EU-CHINA SOCIAL PROTECTION REFORM PROJECT
COMPONENT 3

VOLUME ON 2015 RESEARCH TOPICS

TOPIC 3.3.1
SOCIAL ASSISTANCE FOR SPECIFIC VULBERABLE GROUPS (SASVG)-SERVICES FOR CHILDREN, ELDERLY, PEOPLE WITH DISABLITIES, WITH A SPECIAL FOCUS ON POOR RURAL PEOPLE

Beijing August, 2016

All rights reserved. No part of this publication may be reproduced or utilized in any form or by any means, electronic or mechanical, including photocoping, recording, or by any information storage and retrieval system, without prior written permission from the publisher.

This publication has been produced by the EU-China Social Protection Reform Project is co-funded jointly by the European Union and the Government of the People's Republic of China. The content is the sole responsibility of the authors and can in no way be taken to reflect the views of the European Union or Ministry of Civil Affairs, P.R. China.

Table of Contents

3.3.1 Zuo Ting, Gang Shuge, Social Assistance for Specific Vulnerable Groups (SASVG) - services for children, elderly, people with disabilities, with a special focus on poor rural people - Assessment Report 4

3.3.1 Monika Gabanyi, European Best Practices report on Social Care - Long Term Care -For Elderly, People with Disabilities and Children, Example of Germany 63

3.3.1 Monika Gabanyi, European Best Practices report on Social Care -Long Term Care - For Elderly, People with Disabilities and Children Contracting Social Services, Example Germany 80

3.3.1 Zuo Ting, Social Assistance for Specific Vulnerable Groups (SASVG) - services for children, elderly, people with disabilities, with a special focus on poor rural people - Policy Recommendations 94

3.3.1 Jadwiga Pauli, Social Assistance for Specific Vulnerable Groups - EU experience and policy recommendations 103

3.3.1 Social Assistance for Specific Vulnerable Groups (SASVG) - Services for Children, the Elderly, People with Disabilities, with Special Focus on Poor Rural People

Assessment Report

Zuo Ting, Professor, Development and Social Security Studies, China Agricultural University, P.R. China

Gang Shuge, Associate Professor, Beijing Academy of Social Sciences, P.R. China

Table of Contents

Introduction ... 6
1. Comparative Analysis of the General Social Assistance System (For General Poor People) and Social Assistance for the Specific Vulnerable Groups ... 7
1.1 From the Traditional Rural "Five Guarantee" Program to Social Assistance for the Specific Vulnerable Group (SASVG) ... 7
1.2 Rural Development Oriented Poverty Reduction Program ... 8
1.3 Minimum Subsistence Allowance System (Dibao) ... 9
1.4 Medical Assistance and Temporary Assistance ... 13
1.5 Comparison of SA to Specific Vulnerable Group (SASVG) with Other Assistance Programs ... 17
2. Social Assistance For Specific Vulnerable Group (SASVG) ... 22
2.1 Defining the Specific Vulnerable Group ... 22
2.2 Basic Support Service for SVG ... 28
3. Other Dedicated Social Assistance Programs for SVG ... 39
3.1 Rural Medical Assistance ... 40
3.2 Support to Persons with a Disability ... 40
3.3 Support to Single-Child-Lost Families ... 42
3.4 Support to Street Children and Baby Safety Island ... 43
3.5 Nutrition Improvement for Poor Children and Students ... 46
3.6 Support to Maternal and Infant ... 46
3.7 Subsidy to Seniors ... 48
3.8 Temporary Assistance ... 48
4. General Assessment of Social Assistance for the Rural Specific Vulnerable Groups ... 50
4.1 Achievements ... 50
4.2 Main Challenges ... 52
4.3 Suggestions: Service Provision Centered Policy Improvement ... 54

Acronyms

ACWF	All China Women Federation
CPC	Chinese People's Congress
Dibao	Minimum Subsistence Allowance Program
FG	Five Guarantee Scheme
MoCA	Ministry of Civil Affairs of the People's Republic China
NRMC	New Rural Medical Cooperative program
SA	Social Assistance
SASVG	Social Assistance for Specific Vulnerable Groups
SVG	Specific Vulnerable Groups
Three None's	People with no ability to work, no source of income, and no statutory obligors to provide for them
Wubao	"Five Guarantee" in Chinese Pronunciation
RDOPRP	Rural Development Oriented Poverty Reduction Program

Introduction

Although China has become the second largest economy in the world, it is still largely an agricultural society. The rural population accounts for 50% to 60% of the total population under different criteria. Due to urban-rural dualistic economic characteristics formed under the planned economy, the living standards and the level of social security of the rural population are lower than that of the urban population. Under the background of urbanization, the livelihoods of rural-urban migrants are full of risks and uncertainties. Until now, the majority of China's poor population has remained in rural areas.

In this century, especially since the 18th CPC National Congress, social assistance for the rural poor has been highly valued by the Chinese Government. Among the rural poor, the majority belongs to the income poverty group and some of the remainder, about 7% to 8%, belongs to the physiological poor group. For these people, such as the elderly, children and people with disabilities, a lack of an income source and physical difficulties are their main characteristics. They are the most vulnerable groups and generally referred to as the Specific Vulnerable Group (SVG).

In 2014, Specific Vulnerable Groups were referred to as persons who are aged, disabled or under the age of 16 having no ability to work, no source of income, and no statutory guardians to provide for them or the "three None's" Group referred to in the Five Guarantees scheme (FG), in the "Interim Measures for Social Assistance" and to whom social assistance should be provided. The "Social Assistance to Specific Vulnerable Group" (SASVG) system is the continuation and development of the traditional Five Guarantees. The major research object of this report is the system of SASVG. A systematic presentation and assessment of SASVG has been conducted by the researcher from multi-perspectives including defining and distinguishing the specific vulnerable group, the mode of social assistance and its effects.

Key terms used in this Report:

Social Assistance to Specific Vulnerable Group (SASVG) is listed in Chapter 3 – "Support to Specific Vulnerable Group" in the latest "Interim Measures for Social Assistance" which were issued on May 1, 2014. This scheme covers both the urban and rural areas.

Five Guarantee Scheme (FG) or Wubao, is a traditional and popularly known social assistance scheme. Updated by the "Regulations on the Rural Five-Guarantee Scheme" in 2006, "five guarantees" can be simply understood as guarantees in the five aspects of food, clothing, fuel, education and burial expenses. This scheme covers only rural areas.

Specific Vulnerable Group (SVG), used as general category in SASVG and refers to those who are aged, disabled or under the age of 16 having no ability to work, no source of income, and no statutory guardians to provide for them or the “three None’s” Group referred to in the Five Guarantees schemes. Because the standards for financial support and the types of support and the supporting organization are different between the aged, the disabled or those under the age of 16, in local practice now, the Five Guarantees scheme usually only refers the aged “three None’s”, or SVG aged. For SVG (three None’s) who are disabled and for children under the age of 16, they are supported by specific organizations in higher financial standards.

List of main legal provisions and regulations related SVG:

- *Regulations for the Rural Five-Guarantee Work*
- *Interim measures for Rural old-age home management.*
- *Regulations for the Rural Five-Guarantee Scheme.*
- *Measures for the administration of the rural five guarantees service agencies*
- Etc.

1. Comparative Analysis of the General Social Assistance System (For General Poor People) and Social Assistance for the Specific Vulnerable Groups

1.1 From the Traditional Rural “Five Guarantee” Program to Social Assistance for the Specific Vulnerable Group (SASVG)

The Chinese Government has been making great efforts to establish a new rural welfare system to protect the vulnerable groups. FG recipients are undoubtedly some of the most vulnerable citizens in rural China. In the rural areas of China, as the traditional source of living security is mainly farmland security and family support, in the 1950s the Government established the *five-guarantee scheme* to support those people (mainly the elderly, disabled, and minor below 16 years old) who have no ability to work, no source of income and no statutory guardians to look after them, or whose statutory guardians have no ability to look after them. In 1956, the First National People’s

Congress (NPC) published a directive entitled “Exemplary Charter for Advanced Rural Cooperatives” in which the rural communes were required to provide to farmers in extreme need the so called “five guarantees” including food, clothing, fuel, education and burial expenses, and who had absolutely no responsible kin to care for them or who were too old, too young or too sick to support themselves. Since then, this vulnerable group has been called the “Five-Guarantee Households” (FGHs).

In 2006, the State Council issued the “*Regulations on the Rural Five-Guarantee Scheme*” to reinforce this scheme. The “*Regulations on the Work for Providing the Five Guarantees in the Rural Areas”* was adopted at the 121st Executive Meeting of the State Council on January 11, 2006, was then promulgated and became effective on March 1, 2006. These Regulations are formulated for the purpose of successfully implementing the work of providing FG in the rural areas, ensuring a normal life to persons enjoying the FG in rural areas and promoting the development of the social security system in rural areas. Article 6 indicates that villagers who are aged, disabled or under the age of 16 and have no ability to work, no source of income, and no statutory guardians to provide for them, bring them up or support them, or whose statutory guardians have no ability to provide for them, bring them up or support them, shall enjoy FG in the rural areas.

The “Interim Measures for Social Assistance” were issued and came into force on May 1, 2014. As such, Chapter Three of the “Measures” – “*Support for the Especially Poor”* contains the Five Guarantees. Article 14 stipulates that the State shall grant support to the especially poor, i.e. the elderly, the disabled and minors under 16 years of age who have no persons with statutory obligations to support aging parents, children, or other persons or persons with statutory obligations

to support do not possess the capacity to support them. Article 15 indicates that the support of the especially poor includes: (1) providing basic living conditions; (2) looking after those who cannot take care of themselves; (3) providing disease treatment; (4) handling funeral matters. It is stipulated that the support standard should be determined and announced by the People's Government of each province, autonomous region, municipality, or city with districts. Support for the especially poor shall be integrated with the systems of pension insurance for urban and rural residents, basic medical insurance, the minimum subsistence guarantee and the basic living guarantee for orphans.

1.2 Rural Development Oriented Poverty Reduction Program

After the "Reform and Opening Up", especially since the development of a market economy, the Five Guarantees Scheme, which was based on the collective economy, had been significantly adjusted. In order to solve the problem of absolute poverty in the rural areas, China has launched a special program, the Rural Development Oriented Poverty Reduction Program (RDOPRP). It aims to build the capacity of poor people with development potential and willingness to overcome poverty since the mid-1980s. 500 million poor people have been lifted out of poverty. The main activities of this program include promoting industry, labor force training, improving living conditions and infrastructure of poor village, providing development finance loans and so on. By the end of 2014, there were about 80 million poor people in China and the poverty rate was 7.2%. However, the poverty distribution in China was uneven. Most of the poor are located in the central and western parts of China. For example, in 2014, there were six provinces, each of which still had more than 5 million poor people in rural areas. If we consider the poverty incidence rates in rural areas, Tibet (28.8%), Gansu (23.8%), Guizhou (21.3%), Xinjiang (19.8%), Yunnan (17.8%) are the poorest five provinces. These are all located in the western parts of China.

Table 1: Number of Rural Poor Population and the Poverty Incidence Rate by Province in 2013

Region	Poor Population（million persons）	Rural Poverty Incidence Rate（%）
National	82.49	8.5
Hebei	3.66	6.5
Shanxi	2.99	12.4
Neimenggu	1.14	8.5
Liaoning	1.26	5.4
Jilin	0.89	5.9
Heilongjiang	1.11	5.9
Jiangsu	0.95	2.0
Zhejiang	0.72	1.9
Anhui	4.40	8.2
Fujian	0.73	2.6
Jiangxi	3.28	9.2

Shandong	2.64	3.7
Henan	6.39	7.9
Hubei	3.23	8.0
Hunan	6.40	11.2
Guangdong	1.15	1.7
Guangxi	6.34	14.9
Hainan	0.60	10.3
Chongqing	1.39	6.0
Sichuan	6.02	8.6
Guizhou	7.45	21.3
Yunnan	6.61	17.8
Tibet	0.72	28.8
Shannxi	4.10	15.1
Gansu	4.96	23.8
Qinghai	0.63	16.4
Ningxia	0.51	12.5
Xinjiang	2.22	19.8

Source: Official website of the State Council Leading Group Office of Poverty Alleviation and Development,
http://www.cpad.gov.cn/sofpro/ewebeditor/uploadfile/2014/04/11/20140411095556424.pdf.

1.3 Minimum Subsistence Allowance System (Dibao)

In the short term, it is difficult to improve the living conditions and overcome poverty for a considerable part of the existing rural poor population through the Rural Development Oriented Poverty Reduction Program. For these groups, in 2007, the Minimum Subsistence Allowance System (Dibao) was established and implemented for the rural poor who meet the requirements, aiming to solve the subsistence problem of the rural poor population steadily, permanently and effectively. The target population of Dibao is those rural residents whose household per capita net income is below the defined local minimum living standard. Unlike the requirement of development capacity for the targeted population under RDOPRP, the coverage range of the population for Dibao is wider and it takes a direct financial support approach. Therefore, Dibao has become the mainstay of the social assistance programs in China's rural areas and attracted widespread attention.

The target population of Dibao is those poor people whose household per capita net income is below the defined local minimum living standard. According to the actual situation in different

places, Dibao also focuses on those who are in perennial difficulties because of illness, disability, poor health, no ability to work and poor living conditions.

The standard of Dibao is determined and executed by different local governments that are above the county level. The following aspects are primarily considered: (1) to maintain the local rural resident's basic necessities of food, clothing, water, electricity and other costs; (2) the local economic development level and financial situation; (3) the local price level.

Table 2: Rural Dibao Mean Standard and Expenditure by Province in 2014

Region	Mean Standard (thousand yuan)	Gross Expenditure (million yuan)	Monthly Received by benefit (yuan)
National		79332.06	125.29
Beijing	7.59	279.84	415.46
Tianjin	6.15	350.60	271.48
Hebei	2.54	3075.98	119.81
Shanxi	2.45	2551.43	146.71
Neimenggu	3.63	2962.27	198.74
Liaoning	3.20	1400.28	138.21
Jilin	2.47	1128.18	115.58
Heilongjiang	2.76	1998.73	141.08
Shanghai	7.56	143.23	381.19
Jiangsu	5.35	2959.84	194.94
zhejiang	5.69	1810.79	281.17
Anhui	2.83	3526.75	138.48
Fujian	2.73	1263.73	142.48
Jiangxi	2.64	2631.18	135.69
Shandong	2.94	4538.48	149.91
Henan	1.82	4860.70	103.68
Hubei	2.57	2822.46	102.75
Hunan	2.33	4011.84	111.79
Guangdong	3.84	3064.92	159.53

Guangxi	2.03	4223.90	102.91
Hainan	3.36	435.32	150.66
Chongqing	2.67	993.23	151.92
Sichuan	2.14	5362.70	103.45
Guizhou	2.12	5114.10	96.87
Yunnan	2.14	6600.16	118.75
Tibet	2.23	309.22	78.74
Shannxi	2.26	3114.66	135.25
Gansu	2.28	4469.69	109.8
Qinghai	2.21	716.56	150.4
Ningxia	2.28	560.00	122.44
Xinjiang	2.03	2051.29	127.94

Data Source: Official website of Ministry of Civil Affairs of the People's Republic of China, http://files2.mca.gov.cn/cws/201501/20150126145241251.htm.

At the national level, the gross number of Dibao recipients in 2014 was 52.09 million, of which, 34.8% were female, 39.6% were elderly, 11.1% were children and 8.5% were persons with a disability. Three south-western provinces, Yunnan, Sichuan and Guizhou have the most Dibao recipients (more than 4 million in each provinces) and followed by Henan, Gansu, Guangxi and Hunan (in the middle, northwest and southwest China) with more than 3 million Dibao recipients. Except for Henan Province, the other six provinces also have the most populous distribution of ethnic minority people.

Table 3: Characteristics of Rural Dibao Recipient Group of People by Province in 2014

Region	Number of Dibao Recipient Population(000's)	Female (000's)	Elders (000's)	Children (000's)	Disabilities (000's)	Number of Dibao Recipient Family(000 households)
National	52090.27	18172.61	20644.56	5782.46	4440.51	29391.59
Beijing	51.32	20.91	21.07	6.33	16.37	31.07
Tianjin	101.45	41.68	27.67	17.39	17.82	46.88
Hebei	2099.16	639.79	1230.86	116.82	172.09	1549.53
Shanxi	1407.03	503.67	805.20	67.15	149.31	1120.38

Neimenggu	1221.50	564.74	679.43	31.40	92.15	958.97
Liaoning	805.82	288.65	364.63	63.02	104.95	504.41
Jilin	790.47	373.80	439.83	27.22	58.10	597.53
Heilongjiang	1172.77	445.57	537.12	65.61	78.93	661.13
Shanghai	29.76	14.91	10.04	1.63	10.12	23.57
Jiangsu	1193.47	450.16	475.23	129.44	134.49	647.60
zhejiang	509.60	172.09	188.88	65.16	104.62	323.06
Anhui	2089.17	760.75	852.18	180.85	278.59	1194.50
Fujian	737.90	244.41	214.15	74.71	98.04	377.48
Jiangxi	1701.99	643.42	506.73	294.15	348.55	769.15
Shandong	2582.09	911.75	1503.92	160.53	212.45	1820.72
Henan	3952.57	1181.63	2022.90	310.45	360.02	3018.58
Hubei	2216.38	998.29	922.69	118.84	239.92	1479.56
Hunan	3158.58	941.96	1276.62	304.93	204.94	1791.64
Guangdong	1582.93	493.96	459.12	323.55	138.11	713.20
Guangxi	3319.00	949.19	1193.39	551.96	187.02	1306.49
Hainan	215.14	76.68	56.16	34.00	13.64	91.40
Chongqing	502.39	225.94	139.06	88.64	80.73	277.79
Sichuan	4257.11	1286.52	1869.22	452.32	355.85	2516.73
Guizhou	4183.15	1429.13	1446.26	648.34	247.67	1999.98
Yunnan	4589.41	1722.15	1358.58	539.76	262.90	2488.87
Tibet	323.44	119.05	143.76	66.91	15.27	118.32
Shannxi	1816.37	763.56	607.79	172.43	144.62	811.96
Gansu	3389.49	1133.57	712.27	541.41	164.23	1114.16
Qinghai	372.08	92.60	62.27	66.90	21.34	128.56
Ningxia	391.82	126.26	130.03	26.43	36.41	301.18

Xinjiang	1326.94	555.85	387.51	234.19	91.26	607.21

Data Source: Official website of Ministry of Civil Affairs of the People's Republic of China, http://files2.mca.gov.cn/cws/201501/20150126145241251.htm

1.4 Medical Assistance and Temporary Assistance

To overcome the problems of temporary difficulties and poverty caused by illness which happened during the social transition period, the Chinese Government has increased its efforts of interim assistance and medical assistance to help the targeted population to cope with an emergency difficulty. For example, in addition to the needs of living assistance for people with a disability, medical assistance is one of the most common needs too. Based on the traditional Five Guarantee Scheme, the "Interim Measures for Social Assistance" issued in 2014 reaffirmed the responsibility of the State for the most disadvantaged groups of society, namely the Social Assistance for Specific Vulnerable Groups. This was still called as FG in most areas. According to "The Measures" the Government should provide social assistance to those who are aged, disabled or under the age of 16 and have no ability to work, no source of income, and no statutory guardians to provide for them, bring them up or support them, or whose statutory guardians have no ability to provide for them, bring them up or support them.

Table 4 Needs for Assistance of Rural Disabled Families

Unit：%	2007	2008	2009	2010	2011	2012	2013
Medical Assistance	69.1	66.8	66.2	63.5	63.6	62.3	59.7
Life Assistance	60.2	61.8	65.0	66.2	66.6	68.6	65.6
Recovery Assistance	37.9	35.6	32.0	30.5	29.4	29.8	27.5
Educational Assistance	14.7	12.7	13.9	13.2	11.3	10.2	9.3

Source: Author's calculation based on data from the official website of the Ministry of Civil Affairs of the People's Republic of China.

Currently, the major rural social assistance programs include Minimum Subsistence Guarantee Program (Dibao), Support to Most Vulnerable Group or Five Guarantee Program (Wubao), Medical Assistance Program and Temporary Assistance Program, which are implemented under the Ministry of Civil Affairs social assistance system.

Medical assistance is a medical security system in which the Government grants special aids and economic support via financial, policy and technological supports and social charitable acts to poor people who cannot afford medical treatment or to people with financial difficulties due to the payment of high medical expenses. This attempts to offer them necessary health services, maintain their survival ability and improve their health. The targeted population for medical assistance should meet the following criteria: be poor, be a patient and not be able to pay medical expenses. Specific recipients include:

(1) People having no ability to work, no source of income, and no statutory guardians to provide for them, effectively the "Three None's".

(2) Rural residents who have an injury or illness caused by natural disasters.

(3) Urban residents who have participated in the basic medical insurance, but had difficulties arising from medical expenses.

(4) Unemployed patients and injured persons who have no ability to work and are from families that benefited from the Urban Residents Minimum Subsistence Allowance, the unemployed, elderly above 60 years of age with an injury or illness and juveniles under the age of 16 with an injury or illness.

(5) Key groups that should be given special care, such as disabled veterans, bereaved old ex-service men and bereaved old members of a revolutionary martyr's family.

(6) Other specific vulnerable people who have been assisted but still have difficulties financing medical expenses.

In 2014，Medical Assistance benefited 91.19 million people. Hospital assistance recipients were 11.066million people, outpatient assistance recipients were 12.887 million people and recipients under the New Rural Medical Cooperative program (NRMCP) were 67.237million people.

The total expenditure was 25.26 billion yuan, of which, the hospital expenditure, outpatient expenditure, and New Rural Medical Cooperative program (NRMCP) expenditure was 18.02 billion CNY, 2.4 billion CNY and 4.84 billion CNY respectively. The Medical Assistance standards for hospital, outpatient and NRMC were 1,628 CNY per patient, 186 CNY per patient and 72 CNY per person respectively. Medical assistance policy is also implemented to articulate NRMC in rural China. Medical assistance is delivered in three methods: (1) to hospital expenditure (71.3%); (2) to outpatient expenditure (9.5%); and (3) to pay for NRMC (19.2%).

Table 5 The Situation of Medical Assistance Recipients in 2014

Region	No. of Recipients Supported in Social Medical Insurance(000’s)	No. of Recipients Supported in Rural Medical Cooperatives (000’s)	No. of Recipients supported in medical expenses (000’s)	Of which	
				Hospital fee (000’s)	Outpatient fee (000’s)
National	13109.11	41188.74	20366.70	9864.54	10502.16
Beijing	24.96	44.11	81.18	19.23	61.95
Tianjin					
Hebei	123.45	1577.55	248.74	188.46	60.28
Shanxi	591.22	1374.64	219.68	174.04	45.64
Neimenggu	649.35	1081.16	290.19	211.21	78.98
Liaoning	107.00	280.48	152.33	90.90	61.43
Jilin	260.57	358.86	348.73	206.28	142.44
Heilongjiang	1293.69	1303.90	626.24	283.87	342.37

Shanghai	70.03	9.78	76.20	36.25	39.95
Jiangsu	195.40	996.67	2236.39	481.48	1754.71
zhejiang	24.67	335.77	1871.72	566.23	1305.49
Anhui	514.29	2218.60	933.72	788.62	145.11
Fujian	53.87	555.20	809.25	233.91	575.34
Jiangxi	475.63	1253.01	991.09	356.26	634.83
Shandong	327.52	2221.24	268.07	236.75	31.32
Henan	502.60	2479.22	743.34	588.73	154.61
Hubei	1015.19	2402.92	918.70	754.56	164.13
Hunan	787.98	2189.22	698.34	462.23	236.11
Guangdong	851.70	846.56	883.41	254.01	629.40
Guangxi	215.91	2346.26	380.40	344.12	36.28
Hainan	48.92	141.02	84.62	44.45	40.17
Chongqing	619.57	1136.50	2599.73	637.70	1962.03
Sichuan	1597.07	4515.91	1616.58	1076.11	540.47
Guizhou	302.96	2814.20	273.28	258.30	14.99
Yunnan	922.91	4385.19	770.84	583.66	187.18
Tibet	30.55	21.98	39.48	37.38	2.10
Shannxi	104.11	707.27	360.64	268.67	91.97
Gansu	575.64	2454.88	290.35	207.72	826.33
Qinghai	156.08	283.99	289.45	113.53	175.93
Ningxia	90.93	209.19	267.88	113.34	154.55
Xinjiang	575.35	643.46	996.14	246.55	749.60

Data Source: Official Website of the Ministry of Civil Affairs of the People's Republic of China, http://files2.mca.gov.cn/cws/201501/20150126145241251.htm.

Temporary assistance means emergency and transitional assistance provided by the State to households or individuals who live in strained circumstances due to emergency events, accidental injuries, serious diseases or other special reasons and are not covered by other social assistance systems for the time being or still have serious difficulties with their basic living after receiving

other social assistances. In October 2014, the Notice of the State Council on "Building the Temporary Assistance System in an All-round Way" (Guo Fa [2014] No.47) was issued, indicating that China had built temporary assistance system in an all-round way and would further consolidate the safety network of China's people's livelihood guarantee. Currently, the applicants for temporary assistance are restricted to the following five categories:

- Recipient families of Urban and Rural Minimum Subsistence Allowance (Dibao),
- targeted population of FG,
- urban and rural low income families,
- other families with special difficulties identified by Local Government,
- and rural migrant worker families that have worked more than one year at the migrated place and meet the requirements for identifying a low income family.

In 2014, Temporary Assistance benefited 6.507 million households (of which 3.172 million households were rural; 192,000 were non-residential and 1.168 million received emergency assistance). Total expenditure was CNY 5.76 billion. There are three methods of delivery of temporary assistance service:

- Fund support,
- Material support,
- Transfer and handover to other relevant programs.

Table 6 Situation of Temporary Assistance in 2014

Region	No. of Family Recipients (000's)	By urban/rural		Residential		Type	
		Urban (000's)	Rural (000's)	Local Residents (000's)	None-Local Residents (000's)	Expenditure issue (000's)	Emergency (000's)
National	3017.97	1252.77	1765.20	2926.66	91.31	2499.50	518.47
Beijing	62.27	31.36	30.91	62.27		61.77	0.50
Tianjin	32.61	26.45	6.16	32.61		31.61	1.00
Hebei	39.07	10.61	28.46	37.98	1.09	29.87	9.20
Shanxi	109.92	27.77	82.15	104.26	5.66	88.57	21.36
Neimenggu	122.40	42.84	79.56	117.43	4.97	97.55	24.85
Liaoning	81.85	63.78	18.08	77.46	4.39	76.73	5.12
Jilin	75.65	47.67	27.98	75.65		75.52	0.13
Heilongjiang	57.67	28.52	29.16	56.96	0.72	44.41	13.26

Shanghai	314.22	313.78	0.45	314.22		261.14	53.08
Jiangsu	266.07	97.35	168.72	263.55	2.51	228.37	37.70
zhejiang	87.14	18.53	68.61	86.56	0.58	74.49	12.65
Anhui	81.88	31.92	49.96	80.70	1.18	68.41	13.47
Fujian	47.97	13.79	34.19	46.96	1.02	41.37	6.60
Jiangxi	9.39	2.81	6.58	9.11	0.28	6.60	2.79
Shandong	185.43	52.15	133.28	181.53	3.89	141.93	43.49
Henan	26.13	6.00	20.13	25.27	0.85	15.36	10.76
Hubei	338.11	143.64	194.47	331.75	6.36	288.44	49.67
Hunan	158.27	49.54	108.73	141.72	16.56	102.71	55.57
Guangdong	29.26	8.58	20.68	22.98	6.28	23.02	6.24
Guangxi	45.01	1.58	43.44	44.80	0.22	41.30	3.71
Hainan	15.74	4.08	11.66	15.73	0.008	14.98	0.76
Chongqing	199.39	98.95	100.44	190.09	3.30	173.36	26.04
Sichuan	111.00	38.53	72.48	107.14	3.89	80.74	30.27
Guizhou	59.63	9.36	50.27	54.22	5.41	46.23	13.40
Yunnan	282.33	37.22	245.11	270.13	12.20	242.83	39.51
Tibet	5.35	3.16	2.19	5.33	0.027	3.33	2.03
Shannxi	92.59	18.85	73.75	88.26	4.33	76.95	15.65
Gansu	35.56	8.15	27.42	34.25	1.32	26.08	9.48
Qinghai	6.43	1.74	4.69	6.21	0.22	3.93	2.50
Ningxia	15.11	1.72	13.39	15.01	0.09	14.30	0.81
Xinjiang	24.51	12.37	12.15	20.52	3.99	17.63	6.88

Data Source: Official Website of the Ministry of Civil affairs of the People's Republic of China, http://files2.mca.gov.cn/cws/201501/20150126145241251.htm.

1.5 Comparison of SA to Specific Vulnerable Group (SASVG) with Other Assistance Programs

China has established a social assistance network under which poor rural groups and specific vulnerable group has been specially catered for. With promulgation of the "Regulations on the Rural Five-Guarantees Scheme" in 2006 and "Interim Measures for Social Assistance" in 2014, the social assistance system for specific vulnerable groups has basically formulated. With Dibao, SASVG, Medical Assistance, Temporary Assistance and other social assistance schemes and also the Rural Development Oriented Poverty Reduction Program (RDOPRP), China has built a social assistance network for its rural poor population. The network basically has achieved full coverage of vulnerable people and played the role of satisfying their minimum needs. The support capacity for vulnerable people has also increased and begun to integrate with the basic pension insurance system for residents, basic medical insurance, Dibao and the orphan subsistence allowance system.

As for the SASVG system, its targeted groups are the most vulnerable ones. Although the total number of recipients is less than 6 million, the depth of poverty of this group is the highest on account of them being the "Three None's". This kind of social assistances is the reflection of the State's responsibility and it plays the role of satisfying the minimum needs. The coverage range of the Minimum Subsistence Allowance System is wider and more than 50 million rural residents have benefited from it. Besides, the allowance is provided in accordance with the gap between the defined standard and the various levels of difficulties. The targeted population of RDOPRP is those with development potential and willingness to overcome poverty. Medical assistance, Temporary assistance and other social assistance like Educational Assistance and Housing Assistance are supplementary ways of assisting Dibao recipients and the SVG.

One important institutional difference between RDOPRP, Dibao, and SASVG is that there is a national poverty line for the poverty reduction program and therefore it is possible to compare the numbers of poor in the different provinces. However, as for the income level of Dibao, the central government only requires local governments to provide allowance to those who should be assisted, and different local governments determine their own standard. On the one hand, the determination of standard may refer to local government's understanding of local poverty condition, but on the other hand, it may also reflect local financial conditions and willingness of the government since a higher standard means more recipients and greater financial expenditure. The determining of the assistance standard of FG also reflects the local government's understanding of the situation.

