent and semi-dependent elderly people with low-income and financial difficulties; 4) training and continuous education for caretakers and nurses; and 5) needs assessment and evaluation of quality of services.
- v. Service standards: Local government is required to formulate service standards for elderly care HCBC services and organize regular monitoring and evaluation activities.
- vi. The department of finance will lead the purchase of services. Civil affairs and other concerned parties are required to provide coordination.

6. Opinion on the implementation of involvement of private capital in EC industry development. (Civil Affairs Circular 33), (2015) ²⁹⁴

This is a joint statement by Ministry of Civil Affairs, Reform and Development Committee, Ministry of Education, Ministry of Finance, Ministry of Human Resources and Social Security, Ministry of Land and Resources, Ministry of Housing and Urban-Rural Development, National Health and Family Planning Commission, China Banking Regulatory Commission, China Insurance Regulatory Commission. The statement encourages private sector

²⁹⁴ <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201502/20150200777798.shtml>

- i. in the provision of home and community care including the use information platform (ICT) in EC
- ii. in the provision of franchised and sizeable residential care through share and PPP to realize economy of scale and scope.
- iii. In the provision of grey market such as rehabilitation aids, medicine and nutritional products, clothing etc.,

This is done through enhancement of investment policy in EC, e.g., government guaranteed loan, increasing the proportion of lottery fund available to EC, taxation benefits.

It also covers the development of health and social care integration, allowing health care professionals, e.g., physicians, to practice in social care setting, allowing some health care services provided in social care setting to be reimbursed by national health insurance,. National Health and Family Planning Commission helps to credential health care professionals in social care setting, etc.

7. **Civil Affairs directives on the promotion of active involvement of private capital in EC industry development. (2016)** ²⁹⁵

Civil Affairs issued this statement on May 30, 2016 after the Chinese President made an speech on EC on May 27, 2016. The statement summarized government directions on the following areas:

- iii. Promoting the Development of Elderly Care Service Industry, which reinstates (1) State Council (Circular No. 35). Opinions on Promoting the Development of Elderly Care Service Industry, 2013 and (2) Civil Affairs Circular 33 - Opinion on the implementation of involvement of private capital in EC industry development, 2015. The latter is a joint statement by multiple ministries.
- iv. Government role in creating friendly environment for investment by the private sector such as
 - (F) establishing legal structure (Section #2.1): (1) Legislation on the management of residential care (RC) (2013) and (2) Permission for the establishment of EC/RC facility (2013);
 - (G) enhancing government service function (Section 2.2): (1) transparency, (2) direction, (3) speed up inspection and (4) optimize EC permits application.
 - (H) Enhancing government leadership role in EC investment. For instance, no less than 50% of lottery fund will be invested in EC industry.
 - (I) Supporting fund raising of private sector through different venues: shares, funding pool, insurance, PPP, etc.
 - (J) Creating a fair competition environment for EC industry, e.g., pricing management and EC manpower recruitment and retention.

²⁹⁵ <http://www.mca.gov.cn/article/zwgk/mzyw/201605/20160500000681.shtml>

8. Announcement of establishing subsidizing system for impaired and senior old people with financial difficulties (2014)

Jointly issued by the Ministry of Finance, Ministry of Civil Affairs, and National Aging Committee in 2014, this announcement is aimed to operationalize the State Council's 2013 Opinions on Speeding up the Development of Elderly care industry, which required the establishment of a subsidizing system for impaired and senior old people with financial difficulties. It expects to set up such a system by the end of the 12th Five-Year plan period (2011-2015).