Based on the data of 2014, the simple average of the national rural Dibao standard is similar to the rural poverty line (2008 CNY per person per annum yuan/person in 2014). The standards of Dibao for developed regions are higher than national the poverty line, in some cases more than double. However, the standards of Dibao in poor areas are usually below the national poverty line.

Due to the implications of keeping Dibao at the minimum subsistence level, individual support standards for FG are significantly higher than the standards of Dibao in most provinces. For Anhui province, its individual support standard is 2,894 CNY per person per annum which is very close to its Dibao standard of 2,828 CNY. However, the situation of Fujian province is quite different. Its Dibao standard is 2,732 CNY per person per annum, lower than Anhui's, but its individual support standard for FG is 5,816 CNY, more than double of its Dibao standard. As for Beijing and Shanghai, their collective support standards are exactly the same as their individual support standards.

Another significant difference of SASVG is the service delivery. In Dibao program, only a payment is transferred to recipients. There is no other in-kind service. In the medical assistance program, medical services are provided through hospitals. In SASVG, such as the FG program, particularly the collective supporting FG program, the necessary service provision is an important part of the program. Necessary services include daily care, medical care, etc., the so-called five guaranteed services. Service provision raises many issues such as criteria and quality of service, cost sharing, staffing and facilities, etc. These will be described in the next part.

Table 7: Comparison of SA for the Specific Vulnerable Group (SASVG) with Other Social Assistance Programs

Programs	Characteristics of targeted Groups	Methods for recipient identification	Service delivery
Support to Most Vulnerable Group, or FG, or Wubao	Both economic poor and physically vulnerable, including poor elders, children and disabilities	Naturally verifying and disability certification	Collective support or individual support through allowance transfer
Development oriented poverty reduction	Economic poor, but with development potentials	Means-test in Income verifying, community discussing	Development project
Minimum Subsistence Allowance, or Dibao	Economic poor	Means-test in Income and assets verifying, community discussing	Allowance transfer
Temporary Assistance	Temporary needy	Case by case	Cash tansfer
Medical Assistance	Economic poor, particularly physically vulnerable	Link to situation of Dibao and Wubao	Subsidy for medical insurance, directly cash transfer

Table 8: Standards and Numbers of Different Types of Rural Poor People in 2014

Region	Rural Disposable Income/ person (000 CNY)	Income Standard for Dibao (000 CNY)	No. of Rural Dibao Recipients (000 CNY)	Standard for FG collective support (000 CNY)	No. of FG collective Support recipients (000 CNY)	Standard for FG individual support (000 CNY)	No. of FG individual Support recipients (000 CNY)	No. of Poor in 2013 under national Poverty line (persons)
National	10.49	2.78	52090.27	5.37	1745.99	4.01	3549.50	8,249
Beijing	20.23	7.59	51.32	13.09	1.96	13.09	2.23	
Tianjin	17.01	6.15	101.45	9.30	1.24	7.97	11.04	
Hebei	10.17	2.54	2099.16	5.23	71.00	3.55	161.18	366
Shanxi	8.81	245	1407.03	4.81	25.31	2.91	135.01	299
Neimenggu	9.98	3.63	1221.50	7.30	24.91	4.74	64.05	114

Liaoning	11.19	3.20	805.82	6.08	33.53	3.99	104.39	126
Jilin	10.78	2.47	790.47	4.42	23.85	3.09	91.70	89
Heilongjiang	10.45	2.76	1172.77	5.30	50.62	3.76	85.56	111
Shanghai	21.19	7.56	29.76	9.00	1.14	9.00	1.57	
Jiangsu	14.96	5.35	1193.47	8.10	102.26	7.02	96.04	95
zhejiang	19.37	5.69	509.60	9.43	35.73	8.62	0.76	72
Anhui	9.92	2.83	2089.17	4.56	160.46	2.89	270.14	440
Fujian	12.65	2.73	737.90	6.71	9.19	5.82	75.45	73
Jiangxi	10.12	2.64	1701.99	3.51	120.74	3.10	108.62	328
Shandong	11.88	2.94	2582.09	5.39	167.91	3.67	58.11	264
Henan	9.42	1.82	3952.57	3.93	188.35	2.41	299.32	639
Hubei	10.85	2.57	2216.38	4.69	70.10	3.38	186.52	323
Hunan	10.06	2.33	3158.58	5.69	103.78	3.00	400.64	640
Guangdong	12.25	3.83	1582.93	7.93	28.27	7.65	212.66	115
Guangxi	8.68	2.03	3319.00	4.04	22.14	3.12	268.87	634
Hainan	9.91	3.36	215.14	5.48	2.39	4.64	29.26	60
Chongqing	9.49	2.67	502.39	5.52	64.15	4.86	99.45	139
Sichuan	8.80	2.14	4257.11	4.47	268.76	3.48	236.36	602
Guizhou	6.67	2.12	4183.15	3.30	37.79	2.21	80.03	745
Yunnan	7.46	2.14	4589.41	3.92	38.57	2.61	172.75	661
Tibet	7.47	2.23	323.44	3.87	8.22	3.41	7.59	72
Shannxi	7.93	2.26	1816.37	5.78	48.68	4.92	84.23	410
Gansu	5.74	2.28	3389.49	3.74	12.73	3.52	108.83	496
Qinghai	7.28	2.21	372.08	5.48	4.31	5.00	18.96	63
Ningxia	8.41	2.28	391.82	5.69	4.04	3.71	10.10	51
Xinjiang	8.30	2.03	1326.94	6.75	13.85	4.30	68.10	222

Data Source: Author's calculation based on data from the official website of the Ministry for Civil Affairs of the People's Republic of China.

Table 9: Relative Standards of Poverty and Social Assistance

Region	National povety line (2800 yuan)/Per Capita Income	Dibao Standard/Per Capita Income	Collective Support Standard of FG/ Per Capita Income	Individual Support Standard of FG/Per Capita Income
National	0.267	0.265	0.512	0.382
Beijing	0.138	0.375	0.647	0.647
Tianjin	0.165	0.362	0.547	0.468
Hebei	0.275	0.250	0.514	0.348
Shanxi	0.318	0.279	0.546	0.330
Neimenggu	0.281	0.364	0.732	0.475
Liaoning	0.250	0.286	0.543	0.357
Jilin	0.260	0.229	0.410	0.287
Heilongjiang	0.268	0.264	0.507	0.360
Shanghai	0.132	0.357	0.425	0.425
Jiangsu	0.187	0.357	0.541	0.469
zhejiang	0.145	0.293	0.487	0.445
Anhui	0.282	0.285	0.460	0.292
Fujian	0.221	0.216	0.530	0.460
Jiangxi	0.277	0.261	0.347	0.306
Shandong	0.236	0.247	0.454	0.308
Henan	0.297	0.194	0.418	0.256
Hubei	0.258	0.237	0.433	0.311
Hunan	0.278	0.231	0.565	0.298
Guangdong	0.229	0.313	0.647	0.625
Guangxi	0.322	0.234	0.465	0.359

Hainan	0.282	0.338	0.552	0.468
Chongqing	0.295	0.281	0.582	0.512
Sichuan	0.318	0.243	0.508	0.396
Guizhou	0.420	0.317	0.494	0.331
Yunnan	0.376	0.287	0.526	0.350
Tibet	0.375	0.299	0.518	0.457
Shannxi	0.353	0.285	0.728	0.620
Gansu	0.488	0.397	0.653	0.614
Qinghai	0.384	0.304	0.752	0.687
Ningxia	0.333	0.271	0.676	0.441
Xinjiang	0.338	0.245	0.814	0.518

Source: Author's calculation based on data from the official website of the Ministry of Civil Affairs of the People's Republic of China.

Based on Tables 7 to 9 there are three parallel programs related to SVG. SASVG is the most relevant and targeted one for vulnerable people. Since vulnerable people are weak in their economic, social and physical aspects, the level of financial support of SASVG is higher than for the other two programs. SASVG is a nationally designed programme, however, provincial governments have more implementation responsibility. This results in the different levels of financial support. If using the "Individual Support Standard of FG/Per Capita Income" as an indicator (the national regulation on FG requires local governments to ensure the supporting level is close to neighboring average) , it varies from 0.256 in Henan Province to 0.686 in Qinghai Province. Practical reasons for the variation will include both the level of local livelihoods and the capability and willingness of the local government and others.

In the very recent policy on "Elimination of Absolute Poverty by 2020", the issue of seamless articulation and coordination was raised. In this policy the Dibao and Wubao programs were assigned as the social last resort to provide final support to the poor. The challenge for the Wubao program is not the "criteria" but rather the "service delivery". For SVG recipients, the cash transfer payment is only one part of their needs. Daily care is, and will be, a major part of their needs. In this aspect, local governments, particularly in poor areas, have lot of work to do.

2. Social Assistance For Specific Vulnerable Group (SASVG)

2.1 Defining the Specific Vulnerable Group

In 2006, the State Council issued the "Regulations on the Rural Five-Guarantee Scheme", indicating that villagers who are aged, disabled or under the age of 16 having no ability to work, no source of income, and no statutory guardians to provide for them, bring them up or support them (the "Three None's"), or whose statutory guardians have no ability to provide for them, bring them up or support them would enjoy the Five Guarantees in rural areas. In 2014, the "Interim Measures for Social Assistance" stipulated that the "Specific Vulnerable Group" refers to people who are aged, disabled or under the age of 16 having no ability to work, no source of income, and no

statutory guardians to provide for them, or whose statutory guardians have no ability to provide for them, bring them up or support them. However, in practice, the understanding of the “three None’s” has regional differences or has been developed into more detailed provisions.

In 2010, Cili County Government in Hunan Province issued the “Notice of Implementation Measures of the Rural Five Guarantees Support in Cili County”. It stipulated that the elderly, disabled and teenagers in rural areas under the following conditions can enjoy the FG support.

1) Having no ability to work, including the elderly aged 60 or over, the disabled with second - class or worse situations who have a “People’s Republic of China Disabled Permit” and children under the age of 16 or those already 16 who are in compulsory education.
2) Having no source of income, referring to rural villagers whose subsistence standards are below the county average standard, even though they may earn income from land contracts and management, collective management distributions or other sources.
3) Having no statutory guardians to provide for them, bring them up or support them, or whose statutory guardians have no ability to provide for them, bring them up or support them. The conditions for a statutory guardian who has no ability to provide for a child, bring the child up or support the child means that the statutory guardian needs regular social relief because of subsistence difficulties, or the guardians themselves are elderly, sick, disabled, unable to work or have no source of income.

In the 2014, there were total 6.603 million supported SVG, of whom 934,000 were female, about 1/6 of total. Of the total, 4.5 million or 80% were aged SVG, and 207,000 were children and 916,000 were SVG with disability. Of the total, about one-third of the SVG recipients were collectively supported, the other two-thirds were individually supported.

Table 10: Numbers of different types of SVG

Region	Female SVG(thousand persons)	Elderly SVG(thousand persons)	Children SVG (thousand persons)	Disabled SVG(thousand persons)	Total (thousand persons)
Collectively supported	302.89	1550.76	50.06	278.07	2181.78
Individually supported	631.46	2995.12	157.41	637.65	4421.64
Total(thousand persons)	934.35	4545.87	207.47	915.72	6603.42

Source: Official Website of the Ministry of Civil Affairs of the People's Republic of China, http://files2.mca.gov.cn/cws/201501/20150126145241251.htm.

2.1.1 Elderly SVG

The Elderly SVG are generally referred to as “FG Elderly”. According to “Regulations on Rural Five-Guarantee Scheme”, the FG elderly refers to the elderly who have no ability to work, no source of income, and no statutory guardians to provide for them, bring them up or support them, or whose statutory guardians have no ability to provide for them, bring them up or support them. Elderly with no family refers to the elderly over the age of 60 with no spouse, no children, no one to

take care of them and no ability to work. By the end of 2014, the population of FG support recipients was 5.291 million, of whom the FG elderly was 4.546 million.

In order to implement the requirements of reinforcing the construction of facilities for the rural FG support service from the “Regulations on Rural Five-Guarantee Scheme”, “The Eleventh Five-Year Plan of National Economic and Social Development”, and “The Eleventh Five-Year Plan of the Civil Affairs Development”, and to solve the issues relating to delays in rural FG support facilities, the Ministry of Civil Affairs issued “ Rural Five-Guarantee Support Service Facility Construction Xiaguang Plan ”(2006-2010, 2011-2015) in 2006 and 2011 respectively. The Plan stipulated that from the central level to the local level, the civil affair departments were supposed to allocate part of the retained lottery funds to finance the construction of rural FG support service facilities, to improve the support recipients’ living conditions, to solve their housing problems and to improve support services.

In October 2015, Hunan Province issued the “Notice on Establishing the Basic Pension Service Subsidy System”. The subsidized recipients of this program include rural FG elderly and the totally or partially disabled elderly of Dibao families. The subsidies would come into practice through the governmental purchasing of services, referred to as “ Human Provincial Government Purchase Pension Service Pilot Program” issued jointly by the Provincial Department of Finance, Department of Civil Affairs and the Provincial Working Committee Office on Aging. Specifically, the pension service organizations which the elderly obtain services based on the willingness of themselves and their families would obtain subsidies from the related civil affairs departments at the county, city and district level, departments of Aging or governments of townships. The homestay service institutions, services enterprises, professional social organizations or the aged associations which provide homestay services for the elderly would obtain the subsidies as well. In addition, relatives or neighbors who are entrusted to provide services to the elderly would be subsidized according to the tripartite agreement among the government or authorized local service organizations, the elderly and the service providers.

2.1.2 Child SVG’s

The “Notice on Further Developing Moderate-Widespread- Benefiting Children Welfare System

Construction Pilot” issued by the Ministry of Civil Affairs divides children into four categories, which are orphans, troubled children, children of a troubled family and ordinary children. “Troubled children” refer to the disabled, the sick and waifs. “Children of a troubled family” refers to children in the following situations, those whose parents are severely disabled or sick, those whose parents are in long-time custody or serving in prison, or receiving forced detoxification, those where one parent has died and the other parent cannot assume the obligation to provide support or custody for some reason, and last but not least those who are in vulnerable family and suffering from neglect and abuse. Orphans refers to juveniles under the age of 18 who have lost both parents, or have no accessible information to their natural parents, and both of the situations above are supposed to be determined by relevant terms from civil affairs departments at the county level or above. There into, the definition of juvenile is a citizen under the age of 18 according to the Law of the People’s Republic of China on “Protection of Juveniles”. Actually, in practice, it brings children above 18 yet still being educated in full-time school into as a SV support recipient. By the end of 2014, the population of orphans in China had been 535,000 of whom 95,000 were collectively supported, and the other 439,000 were individually supported.

BOX:

Establishment of a moderate-widespread-benefiting welfare classification system, which is called “one widespread plus four classifications”. Following the idea of “ moderate-widespread-benefiting, different levels, different types, different criteria, and different regions”, with the

principle of "advancing at different levels, establishing standards of different levels, developing systems at different regions, and implementing with different criteria", we should design the child welfare system comprehensively based on the local economic and social development, development needs of the child and the development level of the social welfare system. "Moderate-widespread-benefiting" refers to ultimately developing a moderate welfare system benefiting all children. "Different levels" refers to the four levels of children which are orphans, troubled children, children of a troubled family and ordinary children. "Different types" refers to types of classification of the different levels for a further step. "Orphans" are divided into two groups, the uncared for ones and those being taken care of by welfare agencies. "Troubled children" are the children in trouble themselves, including the disabled, the sick and the waifs. "Children in a troubled family" are the children whose families are vulnerable, including those whose parents are severely disabled or sick, whose parents are in long-time custody or serving in prison, or having forced detoxification, and those where one parent has died and the other cannot assume the obligation of providing support or custody for some reason, and whose families are in poor situations. "Different regions" implies that the child subsidy system would be formulated adaptively based on the local conditions in eastern, central and western regions respectively. "Different criteria" means same standards should match the same types. "Advancing at different levels" refers to figuring out clearly the four levels of orphans, troubled children, children of a troubled family and ordinary children and then expanding the child welfare system accordingly. "Establishing standards" for different types refers to establishing different guarantee standards based on the different types. "Developing systems at different regions" refers to building relevant guarantee systems according to the local economic and social situation. Implementing at different criteria refers to implementing the guarantee work based on those established criteria.

Table 11: Situation of Orphans in 2014

Region	No. of orphans*(000)*	Of which	
		Collectively supported *(000)*	Individually supported *(000)*
National	535.19	95.59	439.60
Beijing	2.28	1.86	0.42
Tianjin	0.89	0.60	0.30
Hebei	15.72	2.20	13.52
Shanxi	15.35	3.38	11.97
Neimenggu	5.77	1.19	4.59
Liaoning	7.73	3.15	4.59
Jilin	5.51	1.61	3.90
Heilongjiang	7.97	1.71	6.27
Shanghai	2.05	1.96	0.10

Jiangsu	18.47	3.79	14.68
zhejiang	5.15	2.70	2.45
Anhui	27.13	3.73	23.40
Fujian	6.46	2.10	4.35
Jiangxi	27.20	6.39	20.80
Shandong	18.02	3.68	14.34
Henan	45.58	5.55	40.04
Hubei	27.76	4.85	22.91
Hunan	50.73	7.22	43.51
Guangdong	41.85	10.02	31.829
Guangxi	23.50	2.60	20.90
Hainan	2.11	0.32	1.79
Chongqing	12.38	1.39	10.99
Sichuan	30.50	3.55	26.95
Guizhou	22.12	2.92	19.20
Yunnan	23.04	2.32	20.72
Tibet	5.87	1.57	4.30
Shannxi	13.02	2.79	10.22
Gansu	22.33	3.40	18.94
Qinghai	15.99	1.45	14.54
Ningxia	6.92	0.46	6.46
Xinjiang	25.79	5.15	20.64

Source: Official website of the Ministry of Civil Affairs of the People's Republic of China, http://files2.mca.gov.cn/cws/201501/20150126145241251.htm.

To implement the spirit of the State Council opinion on "Strengthening the Protection of Orphans" (Guo Ban Fa [2010]No. 54), to establish a comprehensive protection system for orphans, to protect feasibly the legitimate rights of orphans, and to promote their healthy growth, the Ministry of Civil Affairs together with the Ministry of Finance has started to provide basic living expenses to every

orphan nationwide since January 2010. The central financing body set a 2.5 billion CNY budget for special subsidies in 2010, and the standards were 180 CNY per person, 270 CNY per person and 360 CNY per person in the eastern, central and western regions respectively. In addition, the local financial departments are required to coordinate properly the central subsidies and local funds and to develop a natural increase mechanism for the basic minimum living standard. The county departments of civil affairs should sign an agreement with the orphan's guardians. This covers the relevant requirements such as the rules on how to claim the use for the basic living expenses and updates on the situation related to the orphan's upbringing as well as clear responsibilities and obligations which the guardians should assume legally. The county (city) departments of civil affairs should establish children welfare instruction centers with the assistance of the welfare institutions, or independently if the conditions permit. Authorized by the departments of civil affairs, the instruction centers can play the role of building documents for the orphans, inspecting and assessing regularly the situations relating to their upbringing, and providing guidance and training for the guardians. In addition the instruction centers are responsible for the orphans' rights, assisting the departments of civil affairs, finance, health, education, human resources and social security, housing and urban construction and other sectors, to implement the preferential policies related to medical rehabilitation, education, housing and employment, and to provide the necessary services and support for the orphans.

2.1.3 Disabled SVG

The second conference of the 11th National People's Congress revised the Law of the People's Republic of China "Protection of Persons with Disabilities", in which the disabled refers to people who lose completely or partially the ability for certain normal activities due to tissue or function loss or disfunction in psychological, physiological or anatomical aspects. The category of the disabled includes visual disability, hearing disability, speech disability, physical disability, intelligence disability, mental disability, multiple disability and others. By the end of 2014, organizations which provided services for the disabled had reached 16,000. Nationwide, the population of persons with a disability amounted to 29.47 million according to national basic data. Of the number of persons with a disability who were receiving FG support disabled was 662,000.

In November 2015, the State Congress issued "Opinions on the Establishment of a Comprehensive System of Living Subsidies for Persons with Difficult Disabilities and Caring Subsidies for Persons with Severe Disabilities", which was to be implemented from 1 January 2016. This two-subsidy system is the first to be especially established for persons with a disability for the disabled at the national level, in order to solve gradually the difficulties to persons with a disability such as additional living expenses and long-term care expenses. The "Living Subsidies for Persons with Difficult Disabilities" targets persons with a disability with the lowest living allowance. This subsidy could extend gradually to the disabled with low income or other difficulties in some places where conditions permit it. "Caring Subsidies for Persons with Severe Disabilities" target persons with a first or second degree the first or second disability who need long-term care. This subsidy could extend gradually to non-severe intelligence, mental or other disabilities in some places where the conditions permit it, to improve the subsidy system to cover all disabled who need long-term care. According to calculations based on the number of persons with a disability on the national database of persons with a disability population in 2014, these two subsides will eventually benefit 10 million people with difficult disabilities and 100 million people with severe disabilities. From the pilot situations nationally the living subsidy and caring subsidy in most provinces are 50 CNY per person and 50 or 100 CNY per person respectively, whilst the highest payments already reach 700 CNY per person and 300 CNY per person respectively.

2.1.4 Other Specific Vulnerable Groups

In the process of social transformation, there have emerged some other specific vulnerable groups, like children who lost dependence, families who lost their only child, tramps, homeless, etc. Children who have lost dependence refers to children under the age of 16 whose father dies and whose mother does not assume the obligation to provide support after she remarries or gets lost, or whose parents cannot assume the obligation to provide support because of legal reasons or health situations, in which the children have live with a grandparent or be supported by other individuals or organizations. Families who lost the only child refers to the families whose only child dies and the parents would or could not give birth again and who are not willing to adopt. Tramp and homeless teenagers refers to juveniles who leave home and have no ability for accommodation, being or who will be homeless or forced to beg, including juveniles with no accommodation and juvenile beggars with no accommodation as well.

For these groups, the central or local governments have also designed a range of oriented support projects, some of which are being implemented referring to SV children support policies, while some are designed specifically on social assistance.

2.2 Basic Support Service for SVG

2.2.1 The FG Support Institution As Mainstay

The rural FG scheme began in the middle of the 1950s. In the area of the people's commune, FG people are succored and cared by the production team. Article 30 of the "1956 ~ 1967 National Agricultural Development Outline" which was approved at the second session of second conference of the National People's Congress in 1960 decreed that ruled China would implement the FG support system, giving special treatment for disabled soldiers and parents feeding their children. Agricultural cooperatives should take care of vulnerable people who are dependent and arrange for them to do labor if they can. In reality, the team should ensure that the vulnerable receive food, clothing, fuel, education and burial expenses. From then on, the FG support system became a long-term policy in rural areas.

After the household contract responsibility system, FG system basing on collective economics is strongly shocked. To ensure their life, a "township contribution and village reserve" model is built.

In January 1994, the State Council issued the "*Regulations for Rural Five-Guarantee Work"* to implement the protocol institution and stipulate the object, content, form, capacity disposal, supervision and administration of the programme. On March1997, the Ministry of Civil Affairs issued the "*Interim Measures for the Rural Old-age Home Management".* The State Council also approved the *"Regulations on the Rural Five-Guarantees Scheme".* The Ministry of Civil Affairs approved the *"Measures for the administration of the rural five guarantees service agencies"* in 2010, governing the programme's plan, construction, object, content, fund and administration. The content stated in "*Regulations on Rural Five-Guarantee Scheme"* is:

(1) Providing grain, oil, subsidiary food and fuel

(2) Providing clothes, bedding, mattress and pocket money

(3) Providing a suitable house

(4) Providing medical treatment and daily care

(5) Providing funeral arrangements

Now, China has built a social assistance safety net specifically for the rural vulnerable aged, children and disabled with the civil affairs department as its core and the Disabled Persons' Federation, the poverty-relief and housing department as supplements. In practice, the care for the vulnerable disabled is mainly implemented by the Disabled Persons Federation. They have higher standards, a wider range and more professional methods. The standard of vulnerable children is

higher than that for the aged and the amount is smaller. They are supported by professional organizations in the civil affairs department. Support for the vulnerable aged is the most important part of the specific support for vulnerable people. It covers 90% of total recipients (including some disabled). The support models are collective support and individual support.

2.2.2 Procedures for SVG Support Provision

The stakeholder or agent should apply for the specific vulnerable person support and the nation provides the corresponding service. For different groups, the procedures are different. Graph 1 is the procedure of specific aid for the vulnerable old.

The stakeholder can apply in writing. If he has difficulty, he can ask others for assistance. Then the village committee appraises the application and makes public those who are qualified to receive a benefit. If there is no objection, the village committee submits the file to the township government.

The township government should investigate the applicant's family and economic condition within 20 days. It comes to a conclusion and submits the application to the county civil affairs department. The county government is responsible for administering the implementation of the FG allowance system.

The county civil affair department should make a decision within 20 days and issue a rural FG support license to those who are qualified. To those who are not granted approval to be covered by this institution, the department should provide a written explanation. The government, civil affairs, finance, education, health, housing of urban-rural development, human resource and social security department above the county level should take corresponding responsibility for FG affairs.

Where the person is not qualified, or his burial affairs are completed, the village committee or service organizations should report to the township government, then the civil affairs department should carry out a check and cancel the eligibility.

The Ministry of Civil Affairs department arranges the FG allowance system in the country and the Ministries of Finance, Health, Education, Housing and Urban-rural Development, Human Resources and Social Security departments above county level should take the corresponding responsibility for FG affairs.

2.2.3 Modes of Support for SVG

According to the recipient's health condition, willingness and local capacity, there are three modes of support for SVG - collective support, individual support, and third paryt support. The proportion of collective support is comparatively low nationally at about 1/3.

2.2.3.1Collective Support

The main force of collective support is government organizations. FG service organizations, such as Homes for the Elderly, the Child Welfare Institution and the Disabled Welfare Institution, undertake the task of collective support to rural FG recipients and they usually provide food, clothing, housing, medical treatment, funeral and other services. In the rural areas, the main collectively supported FG recipients are the specific groups such as the aged without the ability to work, orphans and persons with a disability. Currently, the management of the elderly support organizations of FG, like Homes for the Elderly is dominated by township or county governments and for child support organizations of FG, like the Child Welfare Institution, county or city governments usually takes charge of the management. By the end of 2014, there were 94,100 various types of age service organizations and facilities, which include 33,000 aged service institutions. For child support, there were 890 institutions with a total number of beds of 108,000 and about 59,000 people who were adopted. This was an increase of 10.3% over the previous year. For support of juveniles, there were 345 institutions in total with 12,000 thousand beds. About

170,000 homeless juveniles were assisted. For support to the disabled, the number of institutions was 16,400 and 479,000 job positions were provided to workers with disabilities. The total number of collectively supported FG recipients was 1.743 million and the annual average standard for supported persons was 5,371 CNY per person, which was an increase of 14.6% on the previous year.

From the perspective of eastern, central, and western economic zones, in 2014 the provinces with the most collectively supported FG recipients were Shandong, Henan, and Sichuan respectively (see table 12). For Shandong, the number of collectively supported FG recipients was 168,000, and the rate of collective support was 74.3%. The annual average standard of support was 5,394 CNY per person. There were 1,525 aged service institutions and 245,000 beds in Shandong. For Henan, the total number of recipients was 189,000 and the rate of collective support was 38.6%. The annual average standard of support was 3,932 CNY per person. There were 4,294 aged and disabled service institutions, 68 child support institutions, and 32 juvenile support centers in Henan. The total number of beds in aged service institutions was 261,000 in all. For Sichuan, the number of collectively supported FG recipients was 269,000 and the rate was 53.2%. The annual average standard for support was 4,468 CNY per person and the total number of beds in aged service institutions was 361,000.

Table12: Situation of Collectively Supported Wubao Recipient in 2014

Region	Number of Collectively Supported Wubao Recipient (000)	Of which				Annual mean of financial standard (000)
		Female (000)	Elders (000)	Children (000)	Disable (000)	
National	1745.99	302.89	1550.76	50.06	278.07	5.37
Beijing	1.96	0.20	1.49	0.02	1.06	13.09
Tianjin	1.24	0.14	1.11	0.01	0.30	9.30
Hebei	71.00	7.15	62.95	1.06	13.08	5.23
Shanxi	25.31	1.72	20.60	0.45	5.89	4.81
Neimenggu	24.91	1.79	20.91	0.17	5.54	7.30
Liaoning	33.53	3.48	29.44	0.58	6.74	6.08
Jilin	23.85	2.57	16.46	0.14	7.62	4.42
Heilongjiang	50.62	9.87	39.99	1.59	12.74	5.30
Shanghai	1.14	0.22	1.04	0.01	0.21	9.00
Jiangsu	102.26	17.34	96.43	1.17	13.98	8.10
Zhejiang	35.73	5.61	33.64	0.33	5.14	9.43
Anhui	160.46	22.48	149.94	2.32	19.13	4.56

Fujian	9.19	1.15	8.08	0.22	1.55	6.71
Jiangxi	120.74	42.09	102.50	11.05	15.76	3.51
Shandong	167.91	31.40	161.68	1.45	14.93	5.39
Henan	188.35	35.99	171.43	5.65	26.40	3.93
Hubei	70.10	13.11	63.19	0.47	11.56	4.69
Hunan	103.78	22.201	91.643	4.34	16.47	5.69
Guangdong	28.27	5.49	26.98	0.40	2.56	7.93
Guangxi	22.14	3.99	20.52	0.56	3.50	4.04
Hainan	2.39	0.71	2.32	0.04	0.10	5.48
Chongqing	64.15	6.72	55.80	0.62	12.26	5.52
Sichuan	268.76	30.39	234.16	7.19	44.99	4.47
Guizhou	37.79	7.08	30.24	4.26	5.61	3.30
Yunnan	38.57	9.18	32.37	1.98	8.75	3.92
Tibet	8.22	3.64	7.09	0.68	0.80	3.87
Shannxi	48.68	7.61	40.00	0.76	13.59	5.78
Gansu	12.73	2.11	10.72	0.81	2.45	3.74
Qinghai	4.31	1.73	3.75	0.39	0.52	5.48
Ningxia	4.04	0.77	3.20	0.17	1.30	5.69
Xinjiang	13.85	4.97	11.08	1.19	3.54	6.75

Data Source: Official Website of Ministry of Civil Affairs of the People's Republic of China, http://files2.mca.gov.cn/cws/201501/20150126145241251.htm.