- i. Target population: impaired and senior old people with financial difficulties. Eligibilities for subsidies for “senior old people with financial difficulties” are determined by county level civil affairs, and that of “impaired old people with financial difficulties” is to be determined by county level health institutions.
- ii. Benefits: elderly care subsidies are for care needs; if these old people meet with difficulties in daily living, they should be provided through pensions, *dibao* and other social assistance programs. Elderly care subsidies can be paid either in cash or vouchers.
- iii. Benefit standards: local government determines the standards based on local economic and financial conditions and changes in the prices of goods. Provincial government can make provincially unified standards if conditions allow, and other places can determine the rate by the city or county government according to their local conditions.
- iv. Funding: local government bears the funding for elderly care subsidies.

9. Legislation on the management of residential care (RC, (2013)²⁹⁶

Ministry of Civil Affairs and covers issued this legislation:

- v. Services to be delivered by RC: ADL/IADL, nursing, rehabilitation, mental health and social recreational activities (Section #9); ADL/IADL including eating, dressing, toileting, bathing, in and outdoor activities (Section #12); preventive health care including periodical functional and health assessment (Section #13); emergent health care and infection control (Section 14)
- vi. Management support in RC: risk and safety management (Section #17, 21, 22, 23 and 24); professional staffing requirements and credentialing (Section #19); privacy (Section #25) and periodical collection of users' feedback (Section #26).
- vii. Monitoring by local Civil Affairs Departments including periodical comprehensive evaluation of RC operation: staffing, facilities, service, management and reputation (Section #29); statistical report by RC operators (Section # 30); inspection on spot and making the inspection reports available to the general public (Section #28); and handling of complaints (Section #31).

²⁹⁶ <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201306/20130600480076.shtml>

- viii. For those RC operators who repeatedly failed to comply with the law, a fine of not more than 30K Yuen will be imposed,

10. Permission for the establishment of EC/RC facility, (2013)²⁹⁷

The Ministry of Civil Affairs and aims at providing a general framework for the establishment of EC/RC facilities in China issued the directive. It includes the operation permit application, renewal and cancellation procedures (e.g., >10 beds), monitoring and liability.

11. Opinions on strengthening the standardization of elderly care, (2014)²⁹⁸

This is a joint directive by the Ministry of Civil Affairs, Standardization Committee of China (SAC), Ministry of Commerce, General Administration of Quality Supervision, Inspection and Quarantine of the People's Republic of China (AQSIQ) and The National Working Committee on Ageing. The directive is set to achieve universal standards of all EC service, management and products covering home, community and residential care (Section #3.1). The directive also suggested the establishment of EC quality management and ranking (e.g., ranking by star) systems through accreditation by an independent 3rd party (Section #3.4). Another important message of this directive is about the standardization of human resources development in EC especially for professionals and managerial; as well as standardization of EC information sharing of EC through the use information technology (Section #4.3). All these can first be proven by pilot and/or demonstration projects before a national roll out.

²⁹⁷ <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201306/20130600480075.shtml>

²⁹⁸ <http://www.mca.gov.cn/article/zwgk/fvfg/shflhshsw/201402/20140200585735>

E. Key Points of National Policy on Health and Social (Elderly) Care Integration²⁹⁹

On November 18, 2015, the Office of the State Council issued The Guidance Opinions for Integrating Health and Elderly Care. Its supporting policy was enacted Family Planning Commission at April 1, 2016, that is the Collaborative Approach for Ministries and Commissions to Integrate Health and Elderly Care in Key Areas. The main policy points are presented herein.

- The existing long term care institutions are encouraged to enter into formal binding agreements with the existing health care organizations in the communities.
- Health care organizations are required to provide timely appointments for the elderly who need outpatient and inpatient health care services.
- The existing hospitals are allowed referring elderly patients to the existing long term care facilities qualified to deliver medical services.
- The existing hospitals and long term care institutions are encouraged to support and integrate with each other to address the total care of all patients/residents, including hospice care.
- The health insurance covers medical care services delivered by the qualified medical component of the long term care institutions.
- Encourage the existing community health centers to provide continuous health managements and services, including home health care, for the frail older people, the disabled, the seriously diseased, and the families lost their single child. Integrating hospital and home health care is encouraged.
- Improve the capabilities of community health centers to deliver home health care. Qualified home health services are reimbursed by the health insurance.
- There are opportunity priorities for private adventures to integrate health and elderly care without any policy barriers.
- Increase financial supports for integrating health and elderly care; and the PPP model is encouraged to practice for this purpose.
- Long term care insurance is encouraged to pilot in some provinces with better conditions.

²⁹⁹ In Appendix 1 of “Targets for integrating health and elderly care” a paper prepared by Andy Qinggong Li, ADB consultant (national), on April 28, 2016.

- Developing any curricula related to elderly care will be supported to train more professionals in geriatric medicine, rehabilitation, nursing, nutrition, mental health, and social work.
- Plan to select pilot projects for integrating health and elderly care as successful models.
- Enhance monitoring seamless elderly care between health and elderly care organizations.
- The integrated health and elderly care system and mechanisms will be developed and resources of both sectors will be shared by the year 2020 in the context of mainland China.

F. Clinical issues of RC (samples)

39. Abuse/Neglect of Clients/Residents
40. Acute Confusion (Clinical Practice Guidelines)
41. Activities of Daily Living
42. Advance Directive and Levels of Intervention (Clinical Practice Guidelines)
43. Agitated Behaviour (Clinical Practice Guidelines)
44. Bereavement (Clinical Practice Guidelines)
45. Bowel Care and Bowel Record Form
46. Catheter Drainage System: Maintenance
47. Catheters: Indwelling Urinary
48. Constipation, Management of (Clinical Practice Guidelines)
49. Dental Services
50. Depression, Management of (Clinical Practice Guidelines)
51. Dysphagia
52. Eye Care
53. Eye Prosthesis: Care of
54. Falling, Management of (Clinical Practice Guidelines)
55. Feeding Techniques
56. Gastrostomy & Jejunostomy in Established Tract: Maintenance
57. Hygiene
58. Least Restraint Policy
59. Medication Update
60. Medications: Obtaining After Regular Pharmacy Hours
61. Medication: Storage and Distribution of Narcotic and Controlled Drugs
62. Mental Status Examination (MMSE)
63. Mouth care
64. Pain, Chronic, Management of (Clinical Practice Guidelines)
65. Perineal Care
66. Podiatry Services
67. Rehabilitation Service
68. Skin Integrity, Management of (Clinical Practice Guidelines)
69. Sleep: Chart and Survey Focus Review
70. Social cultural recreation Services
71. Tracheostomy Tube: Care of Established
72. Vital Signs
73. Wandering Persons
74. Management of Urinary Incontinence (Clinical Practice Guidelines)
75. Management of Wound (Clinical Practice Guidelines)
76. Supplemental Services for Residents

G. EC principles and values

1. Active Ageing – Support the promotion of overall well-being. All EC users are entitled to the services necessary to enable them to achieve and maintain an optimal level of functioning and to assist them to live happy and active lives. EC is to help its users to achieve and maintain an optimal level of functioning and independence; and to acquire the necessary skills to adapt to a changing health status. EC should also prevent its users from moving towards more complex and expensive care due to illness, injury and disease.
2. Ageing in place and deinstitutionalization – Support elderly to stay in their in their most familiar environment and living environment of choice for as long as possible. All EC services are means to meet this end.
3. Mainstream ageing – What good for the elderly should also be good for all other age groups. It aims at creating a society for all and making viewing older people as a positive dynamic rather than a threat/burden to society. Universal design, which is a good example, is good for elderly with irreversible disability and is also good for younger people with temporary disability.
4. Client-focused care - Organize the provision of EC services to meet the changing needs of its users. This calls for better integration of EC services within and outside current EC system through intra and inter sector collaboration. EC users are not passive service recipients and have an important decision making role in their care. They should have access to the necessary information in order to make informed decisions concerning their lifestyle and how they are being taken care of.
5. Family and Volunteer Involvement - Involve families and volunteers in the caring of EC users and recognize families' primary responsibility for the wellbeing of the elderly. Both the families and volunteers could contribute significantly to meet the social and emotional needs of the EC users.
6. Quality of Care - Put emphasis on providing a high quality of care services to the EC users, first by doing no harm, then by doing good. Service Operator should continuously strive to improve the quality of care.
7. Partnership and Community Involvement - Promote collaboration and shared responsibility between Service Operator and the Government; between different professional disciplines (e.g. nurses and social workers) and between different sectors (e.g. profit and nonprofit making, health and social welfare sectors etc.) to achieve positive outcomes and success of the Services.