Currently, there are several problems concerning collective support in the rural areas:

(1) The occupancy rate of social welfare institutions is not high and most recipients of collective support are rural elders who can’t take care of themselves or people with severe disabilities;

(2) Low payment for and education level of welfare institution staff and high staff turnover rate;

(3) The ratio between recipients and nursing workers is far from meeting the national requirement, which causes severe asymmetry and a low quality of support;

(4) With the increasing number of institutions, their size expanding and improving infrastructure and facilities and as the cost of management and maintenance in the later stages continue to rise, there is a resulting larger fiscal gap for poor central and western regions and the unsustainability of the collective support institutions for FG.

Table 13: Situation of Collectively Supporting Organizations in 2014

Region	Number of SA Supporting organizations (000s)	Number of Beds for SA supporting (000s)	Number of staff working in SA supporting organizations (000s)
National	37.80	5865.14	2751.67
Beijing	0.63	141.53	75.03
Tianjin	0.35	59.93	28.17
Hebei	1.51	451.87	114.19
Shanxi	0.90	88.23	40.66
Neimenggu	0.78	100.84	54.30
Liaoning	1.81	215.19	117.55
Jilin	0.90	95.70	48.40
Heilongjiang	1.09	131.15	94.11
Shanghai	0.68	121.79	80.84
Jiangsu	2.47	571.34	219.25
zhejiang	2.04	365.35	143.68
Anhui	1.00	333.33	72.37
Fujian	0.49	123.24	23.10
Jiangxi	2.04	181.90	158.43
Shandong	2.24	603.74	212.82
Henan	2.78	338.89	228.50
Hubei	2.32	263.91	184.21
Hunan	2.59	213.94	137.27
Guangdong	1.59	209.79	82.17
Guangxi	0.53	144.18	23.77
Hainan	0.21	17.09	3.34
Chongqing	0.93	164.96	70.02

Sichuan	3.66	429.64	318.94
Guizhou	0.90	100.55	29.10
Yunnan	0.65	79.64	41.34
Tibet	0.27	11.66	7.13
Shannxi	0.87	117.65	70.55
Gansu	0.55	93.55	20.23
Qinghai	0.17	18.92	6.12
Ningxia	0.10	12.38	7.22
Xinjiang	0.75	63.10	38.73

Data Source: Official Website of the Ministry of Civil Affairs of the People's Republic of China, http://files2.mca.gov.cn/cws/201501/20150126145241251.htm.

Table 14：Situation of Collectively Supporting Organizations by SVG in 2014

	Number of SA Supporting organizations for aged and disabled SVG (000s)	Number of SA Supporting organization for Children (000s)	Number of Beds for aged and disabled SVG supporting (000s)	Number of Beds for children SVG supporting (000s)	Number of staff working in supporting organization for aged and disabled SVG (000s)	Number of staff working in supporting organization for Children SVG (000s)
National	34.14	0.82	3934.39	102.17	2593.26	56.40
Beijing	0.59	0.01	124.12	1.97	71.01	0.98
Tianjin	0.33	0.002	49.87	0.82	26.39	0.56
Hebei	1.31	0.01	200.70	0.78	108.03	0.27
Shanxi	0.81	0.01	66.96	0.78	38.14	0.52
Neimenggu	0.71	0.01	83.45	1.69	49.61	0.96
Liaoning	1.65	0.01	174.91	3.04	108.5	2.38
Jilin	0.80	0.02	76.43	3.97	43.90	1.52
Heilongjiang	0.94	0.02	115.60	2.84	90.42	1.46
Shanghai	0.65	0.01	112.83	1.38	75.96	2.26
Jiangsu	2.32	0.04	364.64	4.85	210.67	2.42
zhejiang	1.92	0.02	288.74	3.02	140.58	1.69
Anhui	0.84	0.05	105.28	6.31	67.60	3.29
Fujian	0.38	0.01	43.19	1.45	18.47	0.79
Jiangxi	1.93	0.01	172.46	1.47	156.88	0.82
Shandong	2.12	0.03	326.23	7.39	205.46	3.60
Henan	2.63	0.02	269.70	3.81	222.24	2.96
Hubei	2.07	0.11	236.47	7.37	175.57	3.64
Hunan	2.36	0.07	166.55	5.64	128.53	2.88
Guangdong	1.44	0.04	149.38	5.09	73.97	2.50

Guangxi	0.43	0.02	30.57	1.99	19.35	0.84
Hainan	0.20	0.003	14.16	0.30	3.14	0.12
Chongqing	0.87	0.01	96.44	3.29	65.91	1.29
Sichuan	3.30	0.09	361.10	6.57	300.29	2.72
Guizhou	0.77	0.02	49.01	3.20	24.79	1.44
Yunnan	0.49	0.04	51.90	3.32	37.31	1.73
Tibet	0.25	0.01	8.86	2.34	5.47	1.48
Shannxi	0.76	0.01	93.61	3.07	66.34	2.33
Gansu	0.46	0.03	33.57	3.83	16.83	2.60
Qinghai	0.13	0.01	12.24	2.24	4.72	1.17
Ningxia	0.08	0.01	9.80	1.26	6.48	0.43
Xinjiang	0.60	0.06	45.69	7.11	30.68	4.75

Data Source: Official Website of Ministry of Civil Affairs of the People's Republic of China, http://files2.mca.gov.cn/cws/201501/20150126145241251.htm.

2.2.3.2 Individual Support

The main subject of individual support is the individual and their daily life care. This is the responsibility of the village committee. From 1949 to 2006, the traditional individual support pattern can be divided into four categories. The first is those people paid for and fed by the village committee with their basic life guaranteed by the village and the community. The second is people paid for by the village committee and fed from the land. The village and the community provide cash to subsidize the FG recipients and the grain comes from their own land. The land can be cultivated by relatives, other villagers or themselves. The third is people paid for and feed by relatives or from their own land. This pattern can also be divided into two forms, one is depending on relatives, the relatives can inherit their land or the house, the other form is depending on responsible land and all supports are from the land, no matter they can cultivate it or not. The fourth one is the temporary assistance institution. FG recipients are seen as the traditional assistance recipients and get support from the government relief fund every year. The "*Regulations on the Rural Five-Guarantees Scheme"* issued in 2006 brought about a change in the traditional support pattern. The allowance paid by the Government gives FG recipients a fundamental guarantee and they can use their land and their property as they want.

By the end of 2014, the number of persons receiving rural individual support was 3.55 million and their average standard was 4,006 CNY per person. This was an increase of 14.5% over the previous year. We can see from the three economic zones (eastern, middle and western) that the provinces that have the most individual support recipients are Guangxi, Hunan and Sichuan (see table 15). The number of FG supported persons in Guangxi was 289,500 (92.9% are individually supported) and the average benefit is 3,119 CNY per person. In Hunan province, there are 504,000 FG

supported recipients (79.2% are individually supported) in 2,370 organizations with an average benefit of 2,998 CNY per Person. In Sichuan, the amount of FG recipients is 505,000 (46.8% are individually supported) and the average standard is 3,484 CNY per Person.

Table 15 Situation of Individually Supported Wubao Recipient in 2014

Region	Number of individually Supported Wubao Recipient (000s)	Of which				Annual mean of financial standard (CNY 000)
		Female (000s)	Elders (000s)	Children (000s)	Disable (000s)	
National	3549.50	631.46	2995.12	157.42	637.65	4.01
Beijing	2.23	0.16	1.79	0.01	1.16	13.09
Tianjin	11.04	1.05	9.53	0.06	2.58	7.97
Hebei	161.18	14.39	142.64	2.92	28.77	3.55
Shanxi	135.01	13.35	97.78	6.57	40.89	2.91
Neimenggu	64.05	5.28	51.38	0.64	15.45	4.74
Liaoning	104.39	12.74	88.91	2.54	21.82	3.99
Jilin	91.70	16.64	58.22	1.92	33.77	3.09
Heilongjiang	85.56	17.15	61.22	2.52	28.57	3.76
Shanghai	1.57	0.22	1.27	0.01	0.46	9.00
Jiangsu	96.04	13.95	90.40	1.49	10.45	7.02
Zhejiang	0.76	0.13	0.68	0.01	0.15	8.62
Anhui	270.14	43.96	247.09	4.71	34.25	2.89
Fujian	75.45	10.22	61.98	2.86	17.05	5.82
Jiangxi	108.62	37.51	90.12	10.97	16.55	3.10
Shandong	58.11	11.24	55.72	0.62	5.16	3.67
Henan	299.32	55.19	270.68	9.69	36.97	2.41
Hubei	186.52	35.95	165.68	1.98	28.38	3.38
Hunan	400.64	78.36	337.49	22.03	66.06	3.00
Guangdong	212.66	33.34	198.07	7.16	18.46	7.65

Guangxi	268.87	45.02	239.74	14.21	36.09	3.12
Hainan	29.26	8.13	27.48	0.76	2.23	4.64
Chongqing	99.45	9.28	82.80	2.08	18.75	4.86
Sichuan	236.36	33.48	203.23	7.71	41.87	3.48
Guizhou	80.03	16.90	57.10	14.52	12.95	2.21
Yunnan	172.75	43.05	119.56	18.23	49.16	2.61
Tibet	7.59	3.72	6.46	0.65	0.83	3.41
Shannxi	84.23	13.48	64.07	3.45	23.54	4.92
Gansu	108.83	21.87	90.76	5.45	22.28	3.52
Qinghai	18.96	6.11	14.65	2.92	3.28	5.00
Ningxia	10.10	2.49	6.74	0.94	3.40	3.71
Xinjiang	68.10	27.13	51.87	7.81	16.32	4.30

Data Source: Official Website of the Ministry of Civil Affairs of the People's Republic of China, http://files2.mca.gov.cn/cws/201501/20150126145241251.htm.

Individual people can still stay in their own living surroundings. Their living habits and psychological demands are satisfied. By now, the problems of the rural FG individual support are: firstly, people who chose individual support are the disabled who cannot take care of themselves well or juveniles without family care. The others are the aged who have lived in villages for a long time, so they cannot adapt to the restraints of an old persons home. Secondly, although people who chose individual support can get an allowance and subsidy as material support, their quality of life is not high due to a lack of daily care and treatment, poor diet and a lack of regularity in their life.

2.2.3.3 Third party support

Third party support is where a county civil affairs department or township government entrusts a third party to provide home care service for FG recipients in the form of buying services from the society. The service includes care during the day, providing or buying dinner, medical related services, cleaning services, spiritual consolation, security and so on. On July 2015, the civil affairs department of Qinghai province issued "A *pilot for a third party service scheme for the vulnerable aged in Qinghai village and herding areas". It* pilots a scheme in 11 towns such as Huangnan, Guoluo, Yushu and Hainan. The scheme is aimed at FG recipients and the "Three None's" - old people who live in a village or herding areas and do not receive help from support organizations, the solitary aged who are covered by the Minimum Subsistence Allowance System (Dibao) and who are above 70 and solitary people with special care needs in village or herding areas. The service provider can be qualified home care centre or other organizations, or who receive services from village organizations, senior associations, village service centres or other warm-hearted people who join together.

2.2.4 Financial Input

The "*Regulations on the Rural Five-Guarantees Scheme"* prescribe that the rural FG fund should be arranged as part of the local government budget. Villages that have a business income can subsidise the FG recipients. If a person give his land to others, the revenue should be returned to him. The central government gives fiscal help to those difficult areas. Currently the funds of the FG allowance system come from the local government budget, the village committee's revenue, central government subsidies, support organizations' productive income, social donation and from the funds of the welfare lottery.

The support standard is usually determined by local government. By the end of 2014, the fiscal fund for rural FG was CNY18.98 billion an increase of 10.2% over 2013. The collective support fund is CNY7.8 billion and the individual support fund is CNY11 billion. The annual collective support level is 5,371 CNY per person and the average individual support amount is 4,006 CNY per person. In fact, the support standards are different for different groups - the standard of collective support for the aged is higher than the individual support. The standard for vulnerable children is higher than for the aged. The standard for persons with a disability is almost the same as for the aged but the PWD have other subsidies.

From research of the three economic zones (eastern, middle and western) the provinces spending the most for FG are Guangdong, Hunan and Sichuan. (see table 16). The data for Guangdong is CNY 1.56 billion, CNY 0.22 billion for collective support and 1.34 billion for individual support. Hunan spent CNY 1.59 billion on the rural FG, CNY 0.52 billion for collective support and CNY 1.07 billion for individual support. Sichuan spent CNY 1.83 billion with collective support of CNY 1.09 billion and individual support of CNY 0.74 billion.

Table 16: Expenditures on Wubao in 2014

Region	Expenditure for collectively support (million yuan)	Of which		Expenditure for individually support (million yuan)	Of which	
		Regular (million yuan)	Temporary (million yuan)		Regular (million yuan)	Temporary (million yuan)
National	7802.32	7554.25	248.07	11032.14	10707.66	324.47
Beijing	17.65	16.57	1.09	20.40	18.14	2.26
Tianjin	10.99	10.49	0.49	79.73	77.57	2.16
Hebei	380.74	359.84	20.90	465.66	448.57	17.09
Shanxi	124.48	124.12	0.36	339.33	337.11	2.22
Neimenggu	149.07	145.00	4.08	244.49	236.67	7.83
Liaoning	171.26	159.93	11.33	333.80	315.89	17.91
Jilin	81.33	78.23	3.10	146.51	143.58	2.93
Heilongjiang	290.13	278.97	11.17	291.93	277.01	14.92
Shanghai	7.21	6.87	0.34	7.60	7.42	0.18

Jiangsu	686.57	662.67	23.90	475.78	456.19	19.58
Zhejiang	247.03	234.92	12.11	3.15	2.89	0.26
Anhui	600.41	595.51	4.90	601.63	595.40	6.22
Fujian	55.51	53.99	1.52	403.76	391.18	12.58
Jiangxi	384.96	383.90	1.06	301.78	297.77	4.02
Shandong	814.47	770.50	43.97	205.91	190.10	15.81
Henan	630.09	621.46	8.63	681.05	675.71	5.34
Hubei	280.11	258.38	21.74	478.56	445.09	33.47
Hunan	519.90	509.21	10.69	1071.29	1027.38	43.92
Guangdong	224.77	217.51	7.25	1341.67	1307.19	34.48
Guangxi	84.90	82.62	2.28	764.08	757.95	6.14
Hainan	13.34	11.75	1.59	135.95	128.66	7.29
Chongqing	313.68	300.92	12.76	447.49	424.26	23.23
Sichuan	1093.79	1088.45	5.34	745.72	741.37	4.34
Guizhou	79.64	72.47	7.17	150.51	141.03	9.48
Yunnan	109.13	108.39	0.74	294.04	292.42	1.61
Tibet	21.86	19.44	2.42	19.66	18.33	1.33
Shannxi	270.86	248.86	22.00	411.47	390.15	21.31
Gansu	36.80	36.50	0.30	334.33	333.77	0.56
Qinghai	18.04	16.70	1.34	76.06	73.74	2.32
Ningxia	24.36	23.47	0.90	22.99	21.71	1.29
Xinjiang	59.25	56.63	2.62	135.85	133.43	2.43

Data Source: Official Website of the Ministry of Civil Affairs of the People's Republic of China, http://files2.mca.gov.cn/cws/201501/20150126145241251.htm.

3. Other Dedicated Social Assistance Programs for SVG

In addition to the support system mainly formed by civil social assistance, social welfare social assistance and social assistance provided by the persons with a disability work department, there are a number of other related policies or programs for SVG. Some significant policies and programs will be introduced in this chapter.

3.1 Rural Medical Assistance

In order to implement the guiding principle of the "*Decision of the Central Committee of the CPC and the State Council on Strengthening Rural Health Work ([2002] No.13)"*, the Ministry of Health and the Ministry of Finance decided to establish and implement the rural medical assistance system and provide medical assistance to FG recipients and poor peasant families who are suffering from critical illness, through multi-channel financing such as government grants and social donations. The medical assistance system was established in 2003 and since then has achieved full coverage of the urban and rural areas. To further enhance the level of medical care for rural residents and reduce the treatment expenditure for rural patients with critical illness, six departments including the General Office of the State Council, the National Development and Reform Commission, and the Ministry of Health jointly issued "*Opinions on the Critical Illness Insurance Program for Urban and Rural Residents"* (CIIP). In these opinions it was decided to expand the coverage of the country's healthcare insurance system to include 20 kinds of critical illness previously only covered by New Rural Cooperative Medical System (NRCMS). According to this policy, more than 70% of the medical costs of rural patients would be paid by NRCMS, and the CIIP would cover more than 50% of the remaining cost when it exceeded the compensation standard. The aim was to prevent rural families from being reduced to poverty on account of healthcare costs.

To implement the guiding principle of the "*Decision on Improving the Medical Social Assistance System and Completely Expanding Medical Social Assistance for Critical Illness by the Central Government" ([2015],30)*, the People's Government of Qinghai province issued the "*Notice on Further Improving and Perfecting Medical SA System"*. This defines the recipients as residents of Qinghai. According to their financial capability, the recipients were categorized into three types: (1) key recipients, i.e. residents with severe difficulties and that mainly ensured that the SVG (the urban "Three None's" residents, rural FG recipients, orphans, and those with severe disability in a low income family were included); (2) low income residents; (3) residents with difficulties in affording medical expenditures. The specific arrangement of medical social assistance includes policies for key recipients including: (1) full sponsorship of the cost of the Basic Medical Insurance for Urban and Rural Residents; (2) 360 yuan per year of subsidy for outpatient service and 100% medical assistance for the remaining amount of expenditure for outpatient services related to critical illness, which was unable be covered by the basic medical insurance; (3) after the reduction of bill and the reimbursement of basic medical insurance and critical illness insurance, providing 100% medical assistance for the remaining amount of expenditure of inpatient services at specific medical institutions; (4) for the medical cost of SVG patients with critical illness at the specific medical institutions, after the reduction of bill and reimbursement of insurance, 60% of the remaining amount of expenditure will be sponsored and the limit of amount is 100,000 yuan per person per annum.

3.2 Support to Persons with a Disability

In 2007, the China Disabled Persons' Federation (CDPF) issued the "*Implementation Rules on the*

Reconstruction Project of Dilapidated Buildings for the Rural Poor Disabled and Regulations on the Funding of the Special Lottery for People with Disabilities". It restricted the recipients of this a subsidy under this project to the rural poor with a disability living in severely dilapidated housing in the central and western regions. The CDPF was in charge of the general planning, implementation and management of this project. Each province was responsible for designing and implementing its own work plan, and also for assigning the task to counties and reporting to CDPF. The county organization of CDPF was accountable for distinguishing subsidy recipients and implementing of the plan in rural areas.

Each recipient family could get a subsidy of CNY 3,000 and the renovation of the recipient's housing was to be financed from the fund of the National Lottery for Public Welfare (NLPW).

Since 2008, a common program, funded by NLPW, was promoted in Zhejiang, Gansu, and Anhui provinces, aiming to implant artificial limbs and provide other assistive devices such as wheelchairs and rehabilitation services to poor FG recipients with a disability, the “Three None’s”, minimum subsistence allowance recipients and disabled veterans. In order to improve the quality of rehabilitation support of welfare institutions and for the poor disabled, the Ministry of Civil Affairs and the National Research Center of Rehabilitation Devices jointly launched the FuKang Program. This aims to provide free artificial limbs and other devices, surgical operations, accessible supporting facilities to the collectively supported disabled recipients of welfare institutions in western regions. At the end of 2013, the percentage of the rural disabled who had received rehabilitation services was 56.6%. This was an increase of 3.5% over the previous year (see Table 17).

Table 17: The Percentage of Rural Disabled Who Had Received Rehabilitation Services

Unit: %	2007	2008	2009	2010	2011	2012	2013
Treatment and Rehabilitation Training	8.4	9.0	9.5	13.3	12.7	18.7	22.1
Supporting Devices	3.0	4.4	3.9	6.7	7.3	12.8	14.9
Psychological Counseling	3.6	4.6	4.5	6.6	8.0	11.8	13.1
Rehabilitation Knowledge Training	3.6	4.9	4.7	11.4	15.7	24.1	29.1
Diagnosis and Needs Assessment *	—	—	—	—	16.1	10.4	12.1
Home Care, Daytime care and Third Part Support*	—	—	—	—	11.8	13.8	14.6
Training for the Disabled and Their Relatives*	—	—	—	—	3.6	6.0	6.5
Follow up and Assessment*	—	—	—	—	5.0	11.6	11.7
Other Rehabilitation Services*	—	—	—	—	11.4	19.8	25.3
Participated in Rehabilitation Services at Least for one time	15.7	19.2	19.3	30.8	45.4	52.6	56.1

Date Source: Official website of the China Disabled Persons’ Federation, http://www.cdpf.org.cn/sjzx/jcbg/201408/t20140812_411000.shtml.

Note: * means items newly added to the rehabilitation services in 2011.

Based on the funding of NLPW, the Central Government set up a special fund to increase support for the education of persons with a disability and implemented the program for special education aid for them (including pre-school and special education of middle and high school). This aimed to

implement the guiding principle of policy documents such as "*Decisions of the State Council on the Current Development of Pre-school Education" ([2010], No.41)*, *"Outline of the Eleventh Five-Year Period for the Development of Work for Persons with a Disability in China"*, and *"Outline of the Twelfth Five-Year Period for the Development of Work for Persons with a Disability in China"*. These grants were set up for to meet the pre-school costs and living expense of children with a disability whose families were in economic difficulties, and according to its regulation, each recipient could get a grant of CNY 3,000 yuan annually for up to three continuous years. With the subsidies for running costs for special education in middle and high schools and the construction of training bases, this program was designed to improve the educational condition of special schools and the construction of training base for disabled students, to promote local governments' support of special education, and to improve the educational quality, and the effectiveness, of establishing special schools.

Since 2007, educational assistance policies such as the "Two Exemptions and One Subsidy" regulation of compulsory education have gradually been strengthened and fully implemented. The proportion of children with a disability who receive compulsory education has shown a rising trend. In 2013, the proportion of disabled children aged from 6 to 14 who received compulsory education was 72.7%. This was an increase of 0.8% over the previous year. At the end of 2014, there were 187 classes of high school of special education and 7,227 students, 1,054 of whom were blind and 6,173 of whom were deaf, 197 classes of middle school of special education and 11,671 students and 7,274 graduates and 5,532 of whom received professional certificates. 7,864 students with a disability were admitted to regular universities and 1,678 students with d disability were admitted to special education academies.

In February 2005, the Ministry of Commerce launched the "Ten Thousand Villages and One Thousand Towns Markets Project". Through subsidies and interest discounts, the State arranged financial funds to guide distribution companies like chain stores and supermarkets to extend their shops to rural areas. The goal was to build modern distribution networks, improving the consumption environment, and meeting peasants' production and living needs in rural areas. By the end of 2014, the disabled aid and poverty reduction program of the markets project had provided 6,865 rural poor disabled with jobs and founded 1,990 village shops for the rural poor disabled.

3.3 Support to Single-Child-Lost Families

In order to solve the special difficulties of single child loss families, the National Health and Family Planning Commission, Ministry of Civil Affairs, Ministry of Finance, Ministry of Human Resources and Social Security and the Ministry of Housing and Urban-Rural Development jointly issued the "*Notice on Further Improving Support to Families of Family Planning with Special Difficulties"*, deciding to completely implement the special support system for Families of Family Planning from 2008 onwards. For single child loss couples who didn't have a second child or didn't adopt a child, the husband and the wife would respectively receive a special subsidy of not less than 80 yuan (if the child was disabled) or 100 (if the child had died) per month. In 2012, the standard of the subsidy was raised to 110 yuan (for disabled) and 135 yuan (for death) per person per month. In 2013, there were 671,000 recipients under this project, 407,000 of whom had lost their single child. From 2014, the state strengthened the support. For urban residents, the subsidy was 270 yuan (for disabled) and 340 yuan (for death) per person per month. For rural residents, the subsidy was 150 yuan (for disabled) and 170 yuan (for death) per person per month. The number would adjust through dynamic growth mechanisms. The Central Government would subsidize the eastern, central and western regions in different proportions.

Based on the Notice issued by the Ministries, Zhejiang province implemented the "New Policies for Single Child Loss or Disabled Families and People with Family Planning Surgical Complications". This covered life support, endowment care, spiritual comforting and other aspects. The aims were

(1) To improve the support standard for people with family planning surgical complications and the standards respectively increased from 300 yuan to 600 yuan, from 200 yuan to 400 yuan, and from 100 yuan to 200 yuan per person per month;

(2) to improve the standard for single child loss or disabled families with disabilities, dementia and no ability to provide self-care, where the wife was aged from 49 to 60, from 500 yuan to 700 per person per month and in addition, to provide a one-time subsidy of 50,000 yuan for single child loss families with an adopted child; for single child loss families who have participated in basic pension insurance for enterprise employees and to provide some subsidies to share the cost of their expenses.

(3) To provide collective support to single child loss families with disabilities, dementia and no ability to provide self-care, or aged 70 and have the willingness, through public age care institutions appointed by the county, city, or district civil affairs departments; to provide third party support to the disabled who both match the requirements and have the willingness, by county, city, and district CDPF; to provide funeral support to single child loss families which match the requirements of rural FG and urban "Three None's"; to arrange the village committee as the guardian to those living alone, with one's consent at first, for realizing guardian duties of entering a nursing home and having medical treatment; to provide a "green channel" at all levels for single child lose parents' medical treatment and specific measures which should be decided by county, city, district health departments.

(4) To provide the psychological care to single child loss families; according to these families' needs. Local governments would choose the combined ways of purchasing of services and volunteer services and provide them with social assistances like life care, support for production, spiritual comforting and psychological care.

3.4 Support to Street Children and Baby Safety Island

To implement the Laws of the People's Republic of China on the *"Protection of Juveniles"*, "*Prevention of Juvenile Delinquency"* and *"Compulsory Education"* and to improve the relief protection mechanism, the General Office of the State Council issued "*Opinions on Strengthening and Improving the Relief Protection of Street Children"*. The specific measures are as follows.

(1) Implementing more proactive relief and protection. The public security departments should escort the street children to the relief protection agencies once finding them. Once coming across the children who are begging with adults, the public security department should investigate and identify the following situations. If the adults forced or tricked the children to beg illegally, they will carry out the punishment by law. If the begging adults are parents or other guardians only carrying the children with them, they would be criticized and educated and then escorted to relief protection agencies for help, and finally be escorted back home with the assistance of public security department. The civil affairs departments would coordinate with each other to carry out active relief, guiding the street children to relief agencies for help. City management departments should report to, and assist, public security departments with the escort process once they find street children. In the case of street children who have a sudden illness, the public security department with the departments of civil affairs and city management are required to escort them directly to designated hospitals. In addition, the role of grass-root organizations such as village (neighborhood) committees is to organize and mobilize citizens to provide assistance, guide the street children to the relevant departments for relief, or make the public security departments aware of the case.

(2) Intensifying the crackdown on the trafficking of juveniles. Public security departments shall collect biological samples of unidentified beggars and children forced to be criminals and

enter the information into the national anti-trafficking DNA database for comparison. In addition, public security departments would also take the following measures. Firstly, strengthening their processing capacity which means they will respond immediately upon receiving an alarm. Secondly, intensifying the filingprocess, which means that they will implement a quick search mechanism with police resources. Thirdly, they will establish cross-sector, cross-unit, and inter-regional coordination mechanisms. In addition, the relevant departments, such as civil affairs, would assist to investigate, collect evidence and rescue the children.

(3) Assist the homeless children to return home as soon as possible. The relief protection agencies and the public security departments should responsibility for seekng parents or other guardians for homeless children based on the relief information system, population management information system, anti-trafficking DNA information database, public bulletins, etc.

For the street children who have found parents or other guardians, the relief protection agencies should arrange promptly for them to return home, in which process departments such as transportation and railways would provide tickets, station access and traveling services. Relief protection agencies of children locating to a new place are required to take the following measures: notify the township government (sub-district office) where the permanent Hukou of the returning children or their guardians is located so that the relief protection could proceed appropriately; to investigate and assess the family guardianship for the children. On the one hand where the family has no ability for guardianship, the relief agencies would assist in entrusting for the child’s custody. On the other hand where family refuses to assume guardianship, the relief agencies could apply to the people’s court to revoke their guardianship and then designate others for guardianship by law.

For street children who temporarily have not found parents or other guardians, the work searching for the family should continue. In the interim, the street children should be taken good care of by the relief protection agencies, social welfare agencies or foster families. For street children who still have not found parents or other guardians after two years or longer, the public security department should transact the Hukou registration for them according to household management regulations, so that the street children could get access to school or jobs. For infants rescued in the process of the trafficking crackdown with no knowledge of parents or other guardians, the department of civil affairs should settle them in social welfare agencies, and the public security department would transact the Hukou registration for them as well.

(1) Education and correction for street children. Relief protection agencies should assume the temporary guardianship of street children, and provide them services such as cultural and legal education, psychological counseling, behavioral therapy and skills training. in addition the relief agency should assist the judicial departments to provide legal aid or judicial assistance for the children whose legal rights were infringed. Under the guidance of the departments of educational administration, the relief protection agencies should help street children to get access to compulsory education or alternatives. For the street children with bad habits, the relief agencies would adopt correction by education; for those with serious misconduct, the relief agencies could send them to professional schools for education and correction according to the relevant provisions; for the disabled street children, the departments of health and DPF could provide the relief agencies guidance in the areas of psychological counseling and rehabilitation training.

(2) Strengthening prevention and management from source. Prevention is a shared responsibility of family, school, government and society, and thus prevention from source is the fundamental solution to the problem of street children. The family is the unit with prime responsibility for solving the problem of street children, so it should assume its legal

obligations and guardianship. Relevant departments and local organizations should play the role of guidance and supervision, to help the family solve practical difficulties and improve the family's upbringing and education ability. Village (neighborhood) committees should develop a random visit system to prevent situations where the parents or guardians do not fulfill their guardianship or infringe the rights of the juveniles. If the circumstances are severe, the committee should report to the public security, to force the guardians to make changes or to impose administrative punishments if the guardians violate security procedures.

On November 30, 2013, the Ministry of Civil Affairs issued the "Emergency Notice on Special Relief Action of Ensuring Warmth during a Severe Winter". This notice required from November through to March 15, 2014 (extended to April 15, 2014 in Northeast and Northwest), the local departments of civil affairs to carry out special relief activities which targeted the homeless and beggars and people who were stuck in living troubles due to no jobs, no relatives or being cheated, etc., through which the poor people could feel warmth from government and society, and get protection of basic living rights. During the special relief action, local departments of civil affairs and relief management agencies would innovate the working methods, improve departmental joint action mechanisms effectively, and take the initiative to rescue and relief, to facilitate the homeless and beggars into shelters. Firstly, they would pay attention to the change in the weather. The relief action should examine and identify the weaknesses and hidden dangers step by step, track and monitor key areas, and thus establish a thorough emergency plan. Secondly, they would strengthen cooperation with departments like public security and city planning management. The joint action should carry out combined inspections especially in key areas at night, guiding the target people to receive relief at relief points such as relief management agencies and open relief sites. Thirdly, according to protective relief principle, the recipient groups including street children and people with a disability would be escorted to relief agencies promptly, among whom the critical patients and the mentally disabled would be sent to medical institutions for treatments.