H. Clinical services of a Medical Rehabilitation Center

1. Transitional care refers to the coordination and continuity of health care during a movement of patient from one healthcare setting to either another or to home. Older person, because of age, may require longer recovery time. They may not be required to stay in hospital during their recovery. Instead, a less acute setting such as geriatric hospital or RC may offer a friendlier convalescent environment for the older patients and may be less costly. In addition, older adults who suffer from a variety of health conditions often need health care services in different settings to meet their many needs. For instance, acute hospital helps to stabilize an acute condition of a disease such as stroke. After an acute stage of a stroke, the patient may be transferred to a sub-acute hospital for continuing care. Transitional care can be either inpatient care at a geriatric hospital, RC or outpatient care through HCBC.
2. Rehabilitation refers to health care dedicated to improving, maintaining or restoring physical and cognitive strengths. It helps people, especially older people to regain greater independence after illness or injury. It is about the process of helping an individual to attain the highest level of function, independence, and quality of life possible. The focus of rehabilitation is not on reversing or undoing the damage caused by disease, but rather on the restoring of individual functioning and wellbeing. For instance, a stroke patient may cause the patient inability to mobile and speak properly. Physiotherapy aims at improving mobility whereas speech therapy aims at improving speech. Rehabilitation can be either inpatient care at a geriatric hospital, RC or outpatient care. Routine rehabilitation can even be carried out in HCBC setting such as adult day care and home care rehabilitation program.
3. Geriatric day hospital refers to health care setting dedicated to the assessment of geriatric patients especially those who suffer from cognitive impairment. It is not easy to identify people with dementia especially at the very beginning of the disease course. One outpatient visit may not provide any clue of cognitive impairment. The geriatric day hospital, which assess prospective patients at interval, such as 2–3 times in a week or month, help to identify inconsistency. Geriatric day hospital is often staff by a multidisciplinary team, which assesses, diagnose and provide guidance of care afterward.
4. End of life care offers health care, not only to those in the final hours or days of their lives, but more broadly to those with terminal conditions that has become advanced, progressive and incurable. End of life care goes beyond pain control; it is about providing physical, psychosocial and spiritual comfort for patients during the final stage of their lives. Thus its approach is always multidisciplinary. With advance in pain control medication, end of life care is now taking place in outpatient clinic with support of HCBC. The patient may then be only admitted to a geriatric hospital with end of life care at their final hours or days. End of life care is one of the health and social (elderly) care integration proposed by the Chinese government.

5. Chronic disease management encompasses education activities conducted by health care professionals to help patients with chronic diseases such as diabetes, high blood pressure, etc., to understand their condition and to live successfully with it. The work involves motivating patients to persist in necessary therapies and interventions and helping them to achieve an ongoing, reasonable quality of life. Patients with chronic conditions have an important role in the management of their conditions through self-management. Quite often, multiple chronic diseases coexist, which calls for input from multiple specialists. This requires close coordination among multiple specialists and settings. Unfortunately, there has not always been the case in practice. This along with the complicated treatment modalities of chronic conditions, makes it hard for patients to comply with treatment protocols. Chronic disease management can take place in primary care clinics of the geriatric hospital as outpatient. In 2012, nearly 80% of deaths among people aged 60+ in China was attributable to chronic (noncommunicable) diseases (WHO, 2012a; see Figure 2).
6. EC special clinics refer health care clinic set up to deal with issues pertaining to EC. These clinics can be part of the primary care clinics or stand alone clinics of the geriatric hospital for elderly residing in the community including RC. EC special clinics may include, but not limited, to the followings:
 - i Memory clinic specializes in diagnosis and management of conditions impacting memory and thinking such as mild cognitive impairment (MCI).
 - ii Wandering clinic specialized in dealing with wandering or getting lost especially among people with cognitive impairment. This behavior can happen at any stage of dementia development.
 - iii Incontinence clinic specialized in bladder control, which can be a common and often embarrassing problem among older people. The severity ranges from occasionally leaking urine when one coughs or sneezes to having an urge to urinate that's so sudden and strong one doesn't get to a toilet in time.
 - iv Fall prevention clinic specialized in dealing with fall which can be a serious medical complications such as hip fractures and head injuries. Fall prevention clinic provides comprehensive evaluation and specific recommendation to people who have a history of falls with unknown reasons.
 - v Eye and hearing clinic specialized in simple eye and hearing examinations and recommendations to improve eyesight and hearing. Poor vision and hearing loss are two contributing factors of fall. Older people tend to attribute these problems to normal ageing process. Improved eyesight and hearing enhance quality of life.

I. Admission criteria for home/community and residential care³⁰⁰

Home/Community Care	Residential Care
Overall	
Clients will be assessed as not able to safely cope in their home or other community living options with or without informal support.	Clients will be assessed as not able to safely cope in their home or in a lower level living option with or without formal support.
Medical conditions	
<ul style="list-style-type: none"> • Medical condition is stable and appropriately managed without a 24-hour on-site RN or LPN. • PRN (unscheduled) medication assistance available if client capable of making request 	<ul style="list-style-type: none"> • Complex unpredictable needs but are clinically stable and can be managed safely with 24-hr. on site RN and regularly scheduled and unscheduled on-site physician support – <ul style="list-style-type: none"> - Complex end of life care - Complex medication management - Complex nursing interventions ▪ Unscheduled assessments are often required to address changing resident care issues.
Cognitive Status	
<ul style="list-style-type: none"> ▪ May have mild dementia but behaviorally stable ▪ May require unscheduled reassurance ▪ No known risk of elopement but may wander, is easily redirected ▪ Awareness of personal space of others ▪ Social behavior does not induce fear and anxiety to other in their living setting ▪ No known risk of self-harm or harm to others 	<ul style="list-style-type: none"> ▪ May have any stage of dementia ▪ May have unpredictable behaviors placing self and others at risk
Functional Status	
<ul style="list-style-type: none"> ▪ Mobilizes independently or with one-person transfer ▪ Requires unscheduled personal care (assistance with management of incontinence, cueing and/or assistance with meals, transportation to meals, direction and/or cueing for initiation and completion of 	<ul style="list-style-type: none"> ▪ Will have complex physical needs with care requirements that cannot be met at home or in a supportive living environment ▪ May require the following types of assistance with Activities of Daily Living (ADL): <ul style="list-style-type: none"> - Complex nutritional intake requirements

³⁰⁰ Alberta Health Services, Canada for publicly funded elderly services or long term care service.

activities, assistance with prepackaged scheduled medications) ▪ Able to call for help using a call system	- Intensive and extensive rehabilitation requirements - Complex elimination requirements
Social Support	
▪ Informal caregivers remain a welcome and integral contributor to the person-centered plan of care	▪ Informal caregivers remain a welcome and integral contributor to the person-centered plan of care ▪ May be complex family dynamics requiring 24-hours/7-days RN/SW on-site interventions
Exclusion Considerations:	
▪ Complete meal assistance if dietitian support / consultation is not available ▪ Mechanical lift transfers ▪ Two-person transfers ▪ Chronic unmanaged incontinence not amenable to interventions	Clients with unstable acute medical or psychiatric conditions who require acute care hospitalization