During the special relief action, local departments of civil affairs and relief management agencies would encourage social organizations, citizens and other social forces to provide multiple ways such as voluntary services, emergency relief, governmental purchase of services, etc., to participate in relief services for the homeless and beggars during severe winter. Firstly, they would mobilize grass-root powers. Relief service points which cover townships (sub-districts) and communities (villager's committees) are responsible to produce initiative reports, provide guides, escorts and emergency relief. Secondly, to mobilize volunteer forces. To mobilize widespread volunteers like sanitation workers, bus and taxi drivers, and security guards on night shift to provide clues on the homeless and beggars, and by recruiting relief information teams, to guide and provide emergency services. Thirdly, to mobilize civil society powers. The government would provide service sites and governmental purchase of services to encourage civil society to participate in the relief initiatives.

Homeless and beggars can dial the local helpline, or head to the community service points, open rescue points or relief management agencies for help, so that they can obtain services as soon as possible. During the special relief action, local departments of civil affairs and relief management agencies would disseminate relief measures against severe winter through multiple methods such as radio, television, newspapers, the Internet, public messages, official microblogs, etc., and provde updates on the relief process and its effectiveness.

To optimize the mechanism of finding and rescuing abandoned babies, and protect their legal rights, the China Child Welfare and Adoption Center developed the "Pilot Program of Baby Safety Island" based on summarizing the practice and positive effects of the Baby Safety Island implemented by Shijiazhuang since June 2011. The Baby Safety Island is a 24-hour system with shift watch-keepers so that they could find and rescue the abandoned babies timely. Normally, the islands are located at the doorways of the child welfare agencies which are identified with signs. Every island is set with

baby incubator, crib, bedding, alarm with delay control, fans and air conditioners, etc. After receiving a baby, the alarm would alert the staff of the welfare house in 5 to 10 minutes, so that the baby could be transferred to hospital or into a welfare center as soon as possible. At the end of June 16, 2014, 32 Baby Safety Islands had been established around 16 provinces nationwide, which have received 1,400 abandoned babies and children in total. Generally, these children suffered from varying degrees of diseases, among whom the proportion with serious conditions was very high, and some babies were in a critical condition.

3.5 Nutrition Improvement for Poor Children and Students

3.5.1 Nutrition Improvement for Rural Students under Compulsory Education

To implement the "*Long-term Education Reform and Development Plan (2010-2020)"*, and to improve the health standards for rural students, especially for those from poor areas and poor families, the executive meeting of the State Council decided to initiate the *"Nutrition Improvement for Rural Students under Compulsory Education"* from the autumn semester of 2011. (1) In the concentrated contiguous poor areas, the central finance agency provides a nutrition subsidy pilot in accordance with the standard of 3 yuan per person per day. The pilot covers 680 counties (cities) and benefits about 26 million students. According to the preliminary estimates, the Central Government would allocate more than CNY 16 billion from central finances every year for the pilot plan. (2) The Central Government encourages Local Governments to focus on the poverty-stricken areas, ethnic and border areas, and former revolutionary areas, and to carry out the pilot projects according to local conditions. The Central Government would grant rewards and subsidies to the good practitioners. (3) Coordinating the renovation of rural primary and secondary schools, of which the dining rooms are the key, to improve students' dining conditions. (4) Increasing by 1 yuan per day for every boarding student from poor families according to the living subsidy standard, which means it would rise to 4yuan per person per day and 5 yuan per person per day for pupils and junior high school students respectively. The central finance agency would grant this subsidy proportionally.

3.5.2 Nutrition Improvement for Children in Poor Areas

To implement the "*Outline for the Development of the Children of China (2011-2020)* and the *"Development Outline for China's Rural Poverty Alleviation (2011-2020)"*, to improve the nutrition and health of infants in poor areas, and to enrich parents' knowledge of scientific feeding, since 2014 the National Health and Family Planning Commission and All China Women Federation (ACWF) together have implemented the "Nutrition Improvement for Children in Poor Areas Plan" in 341 concentrated contiguous poor counties (cities or districts). By providing nutrition supplements (nutrition package) for infants from 6 to 24 months old, the Chinese government expects to disseminate the knowledge and skills of scientific infant feeding nationwide, and to improve the nutrition and health of children in poor areas.

3.6 Support to Maternal and Infant

3.6.1 Maternal Mortality Reduction and Neonatal Tetanus Elimination Project

To realize the goal of reducing by one quarter the maternal mortality rate that was put forward in the "*Implementation of the Program for Chinese Women's Development (2000-2010"),* the Ministry of Finance and the Ministry of Health implemented the "reduction and elimination project" in 378 western villages. By 2015, the program has expanded to 1,000 towns, covering 22 provinces and municipalities. This special fund of the Central Government increased from CNY 0.13 billion in 2014 to CNY 0.44 billion. In 2016, the Ministry of Health issued the "*Notice on Further Regulations to Reduce Maternal Mortality and the Neonatal Tetanus Elimination Project"*. In the notice, the Ministry praised the achievements since the implementation of the project began. The project has improved the hospital delivery rate and reduced the maternal mortality effectively. The

Ministry of Health issued the "*Management Plan On Comprehensive Maternal And Infant Health Project 2010"*.The related notice proposed the goals of the "reduction and elimination project" as: (1) maternal mortality: by the end of 2010, would decrease 55% when maternal compared with 2001 at provincial level; (2) infant tetanus morbidity: reduce the infant tetanus morbidity rate below 1% at county level; (3) Disinfection birth rate≥99%; (4) antenatal examination coverage rate≥95%; (5)"three basics"(basic theory, basic knowledge and basic skill) pass rate of the township medical care institutions' obstetrical departments would be ≥85%. The "*Notice on Implement China Maternal and Infant Development Outline 2011-2020"* issued by the Health Ministry in 2012 claimed to continue the "reduction and elimination project" and to reduce the maternal mortality below 22/100,000, infants' mortality to 12% and the mortality rate of children under 5 to 14% by 2015. By 2020, the goal is to reduce the maternal mortality below 20/100,000, infants' mortality to 10% and the mortality rate of children under 5 to 13%

3.6.2 Subsidy for Rural Maternal In-hospital Delivery

To insure the safety of pregnant women and infants, to reduce the maternal mortality rate put in place the "*Implementation Plan on Medical and Health System Reform* (2009-2011)", to provide guidance on further strengthening rural maternal in-hospital delivery and implement the "*Special Interim Measures for the Management of* the *Rural Maternal Hospital Childbirth Subsidy Project"* 31 provinces and municipalities carried out a subsidy project for rural pregnant women's in-hospital delivery with central special fiscal funds. The local health and finance department drew up the implementation plan and funded management measures jointly, defining local in-hospital delivery service programs and fixing price standards. Local Government should take corresponding responsibility for expenditures and use the fund comprehensively. The women joined the rural cooperative medical insurance system and could get a subsidy from the insurance in addition to the fiscal subsidy after delivery in hospital. The subsidy for the rural pregnant women in-hospital delivery program in Guangdong is more than 500 Yuan. In 2009, the central finance agency subsidized 50 CNY per person in the province and the province government subsidized 50 CNY per person for underdeveloped areas.

3.6.3 Neonatal Disease Screening Program for Poor Areas

To implement the "*Chinese Children's Development Plan" (2011-2020)*, the "*National Program for Rural Poverty Alleviation" (2001-2010)* and discover the infants' hereditary metabolic disease and dysaudia to reduce the infant's intelligence and hearing disability rate, the National Health and Family Planning Commission and the China Disabled Persons Federation jointly began the "*Neonatal Disease Screening Program Plan For Poor Areas 2013"* to implement the subsidy program for poor areas' neonatal diseases screening. By now, the program has covered 200 towns in 21 provinces. 490,000 rural infants have received Phenylketonuria (PKU), Congenital Hypothyroidism (CH) and hearing disability screening. Those children diagnosed with PKU and hearing disability have received rehabilitation aid.

3.6.4 Aid for HIV AIDS Affected Children

To carry out the "*Regulation on the Prevention and Treatment of HIV/AIDS, the "Chinese Action Plan for AIDS Containment and Prevention" (2006-2010)* and the *"Regulation on Strengthening Orphan's Assistance",* the Government decided to strengthen the welfare of HIV/AIDS affected children, including HIV/AIDS orphans, children with an HIV/AIDS parent or parents who had died of HIV/AIDS and HIV/AIDS children. The civil affairs department has provided basic living funds of 600 CNY per person per month and tried to give the guardian a subsidy and support. Children with an HIV/AIDS parent or whose parents died of HIV/AIDS can receive the same subsidy with the HIV/AIDS orphans. HIV/AIDS infected children can get nutritional medical subsidies besides the living fund.

Children affected by HIV/AIDS can get the tuition and fees wavier, free books and the living expenses' subsidy. Children in high school can get educational assistance and work-study opportunities. Welfare organizations receiving HIV/AIDS affected children can get support and guidance.

For the infected children, the Government should provide adaptive medical treatment including free antiviral therapy and opportunistic anti-infections therapy. Other affected children that are not infected should receive basic medical care in town medical organizations. The medical organizations should be encouraged to reduce and exempt medical expenses. The civil affairs department should fund the poor affected children to participate in the medical assistance system and support the clinics in children's welfare organizations. If the expenses are still not affordable, the civil affairs department should pay them from the medical assistance fund.

If the affected children go to high school, they should be funded. If they don't go to high school, vocational training, psychological caring and employment services should be provided to improve their career and social adaptive ability, so they can integrate into society better. The relevant department should provide an unemployed orphan job the training subsidy and the occupation introduction. The small-sum guaranteed loan policy should be implemented to encourage and help them to find a job.

On the principle of "individual support as primary, collective support as supplement", there are methods like family adoption, family foster, organizations collective support and simulative family support to care for HIV/AIDS orphans. The HIV/AIDS orphans should be placed in the family of a relative that are willing and able to foster them. This will provide the children with a good growth environment. Departments should give the foster family a subsidy to encourage the relatives to take responsibility on the basis of Central Government policies. For the simulative family and orphan resettlement organizations, the funding should be guaranteed. In the villages, the guardians should sign contracts with village committee to guarantee the property rights of the orphans and return the land and house to them once they become independent.

To implement the "*Chinese Children's Development Plan" (2011-2020)* and to further promote the construction of the children's welfare system and increase their welfare standard, the Ministries of Civil Affairs and Finance have decided to cover an infected child's living expenses. Every provincial government can define the standard according to their local living standard and the state of their financial resources. Local civil affairs departments should evaluate, verify and enroll the infected children in the orphan living expenses program. The central finance agency provides the subsidy for the living expenses of infected children. The standard benefit for infected children has been more than 600 CNY per person per month and it has varied according to the individual support orphans' living standard. The standard in Tianjin and Shanghai is 1,560 and 1,400 CNY per person.

3.7 Subsidy to Seniors

15 provinces including Beijing, Tianjin, Jilin, Heilongjiang, Shanghai, Yunnan, Ningxia have established a subsidy system for seniors, covering 9 million seniors. On May 2009, Ningxia province issued the "*Notice on the Living Subsidy for Low Income Seniors above 80*" to establish a subsidy system for senior. It became the first province to implement the program. The subsidy is provided to: rural and urban seniors who are registered as permanent residents, are above 80 years old and have no fixed income. Seniors above 100 can get 300 CNY per month, those aged from 90 to 99 can get 130% of the amount of the minimum living standard and those 80-89 years old can get a subsidy equal to the minimum living standard.

3.8 Temporary Assistance

To implement the decision of the 18th National Congress, the second and third sessions, to give effect to social assistance and solve the life difficulties of citizens, the State Council has decided to

establish temporary assistance institutions comprehensively according to the "*Interim Measures for Social Assistance*". The temporary assistance institution is transitional and temporary assistance that government gives to families or individuals getting into trouble after an emergency, accidental injury, serious disease or other reasons. Local Governments are responsible for the institution and provide the temporary allowance, material object and service. The standard matches the local social and economic development level. Governments above township level should define the standard and adjust it on a timely basis according to the needs of the target group and the standard of other assistance systems. The standard should be published and the Provincial Government should promote a relatively unified temporary assistance standard.

Application procedures: firstly, accept the application from those who apply. People who are in accord with the conditions or the village committee can submit the application to the township government for assistance. The township government instigates the application with the help of the village committee, appraises the application democratically, verify their qualification, publish the result in the villages and submit the application to the county civil affairs department. Secondly, accept actively. The township governments and village committees should check for bad conditions like emergencies, accidental injury, serious disease and help citizens to apply for assistance. The department of public security and city inspectors should take measures to help minors in trouble and psycho and critical patients who cannot actively seek help. Thirdly, the township government and the civil affairs department should provide aid first in the case of emergencies in order to prevent irredeemable loss or unchangeable severe sequences. After relieving the emergency, the applicant's files should be submitted.

Table 18: Situations and Conditions of Temporary Assistances – unit is thousand households

Region	TA Households Number of Times (thousand household-time)	Based on Hukou Categories		Based on Registered Residences		Based on TA Categories		Numbers of Traditional Assistance (thousand household-time)
		Urban (thousand household-time)	Rural (thousand household-time)	Permanent Residence (thousand household-time)	Temporary Residence (thousand household-time)	High Expense (thousand household-time)	Emergency TA (thousand household-time)	
National	3017.97	1252.77	1765.20	2926.66	91.31	2499.50	518.47	636.75
Beijing	62.27	31.36	30.91	62.27		61.77	0.50	
Tianjin	32.61	26.45	6.16	32.61		31.61	1.00	0.01
Hebei	39.07	10.61	28.46	37.98	1.09	29.87	9.20	4.60
Shanxi	109.92	27.77	82.15	104.26	5.66	88.57	21.36	6.49
Neimenggu	122.40	42.84	79.56	117.43	4.97	97.55	24.85	22.27
Liaoning	81.85	63.78	18.08	77.46	4.39	76.73	5.12	6.64
Jilin	75.65	47.67	27.98	75.65		75.52	0.13	1.85
Heilongjiang	57.67	28.52	29.16	56.96	0.72	44.41	13.26	4.36

Shanghai	314.22	313.78	0.45	314.22		261.14	53.08	0.01
Jiangsu	266.07	97.35	168.72	263.55	2.51	228.37	37.70	73.94
zhejiang	87.14	18.53	68.61	86.56	0.58	74.49	12.65	4.96
Anhui	81.88	31.92	49.96	80.70	1.18	68.41	13.47	45.59
Fujian	47.97	13.79	34.19	46.96	1.02	41.37	6.60	3.95
Jiangxi	9.39	2.81	6.58	9.11	0.28	6.60	2.79	28.86
Shandong	185.43	52.15	133.28	181.53	3.89	141.93	43.49	0.78
Henan	26.13	6.00	20.13	25.27	0.85	15.36	10.76	23.92
Hubei	338.11	143.64	194.47	331.75	6.36	288.44	49.67	20.92
Hunan	158.27	49.54	108.73	141.72	16.56	102.71	55.57	95.33
Guangdong	29.26	8.58	20.68	22.98	6.28	23.02	6.24	1.03
Guangxi	45.01	1.58	43.44	44.80	0.22	41.30	3.71	117.18
Hainan	15.74	4.08	11.66	15.73	0.008	14.98	0.76	0.05
Chongqing	199.39	98.95	100.44	190.09	3.30	173.36	26.04	13.44
Sichuan	111.00	38.53	72.48	107.14	3.89	80.74	30.27	62.83
Guizhou	59.63	9.36	50.27	54.22	5.41	46.23	13.40	20.71
Yunnan	282.33	37.22	245.11	270.13	12.20	242.83	39.51	39.59
Tibet	5.35	3.16	2.19	5.33	0.027	3.33	2.03	
Shannxi	92.59	18.85	73.75	88.26	4.33	76.95	15.65	2.81
Gansu	35.56	8.15	27.42	34.25	1.32	26.08	9.48	34.46
Qinghai	6.43	1.74	4.69	6.21	0.22	3.93	2.50	0.003
Ningxia	15.11	1.72	13.39	15.01	0.09	14.30	0.81	0.06
Xinjiang	24.51	12.37	12.15	20.52	3.99	17.63	6.88	0.013

Data Source: Official Website of the Ministry of Civil Affairs of the People's Republic of China, http://files2.mca.gov.cn/cws/201501/20150126145241251.htm.

4. General Assessment of Social Assistance for the Rural Specific Vulnerable Groups

4.1 Achievements

4.1.1 Establishment of the Rural Social Assistance Net in which Support to the Most Vulnerable People is Considered as a Key Achievement

Since the 21th century, China has reinforced the construction of institutions and regulations for rural vulnerable groups. Marked by "*Regulations on Rural Five-Guarantee Scheme"* in 2006 and the *"Interim Measures for Social Assistance"* in 2014, the social assistance system for specific vulnerable groups has been basically formed in China. With the Minimum Subsistence Allowance System (Dibao), the Social Assistance for Specific Vulnerable Groups, Medical Assistance, Temporary Assistance and other Social Assistance schemes, and the Rural Development Oriented Poverty Reduction Program, China has built a Social Assistance network for the rural poor population. The network has basically achieved full coverage of SVG and played the role of satisfying minimum needs. The support ability for SVG has also increased significantly and has begun to be integrated with the basic pension insurance system for residents, basic medical insurance, Minimum Subsistence Allowance System (Dibao) and orphan subsistence allowance system.

4.1.2 Formulation of Support System for SVG in Rural Area and Improving Service Level

In more than 30,000 towns in China, nearly every town has built its support organization for the specific vulnerable old and children. By the end of 2014, there were 3.934 million beds for old people and persons with a disability, 102,000 beds for children, and 2.6 million staff, half of whom supported rural SVG. By August, 2015, 5.231 million people were covered by the Five Guarantees Scheme (FG). 1.674 million (32%) of them were collectively supported. The average standard was 5,706 CNY per person per annum for collective support and 4,241CNY per person per annum for individual support. These were a respective increase of 93.3% and 101.7% over 2010 (See Table 14).

Many homes for the elderly are registered as public institutions. Based on choosing either collective or individual support, the township government, homes for the elderly, village committees, cadres in charge of helping villagers and FG recipients sign support contracts respectively to distinguish their responsibilities and obligations. The FG recipients were enrolled by county or district bureau of civil affairs in the New Rural Cooperative Medical Insurance and they do not need to pay in a specific hospital. A service system including town homes for the elderly, village homes and house repair for FG recipients has been formed.

4.1.3 Built-up of Information and Archives System for Supported Most Vulnerable People

The Ministry of Civil Affairs and the State Archives Administration issued the "*Management Measures for the Rural Five-Guarantee Archives",* including 17articles, and implemented it since April 1, 2013. According to the measures, the recipients' information should be timely updated and all specific vulnerable people should be covered by FG if allowed. The administration department should establish archives for the vulnerable people and share the data with other departments. For example, the county construction bureau prioritized FG recipients when implementing the program for renovating dilapidated houses.

TV stations and other governments department also introduced preferential policies for FG recipients, such as reduced cable television fees, water, electricity, coal, fuel subsidies. Judicial and education departments also provide assistance and encourage society to participate in FG assistance.

4.1.4 Different Models of Organizing and Supporting in SA for Vulnerable People

As the establishment and improvement of China's rural social assistance system, the "Three None's" will be the main part of FG collective support. The FG old, children and disabled are covered in different in policies, support levels and themes. The homes for the elderly, the welfare center and the Disabled Person's Federation take part in FG affairs, so the policy may be overlapping and lead

to unequal distribution of public resources. Datong county established a social welfare institute to administer all welfare agencies, including one welfare house for the old, one for children and seven homes for the elderly, in order to increase efficiency.

Hunan province encourages homes for the elderly to start their "courtyard economy". On the one hand it can provide labor opportunities for the elderly whilst on the other hand it can also save on expenditures. The province also encourages agencies aiming for specific vulnerable old people to be open to society. The construction department supports the construction of agencies in village to provide other patterns.

4.2 Main Challenges

4.2.1The Low Standard of FG Support Standard

The "*Regulations on the Rural Five Guarantees Scheme"* in 2006 demanded that the rural FG support level should not be lower than the rural residents' average living standard and be adjusted to account for the improvements in living standards. The funding of FG is afforded by the local government budget and in some areas the funding is not sufficient. Consequently the recipients' living fee cannot satisfy their needs. In central provinces such as Jilin, Anhui, Henan and Hunan, the level is under 30% of the average disposable income.

Table 19: Various Social Assistance Levels in Different Areas

Region	National poverty line/average income	Minimum Subsistence Allowance level/average income	FG collective support level/average disposable income	FG individual support level/average disposable income
National	0.267	0.265	0.512	0.382
Beijing	0.138	0.375	0.647	0.647
Tianjin	0.165	0.362	0.547	0.468
Hebei	0.275	0.250	0.514	0.348
Shanxi	0.318	0.279	0.546	0.330
Neimenggu	0.281	0.364	0.732	0.475
Liaoning	0.250	0.286	0.543	0.357
Jilin	0.260	0.229	0.410	0.287
Heilongjiang	0.268	0.264	0.507	0.360
Shanghai	0.132	0.357	0.425	0.425
Jiangsu	0.187	0.357	0.541	0.469
zhejiang	0.145	0.293	0.487	0.445
Anhui	0.282	0.285	0.460	0.292

Fujian	0.221	0.216	0.530	0.460
Jiangxi	0.277	0.261	0.347	0.306
Shandong	0.236	0.247	0.454	0.308
Henan	0.297	0.194	0.418	0.256
Hubei	0.258	0.237	0.433	0.311
Hunan	0.278	0.231	0.565	0.298
Guangdong	0.229	0.313	0.647	0.625
Guangxi	0.322	0.234	0.465	0.359
Hainan	0.282	0.338	0.552	0.468
Chongqing	0.295	0.281	0.582	0.512
Sichuan	0.318	0.243	0.508	0.396
Guizhou	0.420	0.317	0.494	0.331
Yunnan	0.376	0.287	0.526	0.350
Tibet	0.375	0.299	0.518	0.457
Shannxi	0.353	0.285	0.728	0.620
Gansu	0.488	0.397	0.653	0.614
Qinghai	0.384	0.304	0.752	0.687
Ningxia	0.333	0.271	0.676	0.441
Xinjiang	0.338	0.245	0.814	0.518

Source: Author's calculation based on data from the official website of the Ministry of Civil Affairs of the People's Republic of China.

4.2.2 Incomplete Support in FG Care

In some areas, FG recipients face many problems, for example, daily life, health care, burial affairs and so on. The medical expenses are not fixed, so the administration departments are usually puzzled. Although the medical assistance policy can solve some of the problems, some homes for the elderly still faces problems like high care payments and self-paid medicine, so they cannot make ends meet.

4.2.3Insufficient Numbers of Staff, Shortage of Skilled Staff in FG Support Organizations

Due to the financial system, some workers are regularly employed and some are temporarily employed. Some of them are paid from the government budget and some by the organization. This makes theorganizations lack staff, especially skilled staff. In the homes for the elderly, the ratio

between the residents and the staff is usually 10:1, so they tend to receive independent people and the disabled and dependent people are excluded.

4.2.4 Lower Collective Support Rate, Smaller Scale of FG Support Organization

Most local governments make the town government as being responsible for the FG recipients, so nearly every town runs a home for the elderly. But, many people are life-independent and tend to live in their familiar community alone. The low numbers of people living in homes for the elderly affects their management and service standards. This in turn makes people reluctant to live there.

4.2.5 Identification of SVG

In general, the specific vulnerable people include the “Three None’s”, the elderly, children and persons with a disability. In practice, some provinces have begun to focus on, and succor, children who have no dependents and other vulnerable people, such as children without statutory guardians (they can be categorized as vulnerable children). In some poor rural areas, there are many older young men. To assist them from becoming FG recipients is a topic worthy of study.

4.3 Suggestions: Service Provision Centered Policy Improvement

Support to the rural SVG, in particular to the FG scheme has almost 60 years of history. It was the oldest but most dynamic social assistance scheme. The experiences of the SASVG scheme are worthy of evaluation. Although the number of recipients under the FG scheme is only around one per cent of the total rural population, those recipients are economically poor, socially incomplete and physically vulnerable. They are most needy group and should be always the focus of the social assistance system. The situation of SVGs will reflect the moral values of society. Governments at all levels should consider it as a work priority. Unlike Dibao in which the transfer payment is the main issue, sound care service provision should be the main task of the SASVG program. This includes questions of what kinds of care services should be provided, by what means can sound care services be provided, who will provide daily care services, who will pay for the service provision. There is still much hard work to be done to realize a sound service provision.

4.3.1 Improve Cross Sector Institutional Coordination including Articulation in Different Programs

By now, the vulnerable people support institution framework has been formed. But there are two concepts: specific vulnerable and FG, where responsible bodies for the three groups are quite different. This may lead to mistakes and omissions. The policy of the civil affairs department and the Disabled Persons’ Federation should be unified and assistance should be linked with welfare in the civil affairs department. In addition, the institutional coordination mechanism between departments should be built and communication among education, housing, medical treatment and public utilities should be strengthened. The new “Guidance on Further Improvement of Social Assistance and Support for SVG” includes a special paragraph on coordination between the different programs and a standard platform for the establishment and management of vulnerable persons’ archives should be built up to realize trans-sector coordination.

4.3.2 Base on the new “Guidance” to Conduct Policy Pilot Experimentation

In February, 2016, the State Council organized a thematic standing meeting and promulgated the “Guidance on Further Improvement of Social Assistance and Support for SVG” to strengthen the implementation of the relevant articles of the Interim Measures. These included setting-up of five principles, clarifying the definition, the standard for targeting groups and its procedures, fulfillment of government in service delivery such as food, clothes, housing, daily-care and medical care, increasing government financial input, and the involvement of social participation. Based on the request of the new Guidance, it is necessary to conduct pilot policy experiments on standards of caring and nursing, participation of social organizations, subcontracting of services, etc.

4.3.3 Enhance the Financial Input from the Government's Regular Budget for Sound Services

For some historical reasons, the fund for vulnerable people support mainly comes from local government (especially middle areas). There are poor areas in the middle of China and some local governments cannot maintain the standard "not lower than local residents' average living standard" stated in the "*Regulations on Rural Five-Guarantee Scheme"*. Limited budget will also affect the identification of qualified target groups. The central government should make the regulations for and contribute to financing to take the 5 million vulnerable citizens out of poverty. So far, the financial responsibility between different level of governments on the maintenance and operation of nursing homes is not very clear. Financial support to village committees is also necessary for their duties relating to individually supported SVGs. In the "Guidance on the Further Improvement of Social Assistance and Support for SVG", both basic living standards and caring and nursing standard are proposed but these need to be further studied, so that sound services can be delivered based on the needs of SVGs.

4.3.4 To Strengthen Organizational and Staff Capacity for Rural Super-Township Support Organization for Better Services

Some provinces partially stress the responsibility of township governments and run a home for the elderly in every town. It is difficult to get economies of scale and raise the service level. The principle should be that "the village is responsible for individual support and the town is responsible for collective support" and more cross-town support organizations should be encouraged. The Government should encourage organizations to employ local people and include their salary in the budget. The staff of support organizations should be registered as civil institution personnel to ensure responsibility and incentives. The standards for nursing homes should be developed to provide detailed guidance for practice, including legal entity registration, amount and structure of staff, contents of services, infrastructure and physical conditions, etc.

4.3.5 Recognise More Roles for the Rural Community and the Village Committee for Providing Individual Support

In the future, there will be many people who will choose individual support. The government should respect their choice and strengthen the responsibility of village and fund them. At the same time, the government should encourage social work organizations and volunteers to serve in rural support organizations. Service criteria for individually supported FG clients should be formulated and strengthened.

Currently, about two-thirds of FG clients are individually home-stay supported. Home-stay support is an option when the clients still have the basic ability for daily life. However, risks are still around these SVGs. Therefore, some kind of necessary service should be available and accessible for those people. The local community (including neighbors and relatives) should be supported for the provision of necessary daily services and health care, monitoring, etc.

4.3.6 Encourage Local Innovation in the SVG Support System

In case studies it was found that many support organization practices were well suited to the local situation, such as developing the economy in the organizations and the combination of assistance and welfare in aged affairs. Nursing homes for SVGs can be the leverage for rural general caring facilities for the elderly. In organizations' staff, some of them are listed in the budget, some are set public service jobs and some are recruited by the village leader. Innovation should be encouraged and the communication of experiences should be strengthened. The main areas for innovation include: involvement of social organization/social workers in SASVGs, service procurement of Government from business (or PPP styled). nursing homes, subcontracting to the village community for individual's home-stay support. It is also worth developing the integration of medical care into the SASVG system.

CASE STUDY1: Social Assistance for Rural Specific Vulnerable Groups in Qinghai

Regarding the specific vulnerable groups (SVG), the support organizations and the civil affairs departments at grass root level are the respondents for this survey which selected Jianzha County of Huangnan State and the Datong Hui Turkish Autonomous County of Xining City in Qinghai Province, to get the research data by in-depth interviews and literature review. The case study intends to discuss the definition of SVG in the western region of China, support the manners of these SVG, and highlight the problems found in the survey. This study expects to provide some feasible suggestions for improving the living conditions of SVG and building the SASVG system.

Defining the SVG in Qinghai Province

The "Interim Measures for Social Assistance" were issued and came into force on May 1, 2014. SVG are referred to as those who are aged, disabled or under the age of 16 having no ability to work, no source of income, and no statutory guardians or whose statutory guardians have no ability to provide for them, bring them up or support them. The subject was conducted together with the elderly, children and disabled SVG specifically in the following three categories:

1.1 FG Elderly

The Elderly SVG are generally "the FG Elderly". According to the "Regulations on the Rural Five-

Guarantees Scheme", the FG elderly refers to the elderly who have no ability to work, no source of income, and no statutory guardians or whose statutory guardians have no ability to provide for them, bring them up or support them. Jianzha County has Tibetan, Han, Hui, Salar and other ethnic groups, and has provided collective support for the current 488 FG elderly. Datong Hui Turkish Autonomous County have Han, Hui, Tu, Tibetan, Mongolian and another 26 ethnic groups with currently 941 FG elderly currently and provides collective support for 260 FG elderly.

1.2 Orphans and Troubled Children

The Ministry of Civil Affairs in 2013 divided children into four categories, orphans, troubled children, children in a troubled family and ordinary children. Orphans refers to juveniles under the age of 18, who have lost parents, or have no accessible information on their natural parents, and both of the situations above are supposed to be determined by the relevant terms from the civil affairs departments at county level or above. Troubled children refer to the disabled, the sick and waif children. Children in a troubled family refer to children in the following situations: the ones whose parents are severely disabled or sick, the ones whose parents are in long-time custody or serving in prison, or receiving forced detoxification, the ones whose one parent dies and the other cannot assume obligation to provide support or receive custody for some reason, and last but not least the ones who are in vulnerable family and are suffering from neglect and abuse. Jianzha County has 150 orphans and 196 troubled children. Datong Hui Turkish Autonomous County has 126 orphans and 414 troubled children.

1.3 Disabled SVG

According to "the Law of the People's Republic of China on the "Protection of Persons with a Disability" revised during the second conference of the 11th National People's Congress, the disabled refers to people who lose completely or partially the abilities for certain normal activities due to tissue or function loss or dysfunctions in psychological, physiological or anatomical aspects. The category of the disabled includes those with visual disability, hearing disability, speech disability, physical disability, intelligence disability, mental disability, multiple disability and others. Jianzha County has 1,454 severely disabled SVG at present.

Basic Support Service for SVG in Qinghai Province

In Qinghai, the elderly aged from 70 to 79 obtain 70 CNY each per month; the elderly aged from 80 to 89 obtain 80 CNY each per month; the elderly aged from 90 to 100 obtain 100 CNY each per month; and the elderly over 100 years old receive 140 CNY each per month. Secondly, the SVG medical assistance outpatient benefit standard is 360 CNY each person per year. Thirdly, the disabled SVG monthly living subsidy is 50 CNY in Jianzha County and 100 CNY in Datong Hui Turkish Autonomous County. Fourthly, each orphan and troubled child gets a monthly living allowance of 1,000 CNY including 880 CNY from the central government and 120 CNY from the local government. For the nine years of compulsory education, children can enjoy the "two exemptions and one subsidy" policy. Finally, the rural basic pension standard monthly is 75 CNY.

2.1 Collective support

The main provider of collective support is the government. FG service organizations, such as Homes for the Elderly, the Child Welfare Institution and the Disabled Welfare Institution, undertake the task of collective support for rural FG recipients. They usually provide food, clothing, housing, education, medical treatment, funeral and other services. The FG collective support's standard per person each year is CNY 6,891 in Jianzha County and CNY 8,450 in Datong Hui Turkish Autonomous County.

Jianzha County Homes for the Elderly was built in May 2007, and began to work in 2009. This "three-star" home for the elderly specializes in FG collective support recipients. There are two-people rooms and three-people rooms with 120 beds. Currently, there are 109 FG who are mainly unmarried and single or are severely disabled. There are 69 women and 40 men. The oldest is 94 years old, the youngest is 42 years old and is a disabled SVG. The average age is 79. The percentage of people over 60 years old is 70%, and the percentage of disabled persons is 30%. There are only five Hans. All the others are Tibetans. Jianzha County Children's Welfare Centre has provided collective support for orphans, disabled and trouble children from four counties of Huangnan since September 2006. At the moment there are 510 orphans and disabled children including 15 preschoolers, 99 children in primary school, 107 children in junior high school and 74 children who can enjoy the 1,000 yuan per annum national student allowance in high school.

Datong Hui Turkish Autonomous County Bridge Center Homes for the Elderly was located in Ajiabao village of Suobei township. Construction began in May 2013 and it became operational in December 2014. This "two-star" home for the elderly is close to the primary and secondary schools, hospitals and other public institutions. The homes for the elderly have 60 beds situated in there-people rooms and two-people rooms mainly for the disabled. There are 2 females and 43 males. In terms of age, the oldest is 80 years old and the youngest is 40 years old with a disability. The average age is 46, and 26.7% of the FG collective support recipients are over 70 years old. Among them, there are 3 persons with visual disabilities, 7 persons with physical disabilities, 3 persons with intellectual disabilities, 20 persons with hearing disabilities and 4 persons with language disabilities. The Children's Relief Station has 60 beds to support child SVGs, including orphans, children with a disability and troubled children. It has supported 23 children, including 6 girls and 17 boys. In terms of age, the oldest is 17 years old and the youngest is 6 years old. Among them, there are 10 children in primary school, 12 children in junior high school and one child in high school. During their education, the Station pays all costs for supporting the child SVGs. The average cost per child each year is CNY 400 in the primary education stage. Children eat three meals a day in the welfare institution. All the food comes from the "custard project" or the "nutrition lunch" are allocated to the Children's Relief Station directly.

2.2 Individual support

The main recipients of individual support are individuals and their daily life care is in charge of their village committee. The annual FG individual support standard annually per person is CNY 3,600 in Jianzha County and CNY 7,400 in Datong Hui Turkish Autonomous County. *Lalong is a*

Tibetan villager who is 18 years old. Since his father died, he has lived in the Lejian village of Maketang township in Jianzha County with his mother. The young boy was sick, but had not been well treated due to the poverty. A few years ago, he became intellectually disabled. His mother is a normal rural woman, so his situation is incompatible with the Regulations on the Rural Five-Guarantees Scheme. However, the local department of civil affairs considered the actual situation of his family, and finally decided to put him into FG and his family into Dibao. Another Tibetan old woman is called La Miaoji. She is 87 years old and has no children. She stays in Maketang village of Maketang township with her relatives and chooses self-care. An acquaintance tended her 2 acres of land previously, but the land is idle now. She mainly drank groundwater in the yard and picked up firewood in the village. The township department of civil affairs and native villagers often cared more about her life, and sometimes sent some rice or other food to her. When she was sick, her relatives looked after her.

Wu Chenglin is 54 years old and han, and he lives in Huakezhuang village of Suobei township in Datong Hui Turkish Autonomous County. *He is a blind person, and has been lying in bed for over 20 years. His intelligence has also been severely impacted and he became a severely disabled. There are four members in his family, but his parents died He lives together with his brother called Wu Chengyuan who is 42 years old and single, and has junior high school degree. The government carried out the "reconstruction" project in 2008. Wu Chengyuan spent CNY 15,000 renovating his house, including CNY 2,500 yuan from the government fund and CNY 12,500 yuan from his individual savings. It has 12 acres of land where he mainly plants some vegetables. There are two cows, a tractor used for arable land, TV, sofa and other basic household durables in their family. Their expenses are mainly spent on medicine, electricity, winter coal and social activities.*

2.3 Third party support

Third party support is when the county department of civil affair department or township government entrusts a third party organization to provide home care services for FG recipients by purchasing services from the society. The service includes care during the day, providing or buying dinner, medical related services, cleaning services, spiritual consolation, security and so on. In July 2015, the civil affairs department of Qinghai province issued the pilot third party service scheme for vulnerable aged people in Qinghai village and the herding areas to pilot the scheme in 11 towns such as Huangnan, Guoluo, Yushu and Hainan. The scheme is aimed at FG, the “Three None’s” who live in the rural and herding areas and have not lived in a support organization, single elderly people who are covered by the Minimum Subsistence Allowance System (Dibao) and are above 70 and single people needing special care in the rural and herding areas. The service providers can be legally qualified old people's homes, or village organizations, seniors associations, village service stations and other warm-hearted people can undertake the services.

Main challenges or existing problems

3.1 The salary of the FG collective support staff is too low, and the ratio of nurses to FG recipients is far from reaching the national statutory requirement. Besides, the wage differences existing among the regional institutions causes turnover of workers. Jianzha County Homes for the Elderly has 32 workers and five of them whom have formal qualifications. Temporary nursing staff are secondary school students and the monthly salary for them is about CNY 1,250 yuan. The ratio of nurses to FG recipients is 1:4. The monthly salary for other workers such as cleaners and cooks is approximately CNY 1,150. The Bridge Center Homes for the Elderly has 12 workers. The monthly salary of temporary staff is about CNY 1,875 yuan, but the institution pays the buy pension, medical and unemployment insurance for their employees. The ratio of nurses to FG recipients who have the ability to take care of themselves is 1:6, and the ratio of nurses to FG recipients with a disability is 1:4.

3.2 Due to the low-level education standard and the predominant age range being 30 to 40, the general staff in the children's welfare center do not have the ability to help the children to do better in their school work. The children whose parents are in long-time custody or serving in prison are more easily vulnerable, so the children of the welfare center are eager to have more full-time counseling staff to help them grow up healthily and establish the correct concept of life.

3.3 There are lots of rural bachelors about forty years old. This situation may result in more new FG recipients in the future. There are several reasons. First, poor economic conditions have led to the lack of an essential material basis and the cost of marriage is too high, almost CNY 200,000. The second reason is that the residential areas are remote and inaccessible, and few women are willing to live in these places. Third, the majority of marriageable women have been leaving their villages as migrant workers and they seldom return home.

3.4 Building the welfare agency management system. The Civil Affairs Bureau in Datong Hui Turkish Autonomous County set up the social welfare center, and directly appoints the social welfare president who administers all welfare organizations in the township. Currently, there are seven rural homes for the elderly, one senior welfare center, and one child welfare center. These institutions collectively manage the elderly, the children and the disabled SVG, rationally allocate resources, and improve the efficiency of the department of civil affairs.

3.5 The government should establish archives for SVG, set up a standardized management system, realize a seamless convergence of basic data among the departments and develop the SA mechanism. For example, when the construction bureau carries out a rural reconstruction project, they have priority to provide more funds for SVG. The power sectors can give some subsidy or other discounts to the SVG.

Case Study2: Social Assistance for Rural Specific Vulnerable Groups in Hunan Province

Regarding the specific vulnerable groups (SVG), the support organizations and the civil affairs departments at grass root level are the respondents for this survey which selected Cili County and Yongding District of Zhangjiajie City in Hunan Province to get the research data by in-depth interviews and literature review. The case study intends to discuss the definition of SVG in the western region of China, support the manners of these SVG, and highlight the problems found in the survey. This study expects to provide some feasible suggestions for improving the living conditions of SVG and building the SASVG system

Defining the SVG in Hunan Province

Hunan Province issued the "Regulations on the Rural Five Guarantees Scheme" in 2007, and stipulated that the elderly, disabled and teenagers in rural areas in the following conditions can enjoy the FG support.

1) Those having no ability to work, including the elderly aged 60 or above, the disabled with second-class or severer disabilities who have a " People's Republic of China Disabled Permit", and children under the age of 16 or already 16 but still in compulsory education.
2) Having no source of income, referring to the rural villagers whose subsistence standards are below the county average standards, even though they may earn incomes from a land contract and management, collective management distributions or other sources.
3) Having no statutory guardians to provide for them, bring them up or support them, or whose statutory guardians have no ability to provide for them, bring them up or support them. In addition the condition was that the statutory guardians had to have no ability to provide for the dependents, bring them up or support them and they needed regular social relief because of subsistence difficulties, or the guardians themselves were elderly, sick, disabled, unable to work, having no source of income or missing.

This survey included the elderly, children and disabled SVG in the study.

1.1 FG Elderly

In 2010, Cili County government in Hunan Province issued its "Notice of Implementation Measures of the Rural Five Guarantees Support in Cili County". The FG elderly refers to people over 60 years old, who have no ability to work, no source of income, and no statutory guardians, or whose statutory guardians have no ability to provide for them, bring them up or support them.

1.2 Orphans

The Ministry of Civil Affairs in 2013 divided children into four categories, orphans, troubled children, children in a troubled family and ordinary children. Orphans refer to juveniles under the age of 18, whose parents have died, or one parent has died and the other parent is missing. There are 508 orphans in Cili County. There are 445 orphans in Yongding District, including 70 children with collective support, 372 children with individual support and 3 infected children.

1.3 Disabled SVG

According to "the Law of the People's Republic of China on the "Protection of Persons with a Disability" revised during the second conference of the 11th National People's Congress, the disabled refers to people who lose completely or partially the abilities for certain normal activities due to tissue or function loss or dysfunctions in psychological, physiological or anatomical aspects. The category of the disabled includes those with visual disability, hearing disability, speech disability, physical disability, intelligence disability, mental disability, multiple disability and others. Hunan Province included people with second degree or higher disability who cannot look after their parents and children into the scope of FG. Hunan Province invested reconstruction funds of CNY

56.8 million to renovate 6,997 rural unsafe houses of the disabled, and 8,285 disabled SVG got benefits from this project in 2014.

Basic Support Service for SVG in Hunan Province

In Hunan, the elderly aged from 90 to 100 receive CNY 100 each per month and the elderly over 100 years old receive CNY 200 each per month. The rural basic pension standard monthly is CNY 75. Currently, there are 4,691 FG recipients in Cili County, and 90% of them are male. 1,557 FG recipients are over 90 years old, and 17 persons are “Centenarians”. There are 3,837 FG recipients in Yongding District.

2.1 Collective support

The main provider of collective support is the Government. In Cili County FG collective support covers 1,070 people and the annual standard per person is CNY 6,000. The county began covering funeral expenses with a one-time subsidy of CNY 2,900. The Children’s Welfare Center has 11 orphans who can obtain a living allowance of CNY 1,200 each month. There are 30 homes for the elderly and which employ 115 workers. *Homes for the Elderly of Miaoshi Township was built in 2012 and the local government invested more than CNY 3 million. It belongs to “the provincial pension service demonstration” and has two-people rooms with 30 beds. There are 41 female FG collective support recipients and 9 male FG collective support recipients. In terms of age, the oldest is 87 years old, and the youngest is 49 years old who is a SVG with a disability. There are five staff, basically between the ages of 40 and 50. The “homes for the elderly” dean is held concurrently by the township civil affairs director, whilst the vice-dean manages the home’s daily business and gets a monthly wage of CNY 1,500. Other staff such as cooks, nurses and porters get a monthly salary of CNY1,200. The ratio of staffs and FG recipients is 1:10. The home has 3 acres of land to set up the vegetable and breeding base to meet their daily needs and feeds six big fat pigs to ensure their self-sufficiency as soon as possible. The FG elderly per month can get 30 to 50 yuan of pocket money.*

FG collective support covers 1,232 people and the annual standard annually is CNY 6,600 in Yongding District. No matter who carries out cremation, they have received a CNY4,000 subsidy since 2014. There are 24 homes for the elderly, and 23 of them are legally registered. Among them, 12 homes for the elderly are new. The others make use of abandoned village primary school buildings, old village committee buildings and other public buildings etc. *Yinjiaxi Center Homes for the Elderly is located in Mojiagang village of Yinjiaxi township. Its construction began in May 2010 and it commenced operations in October 2013. This “three stars” home for the elderly has 100 beds, and 92 collective support* recipients.78 of them are *FG elderly. The others reside at their own expense. According to the contribution of the elderly self-care’s capacity, the basic self-care for the elderly who can enjoy the same services as the FG elderly cots CNY 800 per month. This provides their food, housing, clothing, cleaning and other aspects. The ratio of males to females is about 2:1. In terms of age, the oldest is 95 years old, and the youngest is 44 years old. There are ten staff, including one dean, two vice deans, four nurses, two cooks and one laborer. The Chinese Red Cross donated 100 air conditioners to the home in June 2015. It has 4 acres of land to plant cabbages and radishes, and feeds two or three pigs. The FG elderly who have the ability to farm or want to do the planting will get an extra monthly bonus of CNY 100.*

2.2 Individual support

In Cili County there 3,621 persons who receive FG individual support. The annual standard is CNY 2,900 per person. *Tang Huiqing, who lives in Yangliupu village of Yangliupu township, is 49 years old and he is an uneducated man and with a mental disability. His parents and one brother have died, he rely on his younger brother who has been working in Guangzhou. Then he got married to another woman with a mental disease, and had their own daughter in 2007. His daughter has an intelligence quotient lower than ordinary children. Currently, his family has been included in Dibao.*

According to the policy, each person can receive monthly CNY 95. His house was restored in the implementation of the "rural reconstruction" project. It has 1.5 acres of land to plant oranges. Not long ago, he spent more than CNY 3,000 to buy a new tricycle which is mainly used for picking up his daughter and transporting other crops.

In Yongding District FG individual support is provided to 2,605 people. The annual standard per person is CNY3,000. *Tuo Nianhe who lives in Mojiagang village of Yinjiaxi township is 55 years old, and he is a uneducated man with a physical disability. He had suffered from infantile paralysis, soon his two hands and legs got disabled, and he basically lost the ability to work. However ,his parents died, his sister got married to someone from the neighboring village. He got married with mentally disabled woman last year, and has 2 acres of land which is planted by other people for free. It is said that he spent about monthly CNY 200 to buy sixty pounds rice and meat from market. Their living expenses were from FG individual support and the help from his sister and his neighbors. Sometimes village or township leaders will come to see him on festivals. They drank the underground water, picked up some firewood and plant some vegetables in his yard. He can use household electricity with some discounts.*

3.Main challenges or existing problems

Hunan Province is the demonstration point where the province administers counties directly. Because of the SASVG policy, there are differences about the support standards and contents. FG elderly are mainly served by Homes for the Elderly, orphans and trouble children are served by Welfare Center Institution, and the SVG disabled welfare policy is offered by the Disabled Persons' Federations. Cili County published "one-child" family incentive policies for urban workers. They get a one-time payment of CNY 5,000 yuan after retirement. Parents over 60 years old with "an only child" in the rural areas monthly can CNY 100 monthly. Due to the three departments managing SASVG management, it is hard to obtain accurate research data.

Currently, lots of townships in Hunan Province make use of abandoned old village buildings, the township primary school or other public lands to build or renovate the homes for the elderly. These areas are universally small, and the number of beds isn't enough. Meanwhile, their structure is irrational, such as outdated facilities, poor infrastructure, lack of disability or semi-disabled elderly to provide service care settings. On the other hand with rugged mountain roads the local FG collective support rate is not high. FG elderly who have the ability to work temporarily will not choose to stay in the homes for the elderly, and the social elderly participation rate is low. Therefore, Hunan should promote the establishment of "Center Homes for the Elderly" which can provide the services collectively.

Homes for the Elderly also engages in income-generating, and encourages FG collective support recipients who still have the capacity to work or farm. By implementing these policies, they create the "self-sufficiency in vegetable-based" management model. "Institutions developing agricultural economics, to fill their own" has become an effective way to solve the shortage of townships' SASVG financial resources. Homes for the elderly are trying to develop sidelines, such as planting, breeding or pavement leasing by taking advantage of the land, location and other resources, and to enhance their abilities of self-survival and self-development.

3.3.1 European Best Practices report on Social Care-Long Term Care -For Elderly, People with Disabilities and Children, Example of Germany

Monika Gabanyi, EU-China SPRP expert

Table of Contents

Preliminary Remarks....65
Long Term Care Model In Germany....68
1. Decreasing Poverty....68
2. Beneficiaries....69
3. Entitlements....70
4. Assessment....70
5. Benefit Package....71
6. Copayment....72
7. Remuneration....73
8. Cost Control....73
9. Sustainability....74
10. Administration....75
11. Scope of Services....75
12. Long-Term-Care Rights....76
13. Provision of Services....76
13.1 Human Resources....76
13.2 Mix of Public and Private Providers for Social Services....77
13.3 Quality Assurance....77

Preliminary Remarks

In order to understand the context, it has to be underlined that social care services as performed within EU member states cannot be compared to care service in China at the current stage - there are fundamental differences:

- The Chinese understanding of social care for the elderly or other vulnerable groups mainly comprises of the timely payment of pensions and other social assistance benefits and, the entertainment of retirees in terms of offers related to body exercises and cultural affairs.
- The common understanding of social care in the EU, however, covers support to beneficiaries in the“Activities of Daily Life” (ADL) regardless of whether these services are being provided in the beneficiaries’ homes or in residential establishments. Since these services usually have to be provided on a permanent basis, the term “long term care” (LTC) - not only but mainly related to elderly people, people with disabilities and others - is being used in order to avoid misunderstandings.
- The term “social assistance” which is also common in Europe may not be mixed up with social care. It refers to the delivery of services to persons who, for any of a number of reasons, are unable to provide themselves with a decent standard of living. It is a means-tested benefit which is funded by taxes and not by insurance.

Social assistance is targeted to mitigate poverty in Europe and in China. The reality reflects, beside social assistance, increasing dependency on social care services for elderly people and, moreover, when they are poor and left alone[1]. But it also reflects the opposite direction. The moment when you become dependent the family is in charge of taking care of the person in need. This entry point is common in Europe and in China. Most European countries implemented social care systems in order to meet people’s needs and provide basic service packages which can be mixed in terms of benefits in cash and/or kind and, request the quality assurance from professional providers. This system prevents the beneficiary and the family from impoverishment and allows family members to stay in work and contribute to economic growth.

Countries in Europe and elsewhere have been tackling the challenge of service provision to elderly people and other groups in need of social services for a long time. Their experience might be a valuable source of information for China’s policy makers to benefit from.

- In Germany, for instance, it took roughly 20 years of discussion before the Long Term Care Insurance was established. It was the first LTC insurance scheme worldwide based on the principles of the “Bismarck” type of social security system.
- Austria and Italy’s Autonomous Province Alto Adige/South Tyrol have adopted, adjusted and also improved the German system in accordance with their national or provincial needs and intentions.
- Japan and Korea have also implemented the German LTC system principles and adjusted them to their needs.

It will be neither possible nor recommended to replicate any of the existing schemes. The identification of those principles which are appropriate within the specific environment in China is up to the Chinese authorities and Chinese practitioners working in the field.

This report will provide a comprehensive overview of how a social service system is organized.

Introduction

[1] World Bank report on ageing published December 2015
https://openknowledge.worldbank.org/bitstream/handle/10986/23133/9781464804694.pdf

Challenges In Europe

The population of Central and Western European countries is an aging population. The long term trends of raising standards of living, including improvements in health status and lower birth rates, are leading to a steady growth in the proportion of elderly people (defined as anyone over 65 years) in these populations. This development is the result of prior economic and health/social policies, leading to longer life in terms of time and quality. As it does, however, new questions are arising on whether the traditional social policy prescriptions will continue to be sufficient.

The main social policy issue here, social assistance for the elderly and other vulnerable groups, has been seen as the need to create sufficient income to avoid poverty which will follow when people became sick and/or lose their employment or due to other reasons. Later, and this was a change of paradigm, it was seen as essential that vulnerable groups benefit from adequate and sufficient care services, as access to these services was extended to the entire population. All in all, this change of paradigm required a redistribution of income from the working population in terms of funding as well as the development and implementation of a new social care system. Behind all these social policy efforts and changes was the wish to be sheltered when one is growing older or suffering from any handicap and, it was the basic fundamental of the social welfare (ideas) states.

Meanwhile these ideas and the fundamental have been transferred into action through several models of financing social care covering integrated services (medical and social) in home care or in nursing homes. EU best practice highlights community care, which enables all vulnerable groups to take part in society, life and in EU countries it is on the agenda, nowadays.

Focusing on Europe, countries with social insurance systems introduced mainly an additional pillar for long-term care and countries with National Health Systems incorporated this health / social policy item in their local or national budgets.

It has to be mentioned that social care systems are in place in most “old” EU countries whereas in the “new” EU countries systematic social care covering is still missing. Nevertheless, some countries, e.g. Slovenia, have put it on their social policy reform agenda and have the wish to introduce the social care system soon. One can expect the implementation of either compulsory insurance and/or budget solutions. Since Long Term Care coverage should protect the whole population in a certain geographic area, the private insurance solution is not on the agenda due to the economic constraints on the population. And, it has to be mentioned that there is a trend, besides community care, to finance integrated and coordinated services; at least, medical and social care, rehabilitation and household support.

It is wise to be aware of the challenges towards the elderly and to prepare over time adequate solutions. In 1996 the Council of Europe adopted a revised Social Charter. The previous and revised rights include a number of documents which have contributed to the right and co-ordination of social protection for individuals, e.g. the Social Convention on social security and the above mentioned Charter. In addition to social security, the documents deal with the right to social assistance and health care and emphasize the right to independent life and social integration.

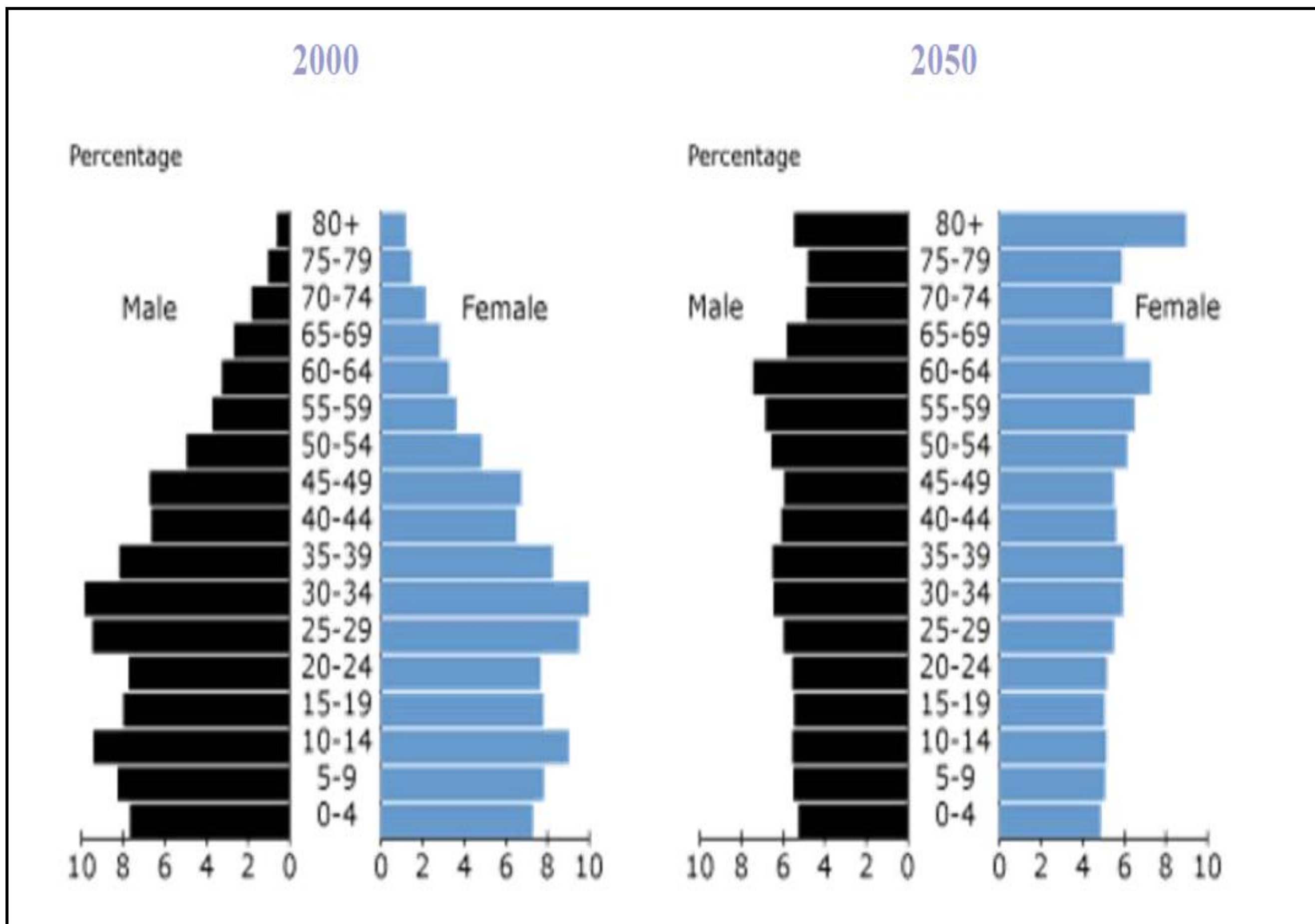
Challenges In China

China’s population growth rate is comparably small at an estimated 0.494% in 2010. This is basically due to the fact that the one child policy, which was started in the late 1970s, has virtually transformed China into a society with a "4:2:1" family structure: two sets of grandparents, two parents and one child.[2] The recently implemented two child policy will take time to change this situation. As a consequence, China is a society which is “growing old before it’s growing rich”.

[2] Graying Markets, in: China Economic Review, February 2011, p.28

More than 13% of the Chinese population was over sixty years of age in 2008[3], and more than 70% of them live in the countryside. With a real income per capita of around US$4,000, China is aging at an early level of development. According to the Asian Development Bank, the US and Japan had average per capita incomes of around US$15,000-16,000 at their similar stages of aging.[4]

The age pyramid in China is therefore developing into something totally different:[5]



Estimates suggest that the number of senior citizens – those aged 65 and over – will grow by seven million on an annual basis between 2015 and 2020, and by an extra 10 million each year between 2030 and 2035. This would bring the total number of seniors from an estimated 180 million in 2009 – the population of Russia – to 350 million – bigger than the present population of the US.[6] – the population of Russia – to 350 million – bigger than the present population of the US.[135] Between 2005 and 2015, the percentage of people older than 60 years of age was supposed to rise from 11 to 16.7%.[7]

Among them, the group of the so-called "old-old" (80 years of age and older) grows even faster than the general share of people aged 60+. It is estimated that already in 2007 this group consisted of 19.7 million people. It goes without saying that this group faces more health problems than younger cohorts, and that the costs related to their treatment - facing more chronic diseases and less acute cases of sickness - will rise and challenge the capacity of health insurance schemes nationwide.[8] But of course, their demand for care - and particularly long term care - is also rising.

[3] National Bureau of Statistics of China, 2008
[4] Graying Markets, in: China Economic Review, February 2011, p.27
[5] World Population Prospects: The 2004 Revision (2005), in: Xiaomei Pei, Long Term Care in China - A Public Health Perspective
[6] Graying Markets, in: China Economic Review, February 2011, p.26
[7] Nursing homes close doors to many, in: China Daily, 2 March 2011
[8] Giacalone, Joseph: Long-Term Care as a Threat to China's Economic Growth, February 2010

Already in 2010 experts estimated that more than 15 million Chinese were in need of long term care.[9]

That means that China faces more pressure and challenges from an aging society than other developing countries in which usually the work force is young and the average age is much lower than in China with a median age of 35.2 years.[10] Yet, the current retirement age is still at 60 years for men and only 50 years for women (in some schemes 55 years).[11]

This situation is made worse by the fact that the traditional care model - the younger generation caring for their parents - is not only threatened by the demographic change but also by the so-called "empty nest" phenomenon: More and more elderly people are left alone by their offspring looking for work in the big cities on China's coastal areas and the mega cities in the East and South of the country. In several big cities the rate of "empty nesters" among the elderly has reached 30%, in some of them it even extends 50%.[12] In rural areas the figure of seniors who are not able to look after themselves was expected to hit 40 million by 2015, according to a report published by the China National Committee on Aging and the China Research Centre on Aging.[13] State-subsidized public nursing homes often cannot afford to invest in beds and professional staff due to their limited budgets - and thus fail to provide enough beds to meet the needs of the elderly population.