J. Expectations/Requirements for Physical Environment of RC

Physical Design	Requirements	Desirable features
Size	(i) Minimum of 50 beds in order to accommodate an adequate and efficient staffing plan	(ii) Potential to expand if required and to support home and community care
General design	<ul style="list-style-type: none"> • Creating a homelike environment that is distinct from an hospital or institutional setting through the use of lighting, wood like materials for doors, frames, pot lights, lamps, millwork. • Furniture that is homelike, use of wood products whenever if possible • Homelike storage areas/cupboards in hallways or key areas to eliminate typical linen/supply carts and equipment of an acute hospital. • Create comfortable, calm and quiet setting with no overhead paging, quiet call bell system, etc. • Internet access 	<ul style="list-style-type: none"> • Use warm light and not fluorescent white light • Wire-in bed alarm system or wireless system using portable phones, pagers with vibrating mode
Resident room	<ul style="list-style-type: none"> • Sufficient space for the maneuver of equipment around bed if necessary • Storage with either a locked drawer or cupboard for personal valuables. • Shelves and ledges for personal belongings and family pictures. • Private phone lines, cable and music system in each room. • Building materials include wood-like products that create a homelike setting (e.g., headboards, cupboards, closets, shelves, storage and over bed tables). • Dimmable lighting or lamps and/or wall sconces. • Provision for safe transfer of residents (e.g., ceiling lift). • Extra electrical outlets (e.g., for TV, stereo, lamps, etc.). • Private room with toilet and sink. 	<ul style="list-style-type: none"> • Ceiling lifts in each resident room (track color may be changed to match ceiling color). • Installation of ceiling lift for transfer of residents in and out of beds and to and from bathroom. Track into resident bathroom; lift and wall charger stored in bathroom. • internet access if possible • Space for a television that residents can watch from their beds. • En suite bathroom with showers are not required; however, if they are present they must be designed to accommodate a wheelchair and safe transfer of residents by multiple caregivers.
Reception area	Reception area should be separated from nurses' station.	Close to the main entrance
Nursing station	<ul style="list-style-type: none"> • Nurses' station screened from view as much as possible in order to reduce "clinical environment". 	

Physical Design	Requirements	Desirable features
	<ul style="list-style-type: none"> • Workspaces for unit clerk, nurses and other team members (e.g., one to six people at any given time). • Provides safe distance from families/residents and allows for staff to chart privately. • Nurse call station. • Medication area with locked medication cupboard, locked cupboard for • resident valuables, medication preparation area, sink, small fridge for meds and security as required, (e.g., locked medication room vs. area in open station). • Space for storing two medication carts and paper supplies. • Computers (2), fax, photocopier, telephone. • Ergonomically correct computer workstations. 	
Memory box	<ul style="list-style-type: none"> • A box located at the entrance of the resident room. The box contains resident's picture and other items for easy room identification 	
Kitchen and dinning room	<ul style="list-style-type: none"> • Main (working) kitchen area should include sink, commercial oven, fridge, commercial dishwasher, cupboard and counter space. • Kitchen area for family to prepare drinks and snacks including a small fridge, cupboards, sink and microwave. • Dining table and chairs to accommodate residents who enjoy group dinning 	<ul style="list-style-type: none"> • Kitchen area wheelchair accessible (at least in part).
Central bathing facilities	<ul style="list-style-type: none"> • "Spa-like" environment. • Adequate circulation space to ensure resident/staff safety. • Wheelchair accessible shower, therapeutic tub, sink, toilet. • Floor drain. 	<p>Stretcher tub with lift preferred; consult with occupational therapist prior to purchase.</p> <ul style="list-style-type: none"> • Should be located near residents' bedrooms.
Access to outdoors	<ul style="list-style-type: none"> • Must have centralized access to outdoor space • In considering access to outdoors, there should be recognition of security issues and issues related to the population served 	<ul style="list-style-type: none"> • Garden can be accessed from patios from individual room • Doors and ramps accommodate beds • Night lighting in garden area