The EU has a lot of experience to offer in this area since its Member States have dealt with aging societies for quite some time. Europe is far from being able to offer a ready-made solution - but on its way to achieving a "Harmonious Society", China might take into consideration some of the conclusions drawn in the previous years.

This paper therefore advocates a more comprehensive solution and intends to initiate a discussion between policy makers on the one hand and practitioners on the other in the area of care provision to the elderly. Besides social assistance schemes by means of cash, both, benefits in cash and in kind are in the focus. The latter, benefits in kind, also contribute to developing new job opportunities and boosting the economy.

Long Term Care Model In Germany

1. Decreasing Poverty

Germany introduced a fifth pillar into its insurance system in 1995, the so called "long term care insurance'. There were several reasons for doing this. The number of older people in the population was growing rapidly and their needs were at least twofold: social care and medical care. Since the health system was overburdened by elderly people's demands through long term stays in hospitals, although the need related to social and not medical care, and the churches lost their prominent role in supporting this part of the population with services, a comprehensive solution was discussed for many years, in terms of funding and developing a service system which met the people needs.

There was high risk for the elderly people to lapse into deeper poverty by that time because with their low pensions they could not afford to pay for social care services, especially not in nursing homes.

But it was also clear that becoming dependent is a risk for the entire population. Therefore, the insurance solution was chosen and implemented and, nowadays, the whole population is covered through this scheme.

[9] According to the Gerontological Society of China, People's Daily Online, 29 October 2010
[10] see 1
[11] Age gap: Improved labor productivity< requires a higher retirement age, in: China Economic Review, February 2011, p. 28
[12] China's aging population to hit 31% in 2050, in: China Daily, 8 December 2010
[13] see 8

Already after two years, in 1997, the social assistance cash benefits for being resident in a nursing home had decreased by 57%. But even 20 years after the implementation of the insurance social assistance benefits amount to 12%. Today, 30% of the beneficiaries depend partially or fully on social assistance “co-financing” Social assistance in terms of cash payment could not be erased at all by reason of relatively low pensions, especially for women in West Germany, different prices per day in nursing homes throughout Germany and, last but not least, the long term care insurance was not meant to cover 100% of expenses.

Sources of Funding for Long Term Care come from the insurance premium, the social assistance scheme, a small part from the welfare for war victims (which is declining) and out of pocket private funding.

The University of Bremen estimated the sources of funding for long term care in 2008

Source of Funding	In million €	As % of public spending	As % of all spending
Public Funding (total):	21,610	100	68,7
LTC Insurance	17,860	82,6	56,8
Private Mandatory Insurance	0,550	2,5	1,7
Social Assistance	2,610	12,1	8,3
Welfare for War Victims	0,590	2,7	1,9
Out of pocket Private Funding (total)	9,840	100	31,3
Nursing Home Care	7,660		24,4
Home Care	2,180		6,9
Total	31,450		100

2. Beneficiaries

The German social care system is compulsory, implemented through long term care insurance, and each citizen is covered and has the right for social care services as soon as the requirements are fulfilled. The majority of social care expenditure is used for elderly people. The statistic shows an increase in the number of beneficiaries from the age of 70 years.

The total number of social care beneficiaries was 2.589 million people in December 2014. Explanation for the table below:

The right column indicates the age groups starting with those younger than 15 years through to those older than 90 years. The column shows number of home care beneficiaries split in three levels of care. The next column sector shows the number of beneficiaries in residential institutions split in three levels. The column sector shows the sum of those in home and residential care split in three levels. The last two columns show the total sum in numbers and then as a percentage.

Age groups and levels of care of all insured social care beneficiaries at December 31st 2014

Age Groups	Home Care				Nursing Home Care				Total Number				
	Levels of Care			Total	Levels of Care			Total	Levels of Care			Total	in %
	Level I	Level II	Level III		Level I	Level II	Level III		Level I	Level II	Level III		
>15	40.765	22.287	10.500	73.552	1.136	227	240	1.603	41.901	22.514	10.740	75.155	2,9
15 >20	13.108	7.414	5.958	26.480	1.280	222	325	1.827	14.388	7.636	6.283	28.307	1,1
20 > 25	10.363	6.419	5.609	22.436	2.506	418	599	3.523	12.869	6.909	6.208	25.986	1
25 >30	9.275	7.139	5.562	21.966	3.320	579	806	4.705	12.595	7.718	6.358	26.671	1
30 > 35	7.997	6.741	4.692	19.430	3.552	567	809	4.928	11.549	7.308	5.501	24.358	0,9
35 > 40	7.821	6.722	3.592	18.135	3.943	577	765	5.285	11.764	7.299	4.357	23.420	0,9
40 > 45	10.506	7.691	3.610	21.807	5.537	908	1.115	7.500	16.043	8.599	4.725	29.367	1,1
45 > 50	17.634	11.270	4.513	33.417	9.113	1.887	1.992	12.992	26.747	13.157	6.505	46.409	1,8
50 >55	26.403	14.511	4.879	45.793	12.288	3.312	2.785	18.385	38.691	17.823	7.664	64.178	2,5
55 > 60	33.936	15.914	4.750	54.600	12.683	4.805	3.254	20.742	46.619	20.719	8.004	75.342	2,9
60 >65	46.959	20.847	5.509	73.315	13.294	6.933	3.999	24.226	60.253	27.780	9.508	97.541	3,8
65 >70	57.116	25.400	6.257	88.773	12.725	8.734	4.793	26.256	69.841	34.134	11.050	115.025	4,5
70 >75	102.831	45.599	10.739	159.169	20.053	18.418	10.060	48.531	122.884	64.017	20.799	207.700	8,1
75 >80	182.119	75.663	16.841	274.623	34.624	36.495	19.955	91.074	216.743	112.158	36.796	385.697	14,2
80 >85	223.550	87.209	19.040	329.799	49.194	51.519	26.575	127.288	272.744	138.728	45.615	457.087	17,8
85 >90	224.169	90.479	19.630	334.278	70.098	70.060	33.938	174.096	294.267	160.539	53.568	508.374	19,8
<90	131.406	70.841	18.205	220.462	65.869	75.072	36.926	177.867	197.275	145.913	55.131	398.319	15,5
Total	1.145.958	522.218	149.876	1.818.052	321.215	280733	148936	750.828	1.467.173	802.951	298.812	2.588.936	100%
Total in %	63%	28,70%	8,20%	100%	42,80%	37,40%	19,80%	100%	57,10%	31,30%	11,60%	100%	
Ministry of Health Germany													

The reason for the higher number of home care beneficiaries is an individual preference is to stay at home for as long as possible. In addition there are several measures favoring home care:

1) Cash benefits for family care
2) Pension benefits for informal care givers in case they interrupt their employment
3) Family member can enjoy four weeks holiday per year and the beneficiary can be transferred to a social care short term institution

3. Entitlements

Who is entitled to long-term-care services and to what extent they receive it depends on the definition of the term “dependency on long-term-care” and the level of dependency that has been assessed.

The term “dependency on long-term-care” is connected to the incapacity of an individual to perform the activities of daily life in a frequent manner, at least for a certain period, e.g. the following 6 months. During the defined period it should be taken into account that clients in the terminal phase of their life are also in need of long-term-care.

Incapacity can be characterized as loss of movement, loss of functions of the inner organs and other sensual organs, loss of functions of the central nervous system, endogen psychosis, neurosis or another mental handicap.

In Germany, during the first 20 years (1995 to 2015) entitlements were focused on physical incapacity with the consequence that activities of daily living (ADL) could not be further managed by a person. Since 2015, the last reform, persons suffering from mental problems (dementia or Alzheimers etc.) demand additional support due to the higher time consumption of social care services.

4. Assessment

The assessment is conducted by a team of independent professionals. In Germany a medical doctor, nurses, social workers and/or psychologists conduct the assessment at the potential beneficiaries’ home. Of importance is the team work and independency. Any link to the funding agent has to be prohibited otherwise a conflict of interest exists.

The assessment grid is a standardized tool throughout the country and the focus is on all issues that cannot be done in daily life. The assessment for the level of dependency distinguishes several degrees. These degrees lead to the entitlement of the services provided for social care: household support, rehabilitation, remedies. As a reference for services or allowances the degrees are also directly connected to the time of support needed.

Reassessment is done every six months. In Germany there are critical voices and discussions about the composition of assessment team especially that medical doctors are in charge of the decisions regarding the level of dependency. It is stressed that medical doctors do not have much interest in social care but in medical care and therefore they might not be interested in social care.

Definition of dependency

	Level I	Level II	Level III
Need of care with basic ADLs	At least once a day with at least two ADLs	At least thrice a day at different times of the day	Help must be available around the clock
Need of care with instrumental ADLs	More than once a week	More than once a week	More than once a week
Required time for help in total	At least 1.5 hours a day, with at least 0.75 hours for ADLs	At least 3 hours a day with at least 2 hours for ADLs	At least 5 hours a day with at least 4 hours for ADLs

Source: §15 Social Code Book (Sozialgesetzbuch XI, SGB XI).

The minimum time consumption for each level has to be defined because of the assessment of the dependency degree and for the calculation of staff needed. Those items have to be linked with emerging costs. And, last but not least to limit or extend the number of beneficiaries. In case the minimum time consumption necessary for ADL is reduced to one hour per day, the number of beneficiaries will increase dramatically, and vice versa. This time determination is one tool among others to run the system in terms of cost containment and planning arrangements.

The assessment results include the level of dependency, but they should also describe the appropriate measures in order to improve the beneficiary’s status or, at least to avoid further progress in dependency.

Rehabilitation is a keyword and quite challenging; the effect is at least twofold. The client can keep his/her status and the funding institutions take into account cost containment over a long term perspective. Also, because of rehabilitation the client can improve his/her status and becomes either independent or, it might be a follow up assessment that leads to the result of lower level of dependency.

5. Benefit Package

The benefit package is twofold: Benefits in kind and benefits in cash or a mix of both options.

Benefits in kind are solely provided for beneficiaries who are living in residential institutions whereas, benefits in cash can be chosen when a beneficiary is staying at home and the family or another person is taking care. Further, home care can be supported by benefits in kind and cash,

when a person decides to hire some care activities from a professional provider plus taking money for the family care taker.

It is well known that family members are in need of a rest. Therefore, the possibility for short term care in an institution is provided for maximum six months per year.

Amount of LTC Benefits (Major Types of Benefits) in 2015 Home care Day and night care Nursing home care

Example: Benefits in cash and in kind per month according to dependency degree in 2015

Degree and time per Day	Home Care in cash/contracted service proved	Benefit in kind day care / living in residential institution
Level I 1,5	244€ / 468 €	468 € / 1064 €
Level II – 3 hours	485€ / 1144 €	1144 € / 1330 €
Level III – 5 hours	728 € / 1612 €	1612 € / 1612 €

It is important is to take into consideration that benefits in kind in social care institutions are just covering the genuine care package.

The benefit in kind package even does not cover the care costs and the out of pocket payment has increased in all three levels since 1999.

6. Copayment

For 2015 the out of pocket payment for social care services in residential institutions were projected as following:

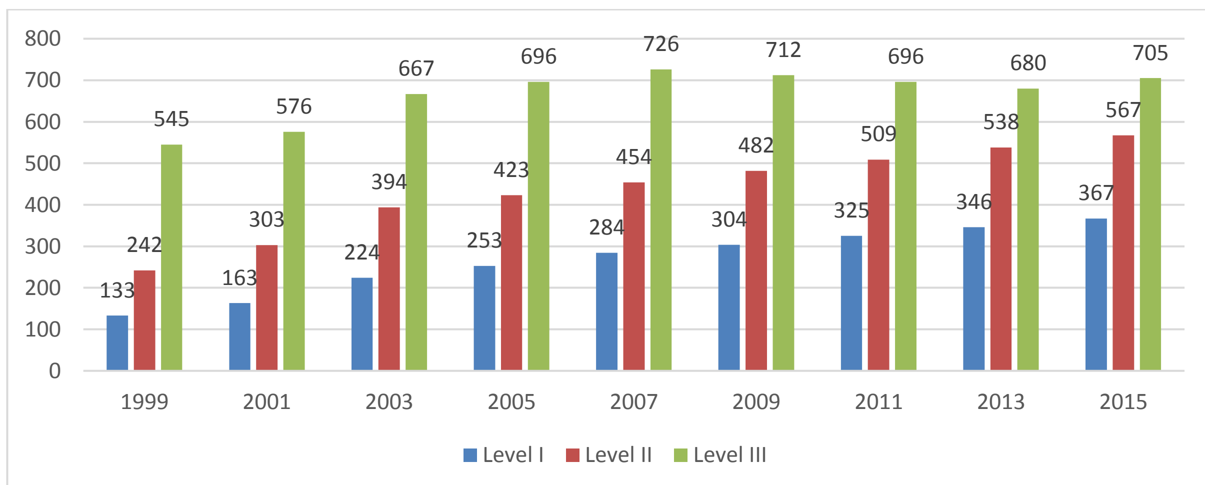
Level 1: 387 €

Level 2: 587 €

Level 3: 705 €

The costs for board, lodging and infrastructure investment are additional expenses paid by the client.

The projection for out of pocket payments in euros for care services in nursing homes per level of dependency



Source: Rothgang projection based on statistics published 2002 – 2009

The aim of the LTC was to cover the care costs in residential institutions. In 1996 the target was reached but from 1999 the rates increased in all levels of care. Already in 2007 the out of pocket payment was 300€ to 700€ and this trend is still valid till 2015.

Since the costs for boarding and investment has to be added, around 1000€, the out of pocket payment is around 1400€ - 1700€ per month per client.

The beneficiaries are in the residential institutions are mainly female. Around 20% of the total beneficiaries who are older than 80 years are living in residential institutions. In 2014 in Germany the life expectancy rate for a male was 78.15 years and for a female 80.46 years.

The average pension for a male is about 1500 euros and for female around 700 euros per month. For women this amount is not enough to cover the costs in residential care institutions. Therefore, either social assistance (in terms of money transfer to the residential institution) and/or the family have to pay the difference.

7. Remuneration

Residential Care is remunerated by daily rates for: Care costs

Board and lodging

Investment (as far as it is not publicly financed)

The Long Term Care Insurance pays just for care cost, as already mentioned above. Board and lodging has to be paid by the beneficiary, his/her family and/or the social assistance agency. Investment should be funded by the provinces. If uncovered, it is on the burden of the beneficiary or the social assistance agency.

The rates are negotiated between the Long Term Care Funds and the Social Assistance Agencies and the nursing homes. Negotiations are based on external comparisons and individual costs. They differ between the provinces. For example in Saxonia the average daily rate amounts to 56€ (the lowest) and in Rhineland 83€ (the highest). In this (weighted) rate the care costs, board and lodging and investment costs are included.

Home Care is based on provided service complexes which also differ between the provinces. Relative price (points per complex) is assigned to the services. The fee scale and the value of one point are negotiated between the long term care insurance funds and providers on provincial level.

8. Cost Control

The funding, benefit package and three party tiers are embedded in a system that promotes cost control, even when the older population is still growing. According to the projections in Germany in 2050 more than 20% of population will belong to the target group for social care services. And the number of beneficiaries will be doubled.

Funding is shared between the insurance system, beneficiary themself, his/her family and the social assistance agency. Funding from the insurance side is capped. There is a ceiling for in home and residential care, per assessed level of care which provides a clear picture of expenditure.

Another positive side effect was – and still is – the tremendous reduction in the budget for social assistance for this group of persons in need. The insurance was implemented in 1995 and from 1996 beneficiaries could enjoy the benefit package which was introduced in two steps. Firstly home care and then one year later care in residential institutions. Already in 1997 the budget for social assistance had declined by 58%.

Also the ceiling on the home and residential care benefit in kind package is equal to level three by design. It is a tool in moral hazard issues. Families should have a barrier in terms of a high financial burden when they put their elderly into residential institutions in order to be free of responsibilities.

For the time being it seems that all parties involved in the financial contribution are in a more or less balanced situation. But there are certain constraints, especially for the beneficiary that should be mentioned as well.

There has been little adjustment to the benefit package since 1995. The first reform and increased package was in 2008, the second in 2012 and the last in 2015.

The LTC pays the same fixed benefits according to the level of care irrespective of the price for the actual goods and services. Thus, the person in need of care has to bear the difference. If recipients cannot pay the total difference out of their income or other assets, or with the help of their children or near relatives, social assistance has to step in and pay the remainder. Additionally, social assistance has a broader definition for being in need for care. Even persons with a temporary impairment, i.e. less than six months, or with less need for support than set in care level I can apply.

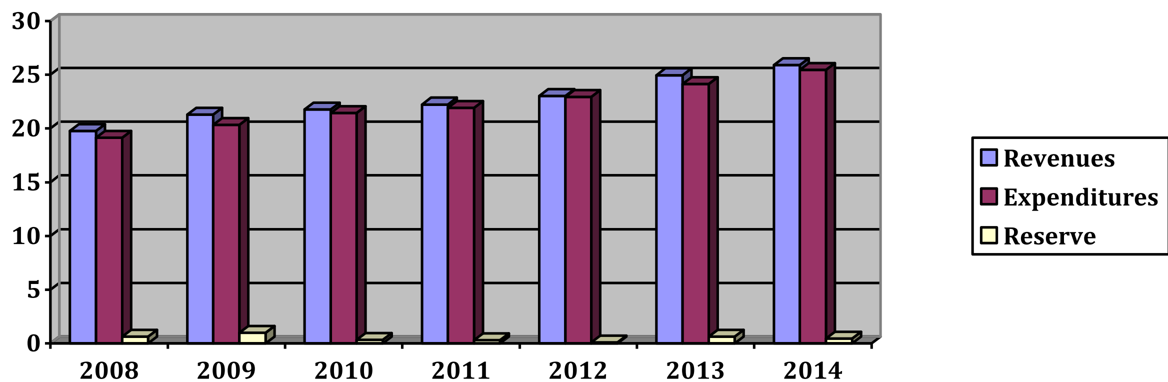
Between 1996 and 2007 there was no change in the nominal amount of the benefits. Hence, due to general price inflation the nominal amount has gradually lost its real value. Monthly benefits were increased for the first time in 2008, with higher increases for home care and care allowance to strengthen both types of arrangements in comparison to residential care ("care at home before residential care"). From 2014 onwards benefits will be assessed every three years and possibly adjusted to keep up with the general price inflation. But it will certainly not decrease the approximate 30% of out of pocket payment by the client or families or by the social assistance agencies.

9. Sustainability

The financial crisis has not had an impact on the financing of LTC in Germany; neither has the current euro crisis. Furthermore, since the German economy is expected to remain growing, negative effects on the social LTCI in the short term are not expected. The value of accumulated capital in the private LTCIs has grown significantly in 2011 and the social LTCI gained a surplus of 100 million Euros raising its capital reserves to 5.5 billion Euros.

In 2011 2.5 million people received benefits from the social or private LTCIs. 1.18 million received a care allowance, 580,000 home care in kind and 740,000 residential care. The number has risen considerably by 24% or by 1.8% per year between 1999 and 2011. At the same time the total expenditures of the social LTCI have grown from 16.3 to 22.0 billion euros, i.e. by 35% in aggregate. Due to an ageing population, the demand for long-term care is expected to increase significantly in the following decades.

The recently published figures for 2014 declared revenues of 25.83 billion euros and expenditures of 25.45 billion euros with the result that the surplus of 0.46 billion euros went to the reserves of the compulsory social insurance.



On the revenue side the contribution rate to the social LTC Insurance was stable at 1.7% of wage income until 2008. In the immediate years after the introduction of the social LTCI, contributions exceeded expenditures and capital was accumulated up to 5 billion euros until 1998. Yet on account of rising expenditures from 2003 on, its capital stock was reduced. With the reform in 2008 the contribution rate increased to 1.95% in general and to 2.20% for insured persons without children. Employers and employees pay half of the premium; pensioners pay the full premium themselves. Therefore, from 2008 on, the capital stock has been growing again. The last reform was in 2015; when benefit packages were adjusted (see table above). The contribution rates have been increased to 2.35% in general and for insured without children to 2.6 % from September 2015.

On one hand sustainability was accomplished by having the same level of benefit packages over a long period, the incentives for home care which keeps expenditures low and the capital stock allowed for a balance of revenue and expenditure regardless of the increasing number of beneficiaries.

Since 2014 the benefit packages have to be reassessed every three years. It is expected that contribution rates will increase as well or other funding options will have to introduced or used. If social benefits are adjusted in the same way as gross wages, the contribution rate might double up until 2040. If the benefits are not adjusted by the 2014 purchasing power index, they will be less than half of their present value but private out of pocket payment and social assistance cash benefit will be higher.

Possible options for future financing may include: ntegration of private LTC Insurance into the social insurance:

- Contribution rate on all kind of income (not just salary)
- Increasing the income cap for contributory income (in 2015: 49.500,00€ per year)
- Supplementary tax financing
- Introduction of a supplementary funded system

10. Administration

Long Term Care Insurance is an independent pillar of the German social security system but it is administered under the roof of health insurance in order to keep its administration costs low.

The Funds have to ensure the provision of benefits and for this purpose they are negotiating contracts with home care service and nursing home providers. The contract negotiation refers to benefits in kind. Benefits in cash are paid to the beneficiary directly.

11. Scope of Services

Since most EU countries have introduced integrated care settings the services provided are to be distinguished between medical and social services including basic care and household support. Additionally, rehabilitation and terminated care are part of the offers as well.

The services offered by the health/social care system are described as follows, taking into consideration that they need to be integrated both within the different levels of care of the health system: vertical integration from hospital to community care and horizontal integration within social services, social and medical care.

12. Long-Term-Care Rights

Within the integrated and coordinated care settings eligible persons have the right for

- Social Care
- Basic Medical Care
- Household support
- Rehabilitation
- Remedies
- Terminal and palliative care

Social care comprises help to the client to dress, move, getting in and out of bed, helping the client to eat and drink and supporting their hygiene. The clients also must have the opportunity to take part either in social life or to get assistance in social support via social workers who support and advise them e.g. in benefit requirements. Early and continuous rehabilitation measures are to be provided by speech-therapists, physiotherapists and other professionals and, remedies like wheelchairs or special beds should be dispatched to the households of the clients'.

One very important issue should be taken into consideration. It is well known that family members are highly affected by caring duties because they take over the duties of the entire care cycle. In order to ensure safe care, relatives and other informal carers have the right (sometimes obligation) to participate in training and learn how to handle the daily requirements in the overall care cycle. Furthermore, they can have a break of six weeks per year and in this period the beneficiary can be cared for in a short term care institution.

13. Provision of Services

13.1 Human Resources

Social care is sometimes seen as a service that can be done by everyone, regardless of whether a person is a professional or not. This opinion is accurate to some point, but it carries a danger e.g.in case there is a client suffering the symptoms after a stroke and there is a layperson (informal care) taking care at home, both of them might be jeopardized due to the appearance of a bedsore. Laypersons are not aware of the first signs and cannot take action in order to avoid this situation. The consequence might be a worsened condition for the client, a lower quality of life and higher costs for the social security institution due to the intensive medical treatment needed.

It does not mean that social care, managed by laypersons make no sense or, that auxiliary staff cannot take over ADL services. First of all, the services needed and provided have to be defined by professionals for each individual client according to assessment indicators to be developed. The process of care has to be assessed frequently as well. This is regardless of whether professionals, auxiliary staff or laypersons are involved in the care cycle.

Therefore, the staff needed for coordinated services at home consists at least of nurses and auxiliary staff. Depending on the service provision, rehabilitation services need to be performed by professionals.

Despite the composition of the different professionals who are acting as a team, the number of professionals and auxiliary staff has to be defined according to indicators taking into account the geographic area, the age structure of the population, epidemiological specifics, and clients' dependency levels and, linked to these items, the time needed to be spent by a provider at the clients' home.

13.2 Mix of Public and Private Providers for Social Services

Whether a social care provider should be, in legal terms, a private or a public entrepreneur is not the pivotal question. Both types of service providers are part of the network of social care providers. Among them are NGOs, foundations, non- and for profit private entrepreneurs, as well as public providers.

What is important is that all of them have to fulfill the accreditation and licensing requirements in order to become part of the network of providers. This is the entry point for contracts with social security funds or institutions that manage local budgets and/or other sources.

In Germany the care providers constitute a big industry. On the supply side the German market is dominated by private providers. In 2011, there were 12,354 nursing homes and 12,349 home care providers. 41% of all nursing homes were private, for profit, 54% were private not-for-profit and 6% were public. In home care even 63% of providers were private for profit, 36% private not-for-profit and 1% public. Market shares (measured by the number of care recipients) are slightly lower than these figures for private for profit providers because they are smaller on average. Concerning investments, there seems to be a reduced interest in building new nursing homes. Due to some overcapacities of nursing homes in recent years, there have been no problems in providing nursing home care. Waiting lists are unknown. However, providers are already reporting difficulties in finding qualified personnel, which is leading to an intensive public debate about the lack of qualified personnel (ASISP 2013)

As the providers must fulfill quality standards for receiving a license and can negotiate the contract with the respective financing institutions, the following quality indicators have to be taken into account and have to be the basis for signing a contract, regardless of whether the provider is public or private.

13.3 Quality Assurance

Quality indicators consist of quality of structure, quality of the process and quality of the outcome. This scheme builds the framework and represents an excellent instrument for measuring the quality of all care processes.

In order to become licensed as social care provider quality assurance has to be fulfilled.

Quality of structure: (these are the minimum standards):[14]

Quality of structure emphasizes and focuses on providers' personnel available, related to the clients' needs and management capacities, the time to be on duty and skilled staff. The defined quality indicators are the professional background of the manager who has to have a solid professional education and passed an exam plus additional education in home care requirements and specific management skills. The provider should assure that the personnel employed are encouraged to attend further education courses and internal supervision rounds.

[14] The following examples are indicators that have to be fulfilled as minimum in Germany

Quality of process:

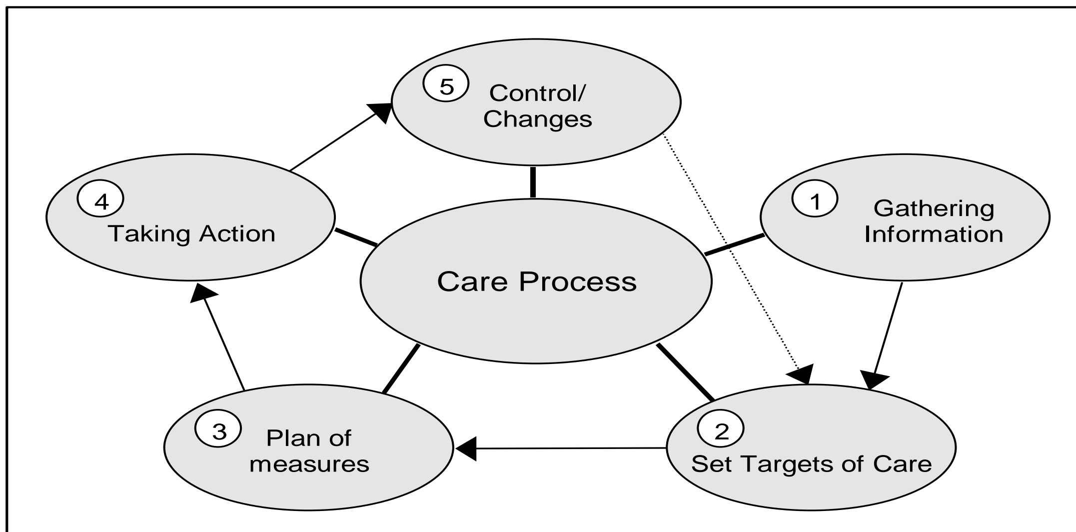
The clients have to be clearly informed about the time on duty and, in geographic areas with high dense population, the providers should go in co-operation with other providers for sharing "emergency" services outside of the normal working hours.

The so called terminus "quality of process" refers to the genuine care process and the work with beneficiaries. In order to provide services of high quality it is necessary to follow such a care cycle.

The cycle consists of:

- Anamnesis and defining the targets to be achieved through the care, treatment and rehabilitation services. This has to be done and agreed upon by the client wishes as well.
- The care plan has to be elaborated and documentation on care measures has to be individually recorded to the professionals who are part of the care process (e.g. social workers, auxiliary staff, rehabilitation personnel etc.). One copy of the documentation has to be stored in the household and one at the services provider(s).
- The measures have to include so called "activated care" which takes into account the client's capabilities and these capabilities have to be stimulated. Prophylaxis and rehabilitation are part of the measures as well.
- The process has to be assessed frequently. In case the aims of the caring process are not achieved the measures have to be adapted and revised.

Scheme of the Care Process



Providing the indicated items for the quality of structure and quality of the care process, the outcome to be determined depends on several facts.

One might focus on the costs, others look at staff's satisfaction and again others determine client/clients' satisfaction as parameters for their outcome quality.

All three mentioned items are worth being taken into account and used as determinants for qualitative outcome(s).

For the assessment of efficiency, quality of care has to be measured. To this end, the so-called transparency reports for formal care were introduced in Germany in 2009. Both, home care providers and nursing homes are audited annually by the independent medical service of the social insurances. The assessment consists of standardized items in five dimensions: (i) care and medicine, (ii) interaction with people with dementia, (iii) social assistance, (iv) board and lodging, (v) interviews of the people in need of care.

However, only few items refer to outcome of quality while most of them are about structural and process quality. Generally, transparency reports are criticized, because the equal weighting of all items makes it possible to compensate “bad quality” in care by “good quality” in other services. There are e.g. no knockout criteria for a bad quality outcome and most of the items are criticized since they only measure the quality of documentation.

Within EU member states the open method of coordination (OMC), a “soft” law and intergovernmental policy making round table without binding character has organized three peer reviews so far, one of them in the area of LTC, held in Germany, in October 2010, on quality in residential care facilities. This topic is a concern in all EU member states and at the EU level. Nine other member states joined the peer review.

Due to the frequent assessment cycles, described above, the German experience stimulated debate and the meeting came to the following agreements or conclusions:

1) Minimum standards are needed for long-term residential care and compliance should be monitored.
2) External quality management systems involve internal quality management systems. The introduction of such systems requires participative leadership, human resource management, training and lifelong learning.
3) Transparency of quality can stimulate performance-based pricing of nursing homes.
4) Modernization of nursing homes entails openness to other parts of the care chain.
5) The relationship between health services and social services needs further discussion.
6) Some countries’ perspectives on LTC are more health-oriented, while others are more focused on social services.