Physical Design	Requirements	Desirable features
	<ul style="list-style-type: none"> Doors and ramps to outdoor area accommodate wheelchairs and reclining chairs Garden area has solid pathways for walkers and wheelchairs 	<ul style="list-style-type: none">
Laundry facilities	<ul style="list-style-type: none"> Must have a commercial laundry specifically for residential care Counter space, laundry sink and flushing sink required for soaking and rinsing soiled linens and garments. Storage space is required for soiled laundry. Laundry room is considered a “soiled” area and a clear functional flow of soiled to clean is required, with separation and storage of soiled and clean laundry. 	<ul style="list-style-type: none"> Depending on numbers of residents, full size heavy-duty washers and full size heavy-duty dryers required; due to regulations, family use of working laundry not permitted.
Meeting room and office space	<ul style="list-style-type: none"> Multi purposes such as family conference, education sessions and team meetings; should have space for table and chairs for 10-12 people; acoustical requirements for confidentiality Adequate office space 	<ul style="list-style-type: none"> Separate office available for supervisors/team leaders
Storage	<ul style="list-style-type: none"> Adequate storage for clean and dirty supplies, linen and equipment (including wheelchairs, walkers, commodes etc.) in order to eliminate clutter in hallways, resident rooms and bathing areas. Storage rooms or cupboards with hidden doors; ability to lock these storage rooms/cupboards. 	
Safety and security	<ul style="list-style-type: none"> Ability to prevent wandering residents from leaving unit/building and safety provide extended hours access to visitors Security for staff safety Secure storage of medication and controlled substance Smoke detectors Emergency generator for provision of minimal service 	
Entrances	<ul style="list-style-type: none"> Two entrances – one for visitors and one for funeral home personnel 	
Parking	<ul style="list-style-type: none"> Adequate and safe parking for visitors, staff and good loading, 	

Physical Design	Requirements	Desirable features
Dirty utility space	<ul style="list-style-type: none"> • Janitorial area may be combined with dirty utility area • Sink and counter space, floor drain and hopper • Include sterilizer for bedpans/urinals • Storage for dirty supplies and equipment, waste, etc. 	
Clean utility space	<ul style="list-style-type: none"> • Shelves for clean medical supplies, linens, blankets, etc. • Include blanket warmer, sink 	

K. Service Specifications of Elderly Care

1. Policy e.g., ageing in place, health and social care integration etc.
2. Philosophy and Values e.g., active ageing, family and volunteer involvement, etc.
3. Objectives: e.g., safety/home like atmosphere/ autonomy/ independence
4. Fee-charging, Admission and Discharge criteria
5. Scope of Care and Services ³⁰¹: e.g.,
 - Clinical issues: e.g., skin integrity/wound, fall, incontinence/ constipation, medication, feeding/tube feeding, infection control, pain, dementia, depression, behavioral such as aggression, end of life care, etc.
 - Activities of daily living such as bathing, dressing, grooming, toileting, eating, etc. Accommodation, catering, counseling, group activities, laundry, transportation, escort for medical appointment, etc.
 - Respite Care - fee charging, admission and discharge criteria
6. Management
 - Vision/mission/value
 - Manuals: operation, clinical, quality, etc.
 - Committees/Task forces, e.g., food, security, infections control, etc.
 - Risk and quality, information, finance, human resources, facility management, etc.
7. Family/resident relations
8. Performance management system
 - Clinical vs. non clinical: e.g., # and % of fall related injury, customer service satisfaction level, etc.
 - Periodical report

³⁰¹ List out all the services for residential and home/community care separately. (分別列出機構和居家社區養老的各項服務)