3.3.1 European Best Practices report on Social Care-Long Term Care - For Elderly, People with Disabilities and Children Contracting Social Services, Example of Germany

Monika Gabany, EU-China SPRP expert

Preliminary Remark

This report is a completion of the paper delivered in December 2015, after the first mission to Beijing and, is ready to be used as a supplement. The already delivered and discussed report is describing the basic facts and figures regarding social care needs for the elderly in China and solutions implemented in EU countries, specifically in Germany. It deals with the historic background and the reasons for the new approaches in social service coverage and provision, eligibility for benefits and the choice of benefit packages in cash and/or in kind. Further, sustainability in terms of the revenue and expenditure situation as well as cost control measures are discussed touching on administration and service provision.

The entire system and systematic was presented in a panel discussion in Beijing in December and, afterwards elaborated in more detail. Our Chines partners expressed the wish to learn more about the contracting procedures and the role of NGOs in the social service provider system in Germany. Therefore, this report is dealing mainly with these subjects but also here and there referring back to the previous report in order to set the context.

In general contracting is a negotiation process between Funds and the providers of social care services at the Federal level. Both parties represent their members by forming associations – the Federal Association of Non-Statutory Welfare and other associations of care providers (e.g. private for profit providers) negotiate with the Federal Association of Funds. It is important to note that all providers negotiate together regardless of legal status, NGO, private enterprise or public institution.

The contract is a framework which indicates the content and quantity of services to be provided, general conditions of care, data protection, reimbursement and economic efficiency. Further, it determines the authorized institutions that have access to providers for controlling purposes and it specifies the catchment area and reimbursement price. An amendment regulates the entire quality assurance measures in detail following the structure, process and outcome indicators. Contracts are collectively signed for two years but, with good reason, can be cancelled after one year.

Introduction

A long-term care insurance scheme, similar in nature to the other social insurance systems in Germany (pension, employment and health insurance), was introduced in 1995. Due to the risk of getting dependent for support in the higher age groups the insurance is compulsory and all employees earning less than the social security earnings ceiling for the German social insurance system are members of this system. Persons who are not covered by the social insurance system (i.e. civil-servants, self-employed etc.) are usually enrolled in private insurance companies.

All members of the social health insurance scheme are automatically covered by the social long-term care insurance. The responsible long-term care insurance funds are affiliated to the corresponding health insurance funds. This strong link was implemented to lower the need for administration and therefore costs. Employees who are not covered by social LTC insurance are permitted to contract with a private long-term care insurance institution as long as they are members of a private health insurance scheme. Around 90 per cent of the German population is consequently covered by the social LTC insurance scheme and around 9 per cent have private LTC insurance cover.

Institutions

The Federal States are responsible for ensuring that an efficient and cost-effective long-term care infrastructure is provided, for guaranteeing that the scale of services on offer is adequate, and for the quality and efficiency of the social service institutions. It is the task of the authorities (the Federal Government, State governments and local authorities) to avoid disparities in support and to ensure a regular supply of long-term care in every region of Germany. This includes assuming the

investment costs of all local, state-owned, and non-profit-making care institutions and private maintenance.

The remit of the long-term care insurance funds is to ensure the supply of permanent care for their insured and to eliminate the shortcomings in quality. They consequently control the quality of the care delivered. Nevertheless, their ability to ensure the supply of care is limited by the fact that they have no appropriate influence on the creation, promotion or maintenance of the infrastructure. This task is assigned to the government of the States.

The LTC Funds as a contractor for social care services, delegate the potential beneficiaries' needs assessment to an independent body. Such independent bodies consist of teams with different professional backgrounds. Mainly doctors, nurses, psychologists, social workers, rehabilitation personnel and household staff. They assign the appropriate level of assistance to the person in need. Funds also offer courses to voluntary care-giving staff, family members, to make home care easier and more efficient. Long term care insurance funds are thus responsible for guaranteeing the service quality on the one hand and paying and bargaining for the costs on the other. The combination of these functions (increasing the quality of services vs. decreasing costs) might be a source of conflict.

Long-term care providers are supported either locally, by the federal states, or by non-profit or private organizations. A supply contract is concluded between these institutions and the insurance funds. This contract is essential for the ongoing social service provision at clients' homes or in residential institutions. The contract qualifies this form of support for the recognized long term care market. The supply contract regulates the type, contents, and extent of the general social care benefits which a social care institution must provide. It also defines the so-called care package which social care institutions must guarantee in terms of human resources, dignified and stimulating support. They must respect human rights. Qualifying care institutions must contribute to the quality assurance procedures.

Contracting

Unlike other countries, Germany places a strong emphasis on using contracts between long term care funds and providers for the quality assurance of long-term care. These contracts articulate the general expectations about provider quality and about the structures and processes that providers should have in place to monitor and improve quality. The contracts serve as tools to enforce quality. In addition, a common theme and discussion point among policy makers is that government oversight of quality will never be adequate and that providers must take a proactive role in the management and improvement of the quality of their own care. Debates often center on whether financing and local expertise are sufficient to enable high quality services and oversight.

Beneficiary Structure

In 1996 after one year of Long Term Care TC implementation about 1.5 million beneficiaries received either social care at home or in residential institutions. The growing demand of social care beneficiaries corresponds with their prolonged life expectancy rate.

Number of beneficiaries qualified for social care 2002 - 2013

	Home care	Institutional	Total
2002	1.289.152	599.817	1.888.969
2003	1.281.398	614.019	1.895.417
2004	1.296.811	628.892	1925.703
2005	1.309.506	642.447	1.951.953

2006	1.310.473	658.919	1.969.392
2007	1.358.201	671.084	2.029.285
2008	1.432.534	680.951	2.113.485
2009	1.537.574	697.647	2.235.221
2010	1.577.844	709.955	2.287.799
2011	1.600.554	714.882	2.315.436
2012	1.667.108	729.546	2.396.654
2013	1.739.337	740.253	2.479.590

Source: Business statistics of the LTCI funds

The overview shows the continuous, annual growth in beneficiaries. In 2014 the number of social care beneficiaries had increased further to 2,589,000.

It is also important to know about the number of beneficiaries per age groups. The table below is structured as follows:

The right column indicates the age groups, starting from younger than 15 years old through to older than 90 years old. The next sector shows the number of home care beneficiaries split into three levels of care. The next sector shows the number of beneficiaries in residential institutions split into three levels. The next sector shows the sum of home and residential care split in three levels and in the last two columns the numbers indicate the total sum in numbers and next as a percentage. From 70 years and older the need of social services is increasing drastically.

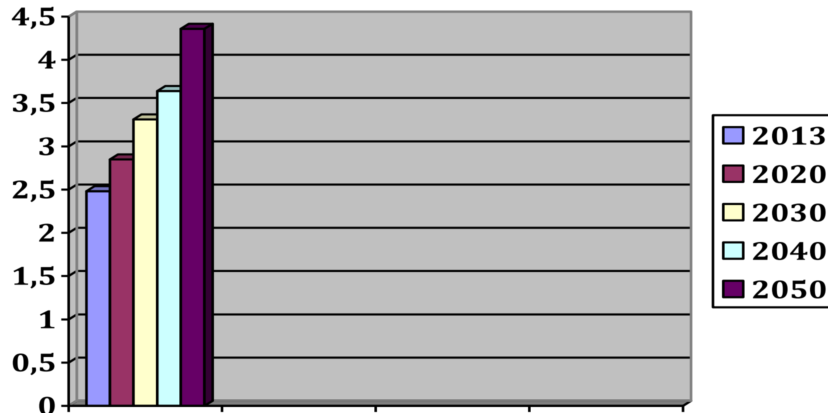
Age groups and levels of care of all insured social care beneficiaries at December 31st 2014

Age Groups	Home Care				Nursing Home Care				Total Number				
	Levels of Care			Total	Levels of Care			Total	Levels of Care			Total	in %
	Level I	Level II	Level III		Level I	Level II	Level III		Level I	Level II	Level III		
>15	40.765	22.287	10.500	73.552	1.136	227	240	1.603	41.901	22.514	10.740	75.155	2,9
15 >20	13.108	7.414	5.958	26.480	1.280	222	325	1.827	14.388	7.636	6.283	28.307	1,1
20 > 25	10.363	6.419	5.609	22.436	2.506	418	599	3.523	12.869	6.909	6.208	25.986	1
25 >30	9.275	7.139	5.562	21.966	3.320	579	806	4.705	12.595	7.718	6.358	26.671	1
30 > 35	7.997	6.741	4.692	19.430	3.552	567	809	4.928	11.549	7.308	5.501	24.358	0,9
35 > 40	7.821	6.722	3.592	18.135	3.943	577	765	5.285	11.764	7.299	4.357	23.420	0,9
40 > 45	10.506	7.691	3.610	21.807	5.537	908	1.115	7.500	16.043	8.599	4.725	29.367	1,1
45 > 50	17.634	11.270	4.513	33.417	9.113	1.887	1.992	12.992	26.747	13.157	6.505	46.409	1,8
50 >55	26.403	14.511	4.879	45.793	12.288	3.312	2.785	18.385	38.691	17.823	7.664	64.178	2,5
55 > 60	33.936	15.914	4.750	54.600	12.683	4.805	3.254	20.742	46.619	20.719	8.004	75.342	2,9
60 >65	46.959	20.847	5.509	73.315	13.294	6.933	3.999	24.226	60.253	27.780	9.508	97.541	3,8
65 >70	57.116	25.400	6.257	88.773	12.725	8.734	4.793	26.256	69.841	34.134	11.050	115.025	4,5
70 >75	102.831	45.599	10.739	159.169	20.053	18.418	10.060	48.531	122.884	64.017	20.799	207.700	8,1
75 >80	182.119	75.663	16.841	274.623	34.624	36.495	19.955	91.074	216.743	112.158	36.796	385.697	14,2
80 >85	223.550	87.209	19.040	329.799	49.194	51.519	26.575	127.288	272.744	138.728	45.615	457.087	17,8
85 >90	224.169	90.479	19.630	334.278	70.098	70.060	33.938	174.096	294.267	160.539	53.568	508.374	19,8
<90	131.406	70.841	18.205	220.462	65.869	75.072	36.926	177.867	197.275	145.913	55.131	398.319	15,5
Total	1.145.958	522.218	149.876	1.818.052	321.215	280733	148936	750.828	1.467.173	802.951	298.812	2.588.936	100%
Total in %	63%	28,70%	8,20%	100%	42,80%	37,40%	19,80%	100%	57,10%	31,30%	11,60%	100%	
Ministry of Health Germany													

Reasons for higher number of home care beneficiaries are individual preferences to stay at home as long as possible. Further, there are several measures favoring home care:

- Cash benefits for family care
- ension benefits for informal care givers if they interrupt their employment
- Family member can enjoy four weeks holiday per year and the beneficiary can be transferred to a short term social care institution

Trends in the Number of Persons (in Millions) Requiring Long-term Care



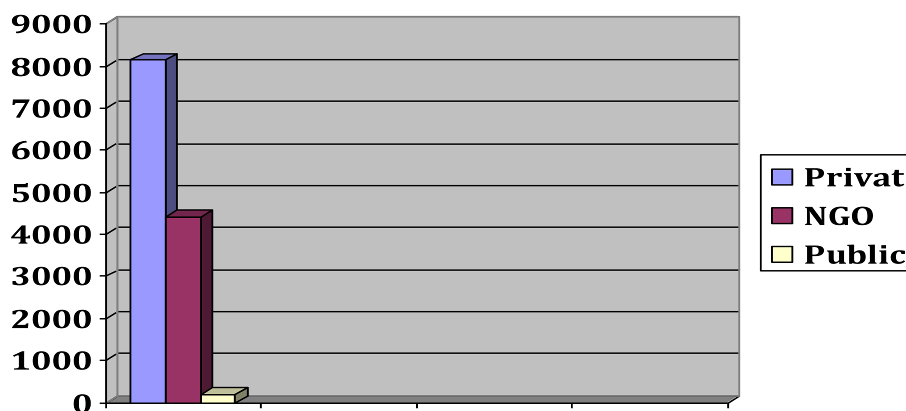
Assumption of a constant durable long term care probability

Source: Business Statistics of the Care Funds

Provider Structure

In Germany the care providers constitute a big industry. On the supply side the German market is dominated by private providers. In 2013, there were 12,745 social care institutions, providing care at the beneficiaries' home. The provider structure shows 63% (8.140) were private for profit, 36% private-not-for-profit (4,422) and 1% public (183).

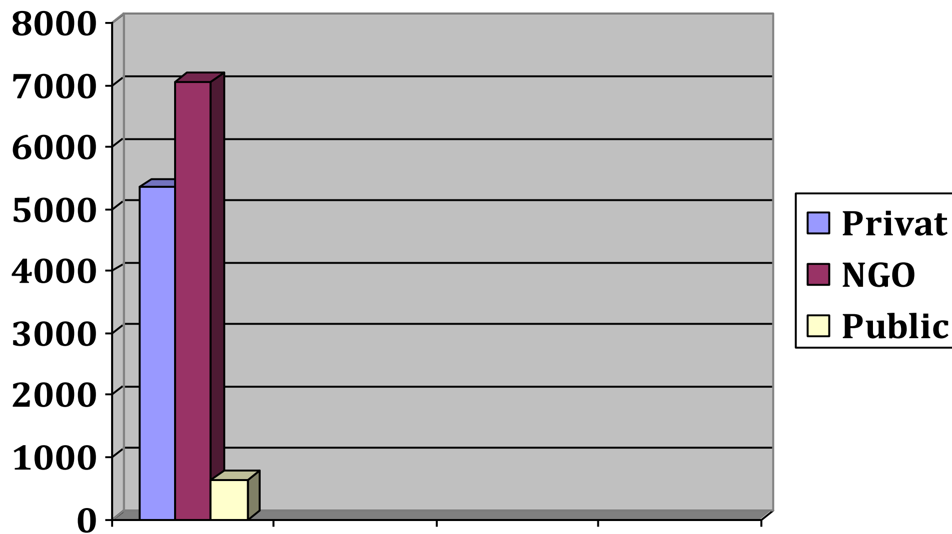
The Number of Home Care Providers And Organizing Institution (2013)



In residential care the situation is slightly different regarding organizing institutions. The total number was 13,030 in 2013. Most providers are NGOs – 7,063 or 54%, followed by private providers with 5349 or 41 %. Public providers hold a market share of 635 0r 5%.

In residential care the number of residents and personnel is considerably higher than in home care. About 70% of all employees (in 2013 the total number of personnel in home and residential care was 1,000,600) are working in residential care. The number of personnel in relation to residents and their individual needs differs from one federal state to another. There are no standards on the National State level and the indicative value is out of date because it was discussed and fixed about 20 years ago. On average a care taker in residential institutions is on duty with 12 clients during the day and 60 during the night.

Number of Residential Care Providers and Organizing Institution In (2013)



The official statistics do not indicate the specific number of residential care institutions. The figure of 13,030 must be reassessed because it includes both day and night care institutions.

The excess supply of private providers and NGO's occurs due to the regulation of the principle of subsidiarity. The main principle is that private and nonprofit NGO providers as well as churches have the right to cover public duties and are eligible to claim subsidies. Even more they have absolute priority in taking up the objectives. In contrast public institutions, mainly communities, have to withdraw from making provider services available, unless they are specifically authorized. This would occur in cases where private providers and NGOs cannot serve the demand side. The aim is to promote competition in the social care market which has arguments for and against.

Competition in the care market has put pressure on pricing with the consequential result of hiring staff from low wage countries within the European Union. It concerns staff coming mainly from the new EU member states.

On the other hand, covering large geographic areas and the guarantee of access for beneficiaries and potential clients requires flexibility and also an increase in providers; especially providers covering a smaller number of clients even in remote areas.

Accessibility is as important for location decision and regional development as it is for the individual life situation of the citizens. The reason is that accessibility determines the regional quality and the provision of infrastructure. An ongoing study focuses on the availability of social care services according to the Eleventh Book of the Code of the Social Law (SGB XI) by analyzing the regional distribution of home care services based on a raster-based GIS accessibility analysis. Thereby the study especially focuses on the regional distribution of social care services in rural areas. It can be concluded, that in Germany a social care service provider needs on average 5.8 minutes at an average speed of 50 km/h to reach its customers. A regionalized analysis shows that in rural areas the distances to be covered are slightly greater than in urban areas. Nevertheless according to the accessibility model 94 % of the people can be reached by a social care service provider within 10 minutes driving time at an average speed of 50 km/h. That corresponds to ca. 95 % of the people in need of social care services.

This situation shows the importance of sufficient number of providers who are serving small number of clients and they are distributed equally (urban and rural areas). The following table indicates number of home service provider and their legal status with the minimum and maximum number of clients (December 2013).

No Clients	Private	NGO	Public
> 10	875	147	10
11 to 15	824	127	8
16 to 20	894	189	10
21 to 25	820	217	12
26 to 35	1406	503	32
36 to 50	1434	754	36
51 to 70	986	896	27
71 to 100	572	804	25
101 to 150	260	501	15
150 +	69	284	8
Total	8140	4422	183

Federal Association of Non-Statutory Welfare

The Federal Association of Non-statutory Welfare (BAGFW) [1] in social welfare. The Arbeiterwohlfahrt, the Deutsche Caritasverband, the Deutsche Rote Kreuz, the Deutsche Paritätische Wohlfahrtsverband, the Diakonische Werk der Evangelischen Kirche in Deutschland and the Zentralwohlfahrtsstelle der Juden in Deutschland are all based on different religions and beliefs.

It belongs to the so called "third sector" and has to be seen as an open and polymorphic area between the state, the market and the family.[2]

The central organizations have a federal structure; their bodies at the local and national level and the member organizations usually form their own legal entity.

Their significance in the social welfare system becomes clear in terms of the number of members and employers working in social welfare sector.

Workers` Welfare Service (AWO)

- 430,000 members, 100,000 volunteers,

[1]Bundesarbeitsgemeinschaft der freien Wohlfahrtspflege

[2] See attached abstract about "Third Sector" research in China 2006

- 146,000 employees in 14,000 social services and establishments.
- 29 associations at regional and state level, 480 associations at district level and3800 local clubs.

German Caritas Association

The organization comprises 27 diocesan Caritas associations, 6 regional associations, 18 professional associations and 8 specialized Catholic charity organizations.

- 24,939 establishments offering more than a million places.
- 520,186 employees (full or part-time), 500,000 volunteers.

German Red Cross

- Part of the International Red Cross and Red Crescent Movement.
- 116,211 employees, approximately 400,000 volunteers.

Welfare Service of the Protestant Church in Germany

- Members are the social welfare organizations maintained by the 24 United Protestant, Reformed and Lutheran state churches, members of the Protestant Church in Germany, 9 free churches with their social welfare facilities and a variety of some 90 professional associations.
- Together they represent 27,300 independent establishments with more than 1 million places.
- 452,200 employees (full or part-time).

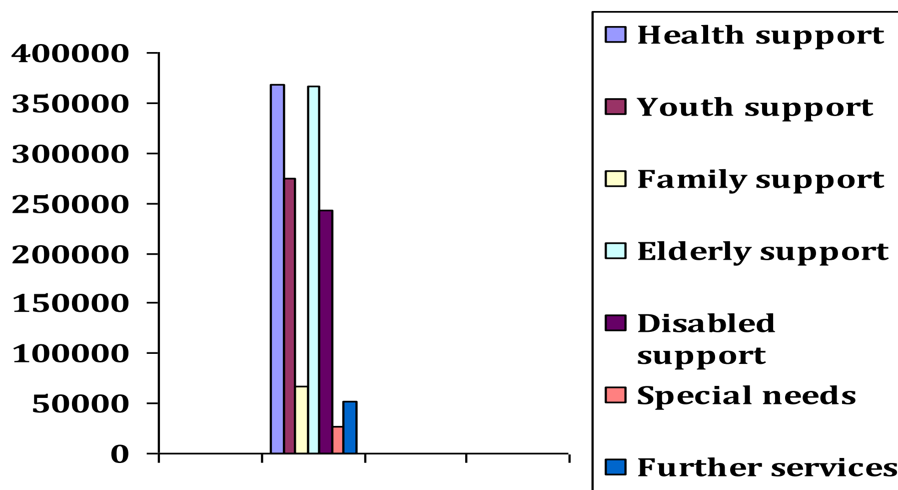
Association of Non-affiliated Charities

- This organization is a grouping independent organizations, establishments and bodies active in social work. It supports and represents 10,000 member organizations in 15 regional associations and over 280 district offices.
- 169,900 employees are working in 24,000 establishments.

Jewish Central Welfare Agency in Germany

100,000 members in 17 Jewish regional associations, 6 independent Jewish local congregations with 100 Jewish communities (in 2008 about 108,000 members) and the Jewish Women`s Association (1000 members) and 50 employees.

The following graph shows the number of employees of the voluntary welfare associations in the specific sectors:



The biggest share of employees is found in health (26%), support for the elderly (26%), youth support (19%) and support for persons with a disability (17%).

The comparison of numbers of employees of the central voluntary welfare associations with numbers of employees of other economic groups shows the relevance of this sector.[3]

- German Mail: 456,716 employees
- Siemens Germany: 428,00 employees
- Daimler Germany: 273,216 employees
- German Caritas Association: 520,186 employees 4
- Welfare service of the Protestant Church in Germany: 452,200 employees
- Workers' Welfare Association: 146,000 employees
- Association of Non-affiliated Charities: 169,000 employees
- German Red Cross: 116,000 employees

The central associations have worked together closely since 1924. Their common objective is the safeguarding and development of social work through community initiatives and socio-political activities. To implement these objectives, the BAGFW maintains an office in Berlin, a representative office in Brussels and the Charity Stamps Department in Cologne. The central associations themselves have a federal structure, i.e. in most instances their sub-divisions are at municipal and federal-state level respectively, as well as their member organizations, are legally independent.

For further information contact coordinates and websites of all six umbrella organizations cooperating in the Federal Association of Non-statutory Welfare:

Arbeiterwohlfahrt Bundesverband e. V. (Workers' Association) Blücherstraße 62 / 63D–10961 BerlinPhone: +49 (0)30 263 09 – 0Fax: +49 (0)30 263 09 – 32599E-Mail: info@awo.orgwww.awo.org

Der Paritätische Gesamtverband e. V. (Association of Non affiliated charities) Oranienburger Straße 13–14D–10178 BerlinPhone: +49 (0)30 246 36 – 0Fax: +49 (0)30 246 36 – 110E-Mail: info@paritaet.orgwww.paritaet.org

Deutscher Caritasverband e. V. (German Caritas) Karlstraße 40D–79104 Freiburg im BreisgauPhone: +49 (0)761 200 – 0Fax: +49 (0)761 200 – 572E-Mail: info@caritas.deBerliner Büro:Reinhardtstraße 1310117 BerlinTelefon: +49 (0)30 284 44 – 76Fax: +49 (0)30 284 44 – 788E-Mail: pressestelle@caritas.dewww.caritas.de

Deutsches Rotes Kreuz e. V. (German Red Cross) Carstennstraße 58D–12205 BerlinPhone: +49 (0)30 854 04 – 0Fax: +49 (0)30 854 04 – 450E-Mail: drk@drk.dewww.drk.de

Diakonie Deutschland – Evangelischer Bundesverband Evangelisches Werk für Diakonie und Entwicklung e. V. (Welfare Service oft he Protestant Church in Germany) Caroline-Michaelis-Str.1D–10115 Berlin Phone: +49 (0)30 652 11 – 0Fax: +49 (0)30 652 11 – 3333E-Mail: diakonie@diakonie.dewww.diakonie.de

Zentralwohlfahrtsstelle der Juden in Deutschland e. V. (Jewish service association) Hebelstraße 6D–60318 Frankfurt am MainPhone: +49 (0)69 944 371 – 0Fax: +49 (0)69 494 81 – 7E-Mail: zentrale@zwst.org

[3] Figures 2009
[4] The Churches (Catholic/Caritas and Protestants) are the biggest employers in Germany's non-statutory welfare system

Funding Non Statutory Welfare Associations

Consistent with the principle of subsidiarity, the German nonprofit sector including the voluntary welfare associations receives the bulk of its revenue from public sector sources.

The sources of financing of voluntary welfare services can basically be divided into three groups:

- Remuneration for services,
- Public grants-in-aid and
- Donations and internal funding

The welfare associations receive remuneration in return for the services that they provide in certain areas (hospitals, nursing homes and out-patient services among others). Either care recipients have to pay themselves (often with a right to reclaim the charges from social welfare) or the public welfare agencies pay directly as well as the insurance funds.

As for funding in the form of public grants-in-aid, its legal basis lies in the pubic obligation to provide appropriate support for voluntary welfare agencies.

The public grants-in-aid are financing

- Investment aid for the building facilities and
- Assistance for their operation.

This funding is in part stipulated in law and in part furnished according to political judgement. The form and extent of public grants-in-aid varies according to the respective field of work, and depends on the Land (Federal County), district or municipality responsible.

The traditional sources of income for the welfare associations are the financial and material donations from their public appeals, households and street collections. Internally, the associations receive contributions from their own members, friends and supporters.

A further self-financing activity is the sale of welfare coupons which contain a surcharge and revenues from lotteries are also important.

Finally, the voluntary welfare sector makes a considerable contribution itself. First and foremost there is all the work performed by voluntary helpers, even if these do not appear on any balance sheets as a financial item. Voluntary work saves enormous amounts of money which would otherwise have to be covered by the public through taxes or insurance contributions.

The different shares of financing are:

- Remuneration for services 64.1 %
- Public grants-in-aid 20.2 %
- Donations 3.2 %
- Internal funding 12.5 %.

Almost two-thirds of non-statutory welfare is financed through insurance (long-term-care and health) and through the welfare institutions which support persons with special needs. In terms of long term care insurance, financing contracts are negotiated every two years at the Federal level. The provider side is represented by the Association of Non-Statutory Welfare and other associations (e.g. private providers).

Quality Assurance is Condition for Contracting

The funds, which administer the long-term care program, must ensure that beneficiaries have access to quality care, consistent with contemporary care standards, through their contracts with providers

(Long-Term Care Law (SGB XI) paragraph 69). The funds, however, must contract with all providers that meet the minimum requirements, thus limiting their leverage with providers. This requirement reduces the providers' incentive to compete on quality, although once they contract with funds, they must still compete to attract consumers. In setting quality standards, coalitions of funds negotiate with coalitions of providers. Consensus among the negotiating parties is critical to the adoption and implementation of any initiatives.

Quality indicators consist of quality of structure, quality of the process, quality of the outcome. This scheme builds the framework and represents an excellent instrument for measuring the quality of all care processes.

Quality of structure:[5]

Quality of structure emphasizes and focuses on providers' personnel available, related to the clients' needs and management capacities, the time to be on duty and skilled staff. The defined quality indicators are the professional background of the manager who has to have a solid professional education and passed an exam plus additional education in home care requirements and specific management skills. The provider should assure that the personnel employed are encouraged to attend further education courses and internal supervision rounds.

Quality of process:

The clients have to be clearly informed about the time on duty and, in geographic areas with high dense population, the providers should go in co-operation with other providers for sharing "emergency" services outside of the normal working hours.

The so called terminus "quality of process" refers to the genuine care process and the work with beneficiaries. In order to provide services of high quality it is necessary to follow such a care cycle.

The cycle consists of:

a) Anamnesis and defining the targets to be achieved through the care, treatment and rehabilitation services. This has to be done and agreed upon by the client wishes as well.

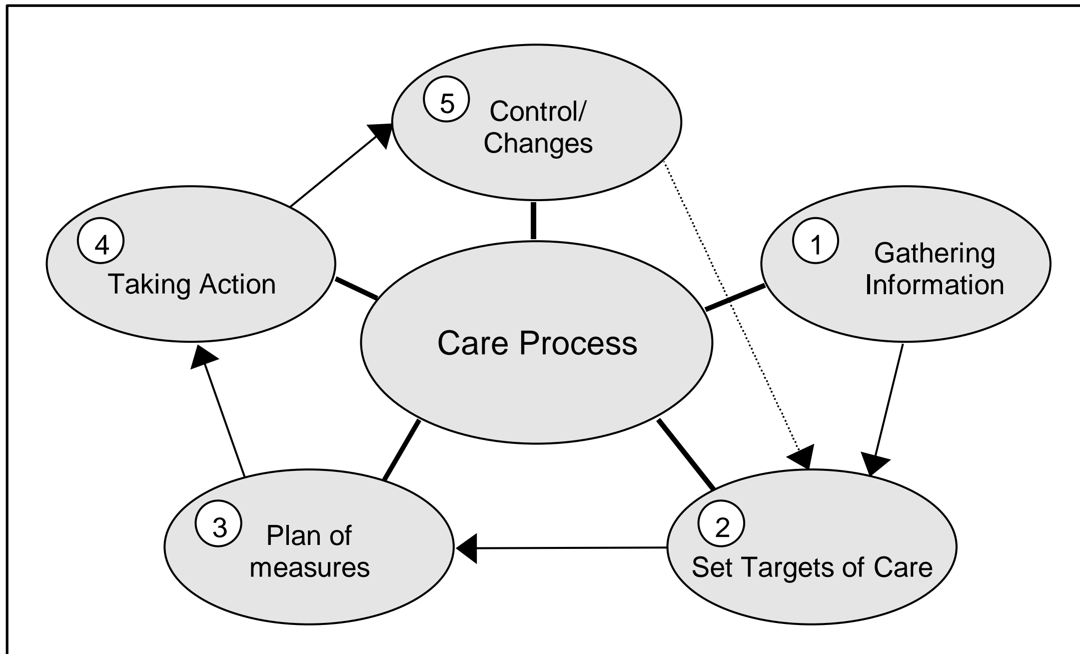
b) The care plan has to be elaborated and documentation on care measures has to be individually recorded to the professionals who are part of the care process (e.g. social workers, auxiliary staff, rehabilitation personnel etc.). One copy of the documentation has to be stored in the household and one at the services provider(s).

c) The measures have to include so called "activated care" which takes into account the client's capabilities and these capabilities have to be stimulated. Prophylaxis and rehabilitation are part of the measures as well.

d) The process has to be assessed frequently. In case the aims of the caring process are not achieved the measures have to be adapted and revised.

Scheme of the Care Process

[5] The following examples are indicators that have to be fulfilled as minimum in Germany



Providing the indicated items for the quality of structure and the quality of the care process and the outcome to be determined depends on several facts.

One might focus on the costs, others look at staff satisfaction and again others determine client/clients' satisfaction as parameters for the outcome of quality.

All three mentioned items are worthy of being taken into account and used as determinants for qualitative outcome(s).

Control of Quality in Residential Institution

Two documents guide long-term care provider quality. Funds, key provider associations, and social assistance programs at the national level must agree on general quality assurance standards. Setting the standards through negotiations among interested parties under the auspices of a non-governmental body is based on provider-payer consensus. These groups had developed the principles and measures already in 1996 in the implementation phase of long term care.

In 2001 the Law on "Long-Term Care Quality Assurance" introduced the concept of quality contracts between funds and providers. Federal standards do not contain detailed guidelines for the contracts, which are implemented at the federal level as "service and quality" contracts between providers and sickness funds and are negotiated primarily through the collective bargaining contract negotiations.

These "service and quality contracts" were to be signed by all providers by January 1, 2004.

Separate contracts for services and quality allow funds to review the providers' quality when negotiating the reimbursement rates, creating an opportunity to incorporate quality measures into rate negotiations in a more systematic way. This structure relies on enforcement of contractual provisions between payers and providers to ensure quality.

Every two years, providers must demonstrate to the funds that they have quality assurance mechanisms in place and that they have delivered services in accordance with the service and quality contracts. The 2001 quality law also made a range of sanctions available to funds when quality problems are discovered, such as temporary reductions in payment rates, refunds of payment and temporary bans on client admissions.

Another part of the 2001 law clarifies that the medical offices [6] of the funds have the authority to conduct inspections, which may be unannounced and may occur at night. Quality assurance in residential settings is considered a higher priority than quality assurance in home and community settings.

The designed inspection instruments used by the medical offices' teams follow the initial structure, process, and outcome measures of quality.

Control of Quality at Beneficiaries' Home

Although funds assure quality for home care service providers through contractual requirements, at Federal and Local Government level it is not possible to control these providers directly. Funds may cut payments or exclude providers entirely if the services are not delivered as agreed or if quality problems are detected. However, such sanctions are seldom imposed.

In home care, special provisions are made for long-term care beneficiaries who choose the cash benefit. Everyone selecting cash benefits receives regular, generally every six months, supervision visits from a home care service provider to confirm that the care is in place. The format of these control visits has been agreed on by the funds and the provider associations.

However, because caregivers are almost always family members, actions are very rarely taken because it is thought inappropriate to interfere in family relationships. Because there are no restrictions on how the cash benefit is used, some observers argue that this enormous flexibility increases consumer satisfaction. Despite such arguments, there is little intention to announce detected problems. Home-care service providers have the task to supervise and support family members every six months and the supervision should end in the improved manner. Change for the worse would discredit the provider.

As prevention, several best practice protocols have been developed by the medical offices with other experts to develop care standards through a consensus process. The standards include suggestions to providers and are meant to be educational and consultative.

Once consensus is reached, the standard becomes the focal point of an education and publicity campaign. The medical office then announces that care in this area will be an area of special focus in upcoming inspections.

References:

ANCIEN Accessing Needs of Care in European Nations

Riedel Monika, Kraus Markus; The Organization of formal LTC for the elderly, ENEPRI Research Report, November 2011

ANCIEN website http://www.ancien-longtermcare.eu

Federal Ministry of Labor and Social Affairs. (2014a) National Social Report 2014 (NSR) - Germany. Available from:

http://www.bmas.de/EN/Service/Publications/a360-14e-national-socialreport-2014.html

The third sector and policy process in Germany;

European Policy Working Paper No 9

Zimmer Anette et al., November 2009

[6] The medical office is the independent body , consisting of teams with different professions, described under the headline "Institutions"

Charter of Rights for People in Need of Long-term care & Assistance (Long-Term Care Charter) – Practical Support for the Implementation of the Long-Term Care Charter by Home-based Care Institutions – Manual for the Self-Evaluation of Long-Term Care Home Care Services based on the

Konkret Consult Ruhr in cooperation with the Information Centre on Long-Term Care Charter at the German Centre for Gerontology, 2011

Büscher, Andreas; Public reporting, expert standards and indicators. Different routes to improve quality of German Long Term Care. Article in Eurohealth, Vol. 16 No 2 andreasbuescher@osnanet.de

Federal Ministry of Health, Selected Facts and Figures about LTC Insurance, 2015

www.bmg.bund.de

Brochure: Non Statutory Welfare, Published by Association of Non-Statutory Welfare 2015

www.bagfw.de

Attached Abstract:

Non-State Care Homes for Older People as Third Sector Organisations in China's Transitional Welfare Economy

---

LINDA WONG [a1] and TANG JUN [a2]
[a1] Department of Public and Social Administration, City University of Hong Kong, 83 Tat Chee Avenue, Hong Kong, China email: Linda.Wong@cityu.edu.hk
[a2] Center for Social Policy Studies, Institute of Sociology, China Academy of Social Science, 5 Jianguo Mennei Street, Beijing, China 100372

Article author query

wong l [PubMed][Google Scholar]

jun t [PubMed][Google Scholar]

Abstract

The rise of the third sector has been a global welfare phenomenon. In China, the growth of social organisations has been a remarkable feature of the transitional society after the adoption of market reforms and political liberalisation. In its emergent welfare economy, the third sector has been hailed as a new growth point in social care as the state retreats from direct provision of welfare services. This article examines non-state care homes for older people in urban China based on a survey of 137 homes in three cities. It begins with a brief review of the theory of the third sector, non-governmental organisations and private markets in the production of welfare. This is followed by a discussion of third-sector organisations, markets and the state in the special context of China. The next section appraises the factors that contribute to the surge of non-state residential provision for the elderly. The final part of the article presents empirical findings on the development, key features and authority relations of 137 non-state care homes for older people. It is argued that their uniqueness marks them out as a special form of third-sector organisation in China's welfare economy.

(Published Online March 3 2006) Non-State Care Homes for Older People as Third Sector Organisations in China's Transitional Welfare Economy

3.3.1 Social Assistance for Specific Vulnerable Groups (SASVG) - services for children, elderly, people with disabilities, with a special focus on poor rural people - Policy Recommendations

Zuo Ting, Professor, Development and Social Security Studies, China Agricultural University, P.R.China

1. Policy Overview on Social Assistance for Specific Vulnerable Groups

Although China has become the second largest economy in the world, it is still largely an agricultural society. The rural population accounts for 50% to 60% of the total population under different criteria. Due to urban-rural dualistic economic characteristics formed under the planned economy, the living standards and the level of social security of the rural population are lower than that of the urban population. Under the background of urbanization, the livelihoods of rural-urban migrants are full of risks and uncertainties. Until now, the majority of China's poor population has remained in rural areas.

In this century, especially since the 18th CPC National Congress, social assistance for the rural poor has been highly valued by the Chinese Government. Among the rural poor, the majority belongs to the income poverty group and some of the remainder, about 7% to 8%, belongs to the physiological poor group. For these people, such as the elderly, children and people with disabilities, a lack of an income source and physical difficulties are their main characteristics. They are the most vulnerable groups and generally referred to as the Specific Vulnerable Group (SVG).

The Chinese government has been making great efforts to establish a new rural welfare system to protect the vulnerable groups. In 1956, the First National People's Congress (NPC) published a directive entitled Exemplary Charter for Advanced Rural Cooperatives, in which the rural communes were required to provide to the farmers in extreme need of the so called "five guarantees" including food, clothing, fuel, education and burial expenses, and who had absolutely no responsible kin to care for them or who were too old, too young or too sick to support themselves. Since then, the vulnerable group has been called 'Five-Guarantee Households' (FGHs).

The "*Regulations on the Work of Providing Five Guarantees in Rural Areas"* adopted at the 121st Executive Meeting of the State Council on January 11, 2006, were then promulgated and became effective as of March 1, 2006. These Regulations are formulated for the purpose of bringing to success to the work of providing FG in rural areas, ensuring a normal life for persons receiving FG in rural areas and promoting the development of the social security system in rural areas. Article 6 indicates that villagers who are aged, disabled or under the age of 16 and have no ability to work, no source of income, and no statutory guardians to provide for them, bring them up or support them, or whose statutory guardians have no ability to provide for them, bring them up or support them, shall enjoy FG in rural areas.

In 2014, Specific Vulnerable Groups (SVG) were referred as those who are aged, disabled or under the age of 16 having no ability to work, no source of income, and no statutory custodians or to provide for them, or the "Three None's" Group called in the Five Guarantees scheme (FG), by the "Interim Measures for Social Assistance" and social assistance should be provided to them. The Social Assistance to Specific Vulnerable Group (SASVG) system is the continuation and development of the traditional FG. The major research object of this report is the system of SASVG. A systematic presentation and assessment of SASVG has been conducted by the researcher from multi-perspectives including the defining and distinguishing of specific vulnerable group, the mode of social assistance and its effects.

Article 14 of the Interim Measures stipulates that the State shall grant support to the especially poor, i.e. the elderly, the disabled and minors under 16 years of age who have no persons with statutory custodians to support aging parents, children, or other persons or persons with statutory custodians to support them but who do not possess the capacity to support them. Article 15 of the Interim Measures indicates that the support for the especially poor includes:(1) providing basic living conditions; (2) looking after those who cannot take care of themselves; (3) providing disease treatment; and(4) handling funeral matters. It is stipulated that the support standard should be determined and announced by People's Government of each province, autonomous region, municipality, or city with districts. The support of the especially poor shall be integrated with the

systems of pension insurance for urban and rural residents, basic medical insurance, minimum subsistence guarantee, and basic living guarantee for orphans.

In October 2015, in order to achieve the great goal of well-off society being built by the year 2020, the Central Government set up a new poverty elimination strategy in which social assistance was assigned a fundamental role. In February, 2016, the State Council organized a thematic standing meeting and promulgated the "Guidance on Further Improvement of the Social Assistance and Support for SVG" to strengthen the implementation of relevant articles of the "Interim Measures" which included the setting-up of five principles, clarifying the definition, the standard for targeting groups and procedures, fulfillment of the Government in service delivery such as food, clothing, housing, daily-care and medical care, increasing the Government's financial input, and involvement of social participation.

2. Implementation of Social Assistance for Specific Vulnerable Groups

With the promulgation of the "Guidance on Further Improvement of the Social Assistance and Support for SVG" (dated February. 14 2016), the social assistance net for rural specific vulnerable aged, children and disabled people has been built-up, in which Civil Affairs Department is the core and the Union of Disabled Persons (UDP) and poverty-relief, social insurance, medical health, education and housing departments as a supplement. In practice, the care for vulnerable disabled is mainly implemented by Union of Disabled Persons (UDP). It has higher standards, a wider range and more professional methods. The support standard for vulnerable children is higher than that for the vulnerable aged, so they are supported by professional organizations inside the Civil Affairs Departments. The vulnerable aged is the most significant group of specific vulnerable people; they make up 90% (including some disabled) and the support models are collective support and individual support. The content stated in the "*Regulations on the Rural Five Guarantees Scheme*' is (1) providing grain, oil, subsidiary food and fuel; (2) providing clothes, bedding, mattress and pocket money; (3) providing qualified housing; (4) Providing medical treatment and daily care and (5) Providing funeral arrangements.

Table: General Situation of SVG in China, Oct.-Dec. 2015

	Sub-total	Female	Elderly	Children	Disabled	Averaged Support (CNY)
Collectively Supported	1618013	276627	1428237	46443	266969	6026
Individually Supported	3556830	595351	3001306	134369	655400	4490
Total	5174843	871978	4429543	180812	922369	

Source of Data: Ministry of Civil Affairs,
http://www.mca.gov.cn/article/sj/tjjb/sjsj/201602/20160200880174.htm

At the end of 2015, there were a total 5,174,843 (as opposed to 5,669,063 in 2014) of supported SVG, of whom 871,978 were female, about 1/6 of the total. According to the recipients' health condition, willingness and local capacity, there are three modes of support for SVG: Collective support, Individual support, and Third party support. The proportion of collective support is comparatively low nationwide, less than 1/3 (31% in 2015). The personal average support level for collective support was CNY 6,026, and that for individual support was CNY 4,490.

The main bearers of responsibility for collective supports are government organizations. FG service organizations, such as Homes for the Elderly, the Child Welfare Institution, and the Disabled Welfare Institution, undertake the task of collective support to rural FG recipients and they usually provide food, clothing, housing, medical treatment, funeral and other services. In rural areas, the main collectively supported FG recipients are the specific groups such as aged without the ability to work, orphans, and people with a disability. Currently, the management of the elderly support organizations of FG, like Homes for the Elderly, is dominated by township or county governments, and for children support organizations of FG, like Child welfare institution, county or city governments usually takes charge of their management.

Currently, there are several problems concerning collective support in rural areas: (1) The occupancy rate of social welfare institutions is not high and most recipients of collective support are rural elders who can’t take care of themselves and people with severe disabilities; (2) Low payment for and the educational level of welfare institution staff and a high employee turnover rate; (3) The ratio between recipients and nursing workers is far from meeting the national requirement, which causes severe asymmetry and low quality of support; (4) With the increasing numbers of institutions the expansion of their size, and the improving of infrastructure and facilities, the cost of management and maintenance in later stages continues to rise, resulting in a larger fiscal gap for the poorer central and western regions and the unsustainability of the collective support institutions for FG.

The main subject of individual support is the individual and their daily life care is in charge of the village committee. The traditional individual support pattern can be divided into various categories considering the different roles of the village committee, villager group, contracted land, relatives and other villager neighbours. The “*Regulations on the Rural Five Guarantees Scheme”* issued in 2006 required the Government to play the fundamental role of guarantor.

Individual people can still stay in their living surroundings, so their living habits and psychological demands are satisfied. Currently the problems of the rural FG individual support are as follows: firstly, the people who chose individual support are the disabled who cannot take care of themselves or juveniles without family care. The others are the aged who have lived in villages for a long time, so they cannot adapt to the restraints in a geracomium. Second, although people who chose individual support can get an allowance and subsidy for material support their quality life quality is not high for a lack of daily care and treatment, poor diet and lack regularity in their life.

Third party support is whereby the county civil affairs department or township government entrusts a third party to provide home care service for FG people in the form of buying service from the society. The service includes care during the day, providing or buying dinners, medical related services, cleaning services, spiritual consolation, security and so on. On July 2015, the civil affairs Department of Qinghai province issued the “P*ilot Third Part Service Scheme for the Vulnerable Aged in Qinghai Village and Herding Areas* to pilot the scheme in 11 towns such as Huangnan, Guoluo, Yushu and Hainan. The scheme is aimed at FG and the elderly “Three None’s” who lived in villages and the herding areas and who do not have live-in support organizations, the single aged who are covered by the Minimum Subsistence Allowance System (Dibao) ad who are aged over above 70 and single people with special care needs in the village and herding areas. The service provider can be a qualified geracomium or other organizations, or it can be undertaken by village organizations, seniors associations, village service stations and other warm-hearted people in the form of delegation.

The *“Regulations on the Rural Five Guarantees Scheme”* provide that the rural FG fund should be arranged as part of the local government budget. Villages that have business incomes can subsidise the FG recipients. If the person gives his land to others, the revenue should be returned to him. The Central Government gives financial help to those in difficult areas. Currently the

funds of the FG allowance system come from: local government budget, village committee revenue, central government subsidy, support organizations' productive income, social donations and the welfare lottery public fund. The support standard is usually determined by local government. By the end of 2014, the fiscal fund for rural FG was CNY 18.98 billion an increase of 10.2% over 2013 of which , the collective support fund is CNY 7.8 billion and the individual support fund is 11 billion. In fact, the support standards are different for different groups, the standard of collective support for the aged is higher than the individual support. The standard for vulnerable children is higher than for the aged. The standard for persons with a disability is almost the same as for the aged with aged but they receive other subsidies. The standards in different provinces vary. In 2014, the average standard for collective support and individual support was CNY 5,371 and CNY 4,006 respectively, whilst in the lowest province (Guizhou) it was only CNY3,298 and CNY2,206 respectively (which was lower than the official poverty line).

3. Achievements and Challenges of Social Assistance for Specific Vulnerable Groups

3.1 Achievements

3.1.1 Establishment of the Rural Social Assistance Net in which Support to the Most Vulnerable People is Considered as a Key Achievement

Since the 21th century, China has reinforced the construction of institutions and regulations for rural vulnerable groups. Marked by "*Regulations on Rural Five-Guarantee Scheme"* in 2006 and the *"Interim Measures for Social Assistance"* in 2014, the social assistance system for specific vulnerable groups has been basically formed in China. With the Minimum Subsistence Allowance System (Dibao), the Social Assistance for Specific Vulnerable Groups, Medical Assistance, Temporary Assistance and other Social Assistance schemes, and the Rural Development Oriented Poverty Reduction Program, China has built a Social Assistance network for the rural poor population. The network has basically achieved full coverage of SVG and played the role of satisfying minimum needs. The support ability for SVG has also increased significantly and has begun to be integrated with the basic pension insurance system for residents, basic medical insurance, Minimum Subsistence Allowance System (Dibao) and orphan subsistence allowance system.

3.1.2 Formulation of a Support System for SVG in Rural Area and Improving Service Levels

In more than 30,000 towns in China, nearly every town has built its support organization for the specific vulnerable old and children. By the end of 2014, there were 3,934,390 beds for the old and the disabled, 102,174 beds for children, and 2,600,000 staff, half of whom were for rural SVG. By August 2015, 5,231,000 people were covered by the Five Guarantee Schemes (FG), and 1,674,000 (32%) of them were collectively supported. The average standard was CNY 5,706 per person per annum for collective support and CNY 4,241 per person per annum for individual support, achieving an increase of 93.3% and 101.7% respectively over 2010. Many homes for the elderly are registered as public institutions. Based on choosing either collective or individual support, the township government, the homes for the elderly, the village committee, the cadres in charge of helping villagers, and the FG recipients sign support contracts respectively for differentiating responsibilities and obligations. The county or district bureau of civil affairs enrolls FG recipients in the New Rural Cooperative Medical Insurance and they do not need to pay in a specific hospital. A service system including town homes for the elderly, village home and house repairs for FG recipients has been formed.

3.1.3 Building up an Information and Archives System for Supported Specific Vulnerable Groups

The Ministry of Civil Affairs and the State Archives Administration issued the "*Management Measures for the Rural Five-Guarantee Archives",* including 17articles, and implemented it since April 1, 2013. According to the measures, the recipients' information should be timely updated and

all specific vulnerable people should be covered by FG if allowed. The administration department should establish archives for the vulnerable people and share the data with other departments. For example, the county construction bureau prioritized FG recipients when implementing the program for renovating dilapidated houses.

TV stations and other governments department also introduced preferential policies for FG recipients, such as reduced cable television fees, water, electricity, coal, fuel subsidies. Judicial and education departments also provide assistance and encourage society to participate in FG assistance.

3.14 Different Models of Organizing and Supporting Social Assistance for Vulnerable People

As the establishment and improvement of China's rural social assistance system, the "Three None's" will be the main part of FG collective support. The FG old, children and disabled are covered in different in policies, support levels and themes. The homes for the elderly, the welfare center and the Disabled Person's Federation take part in FG affairs, so the policy may be overlapping and lead to unequal distribution of public resources. Datong county established a social welfare institute to administer all welfare agencies, including one welfare house for the old, one for children and seven homes for the elderly, in order to increase efficiency.

Hunan province encourages homes for the elderly to start their "courtyard economy". On the one hand it can provide labor opportunities for the elderly whilst on the other hand it can also save on expenditures. The province also encourages agencies aiming for specific vulnerable old people to be open to society. The construction department supports the construction of agencies in village to provide other patterns.

3.2 Main Challenges

3.2.1 The Current Standard is Insufficient for the Needs of SVGs such as Caring and Nursing

The "*Regulations on the Rural Five Guarantees Scheme"* in 2006 demand that rural FG support level should not be lower than rural residents' average living standard and adjusted for the improvement in the living standard. The fund of FG is afforded from the local government budget and in some areas the fund insufficient. Accordingly, the recipients' living fee cannot satisfy their need. In central provinces such as Jilin, Anhui, Henan and Hunan, the level is under 30% of average disposable income.

3.2.2 The Low Standard of FG Support Standard

In some areas, FG recipients face many problems, for example, daily life, health care, burial affairs and so on. The medical expenses are not fixed, so the administration departments are usually puzzled. Although the medical assistance policy can solve some of the problems, some homes for the elderly still faces problems like high care payments and self-paid medicine, so they cannot make ends meet.

3.2.3 Capacity Challenges for Support Organization

Many support organizations faced barriers of registration as legal entities. Some of them are paid from the government budget and some by the organization's self-raised funds. This makes the organizations lack staff, especially skilled staff. In practice, insufficient numbers of staff and, shortages of skilled staff of support organization are popular constraints. Due to the financial system, some workers are regularly employed and some are temporarily employed. In the homes for the elderly, the standarized ratio between the clients and staff is usually 10:1, so they tend to receive life-independent people and the disabled and dependent people are excluded.

3.2.4 Incomplete Support in SVG Care

In some areas, SASVG recipients face many problems, for example, daily life, health care, burial affairs and so on. The medical expenses are not fixed, so the administration departments are usually

puzzled. Although the medical assistance policy can solve some of the problems, some homes for the elderly still faces problems like high care payments and self-paid medicine, so they cannot make ends meet.

3.2.5 Lower Collective Support Rate, Smaller Scale of FG Support Organization

Most local governments take the town government as being responsible for the FG recipients, so nearly every town runs a home for the elderly. But, many people are life-independent and tend to live in their familiar community alone. The low numbers of people living in homes for the elderly affects their management and service standards. This in turn makes people reluctant to live there.

3.2.6 Identification of SVG clients

In general, the specific vulnerable people include the “Three None’s”, the elderly, children and persons with a disability. In practice, some provinces have begun to focus on, and succor, children who have no dependents and other vulnerable people, such as children without statutory guardians (they can be categorized as vulnerable children). In some poor rural areas, there are many older young men. To assist them from becoming FG recipients is a topic worthy of study.

4. Policy Recommendations: Service Provision Centered Policy Improvement

Support to the rural SVG, in particular to the FG scheme has almost 60 years of history. It was the oldest but most dynamic social assistance scheme. The experiences of the SASVG scheme are worthy of evaluation. Although the number of recipients under the FG scheme is only around one per cent of the total rural population, those recipients are economically poor, socially incomplete and physically vulnerable. They are most needy group and should be always the focus of the social assistance system. The situation of SVGs will reflect the moral values of society. Governments at all levels should consider it as a work priority. Unlike Dibao in which the transfer payment is the main issue, sound care service provision should be the main task of the SASVG program. This includes questions of what kinds of care services should be provided, by what means can sound care services be provided, who will provide daily care services, who will pay for the service provision. There is still much hard work to be done to realize a sound service provision.

4.1 Improve Cross Sector Institutional Coordination including Articulation in Different Programs

By now, the vulnerable people support institution framework has been formed. But there are two concepts: specific vulnerable and FG, where responsible bodies for the three groups are quite different. This may lead to mistakes and omissions. The policy of the civil affairs department and the Disabled Persons’ Federation should be unified and assistance should be linked with welfare in the civil affairs department. In addition, the institutional coordination mechanism between departments should be built and communication among education, housing, medical treatment and public utilities should be strengthened. The new “Guidance on Further Improvement of Social Assistance and Support for SVG” includes a special paragraph on coordination between the different programs and a standard platform for the establishment and management of vulnerable persons’ archives should be built up to realize trans-sector coordination.

4.2 Based on the new “Guidance” to Conduct Policy Pilot Experimentation

The new “Guidance on the Further Improvement of Social Assistance and Support for SVGs” has been made recently. There are many contents in this guidance that need to be made in detail. In relation to but not limited to this EU-China SPRP, it is suggested that participatory action policy research and pilot experimentation be conducted to specify the Guidance. The contents should include the definition of clients under the SASVG scheme, the standards of services (in particular caring and nursing services), the standards of operation and staffing of nursing homes, management systems, monitoring and management for individual support, third-party support, integration

between nursing and medical caring and involving social forces. Such action research and pilot testing will help improve the policy process.

4.3 To Enhance the Financial Input from the Government's Regular Budget for Sound Services

For some historical reasons, the fund for vulnerable people support mainly comes from local government (especially middle areas). There are poor areas in the middle of China and some local governments cannot maintain the standard "not lower than local residents' average living standard" stated in the "*Regulations on Rural Five-Guarantee Scheme"*. Limited budget will also affect the identification of qualified target groups. The central government should make the regulations for and contribute to financing to take the 5 million vulnerable citizens out of poverty. So far, the financial responsibility between different level of governments on the maintenance and operation of nursing homes is not very clear. Financial support to village committees is also necessary for their duties relating to individually supported SVGs. In the "Guidance on the Further Improvement of Social Assistance and Support for SVG", both basic living standards and caring and nursing standard are proposed but these need to be further studied, so that sound services can be delivered based on the needs of SVGs.

4.4 To Strengthen the Organizational and Staff Capacity for Rural Super-Township Support Organizations for Better Services

Some provinces partially stress the responsibility of township governments and run a home for the elderly in every town. It is difficult to get economies of scale and raise the service level. The principle should be that "the village is responsible for individual support and the town is responsible for collective support" and more cross-town support organizations should be encouraged. The Government should encourage organizations to employ local people and include their salary in the budget. The staff of support organizations should be registered as civil institution personnel to ensure responsibility and incentives. The standards for nursing homes should be developed to provide detailed guidance for practice, including legal entity registration, amount and structure of staff, contents of services, infrastructure and physical conditions, etc.

4.5 To Recognise More Roles for Rural Communities and Village Committees in Individual Support

In the future, there will be many people who will choose individual support. The government should respect their choice and strengthen the responsibility of village and fund them. At the same time, the government should encourage social work organizations and volunteers to serve in rural support organizations. Service criteria for individually supported FG clients should be formulated and strengthened.

Currently, about two-thirds of FG clients are individually home-stay supported. Home-stay support is an option when the clients still have the basic ability for daily life. However, risks are still around these SVGs. Therefore, some kind of necessary service should be available and accessible for those people. The local community (including neighbors and relatives) should be supported for the provision of necessary daily services and health care, monitoring, etc.

4.6. To Encourage Local Innovation in SVG Support System

In case studies it was found that many support organization practices were well suited to the local situation, such as developing the economy in the organizations and the combination of assistance and welfare in aged affairs. Nursing homes for SVGs can be the leverage for rural general caring facilities for the elderly. In organizations' staff, some of them are listed in the budget, some are set public service jobs and some are recruited by the village leader. Innovation should be encouraged and the communication of experiences should be strengthened.

The main areas for innovation include: involvement of social organization/social workers in SASVGs, service procurement of Government from business (or PPP styled). nursing homes, subcontracting to the village community for individual's home -stay support. It is also worth developing the integration of medical care into the SASVG system.

3.3.1 Social Assistance for Specific Vulnerable Groups
EU experience and policy recommendations

Jadwiga Pauli, EU-China SPRP expert

Table of Contents

Introduction 105

1. Characteristics of specific vulnerable groups (SVG) in a rural area 105

2. Directions of EU social policy towards vulnerable groups – 107

2.1 General approach 107

2.2 Examples of a variety of social services supplied to vulnerable groups 108

3. Cooperation between stakeholders 117

4. Workforce development 119

Introduction

According to the strategic documents of development[7] the Member States of the European Union policy aim is to tackle poverty in order to guarantee inclusive growth. Likewise the Chinese Government's policy is to do away with poverty by 2025. Regardless of the economic growth, on the one hand, there is a big disparity and social inequality within the social structures in Europe and in China. That is why in the policy of improving the life conditions of society special attention should be paid to the most vulnerable groups. These are the people whose possibilities and independence are limited due to objective reasons like age, impairment, health problems or social causes - particularly the elderly, people with a disability and children.

Solutions proposed to be implemented to the practice should be developed in a line with the general understanding of human rights e.g. children's rights to remain in a family environment, the right of people with disabilities and mental health problems to live independently and be included in the community, the rights of the elderly to services responsive to their needs to prevent isolation or segregation from the community.

According to the assessment and policy recommendation of China's experts several issues will be taken into consideration in this report:

- examples of variety of social services supplying vulnerable groups
- multidisciplinary co-operation and co-ordination among key institutions in the field
- the importance of meaningful of participation by social forces in assisting in the planning and setting the approved model
- developing the workforce for the social sector

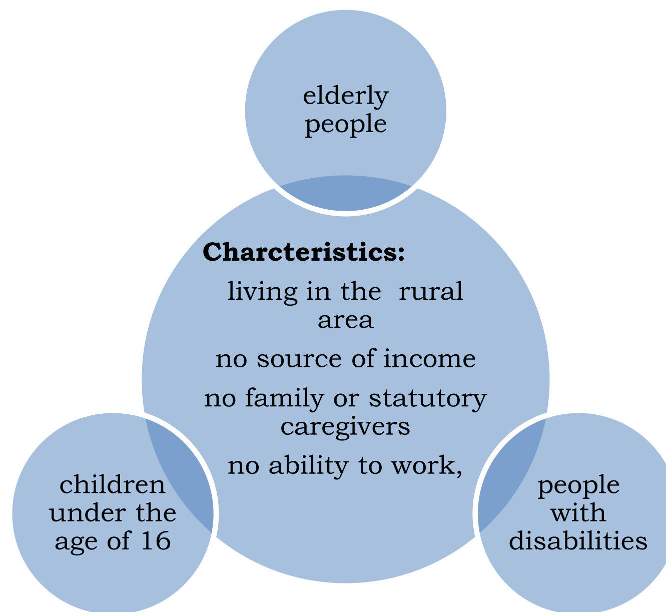
1. Characteristics of specific vulnerable groups (SVG) in a rural area[8]

Any recommendations on the existing policy concerning the social sector in China should refer to the recognised assessment of the social living condition. An assessment helps to ensure that the real needs and challenges are addressed and that resources are used efficiently. As assessing the situation is central to developing a comprehensive, effective strategy and action plan, it will be very useful to start with statements raised and highlighted in the reports prepared by the Chinese experts.

Upon the assessment reports on social situation in rural areas provided by Professor Zuo Ting and Gang Shuge it clearly appears that one of the challenges for social policy of today's China is the increasing number of so called vulnerable groups which include the elderly, people with disabilities and children under the age of 16 living in rural areas. What makes the situation of those people even worse is the fact that they have no perspective to live independently due to their inability to work, no source of income, and no family or statutory caregivers, which means, they are completely reliant on the social care/ assistance system.

[7] "Europe 2020 A strategy for smart, sustainable and inclusive growth" source: http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:2020:FIN:EN:PDF

[8] - based on China's experts 3.3.1. assessment report.



Categories and characteristics of specific vulnerable groups in a rural area

Elderly people in the rural areas mostly face existential problems, as they have no income, they stay in very poor living conditions, they live by themselves out of the family and most of them suffer from different diseases. It is enough to say that practically they are left to their own devices so it is very difficult for them to manage in their household. We have to keep in mind that the likelihood of disability increases with age. As, at the rural area the access to relevant and sustainable medical care system is practically out of reach, we can understand that a system of nursing and care services need to be absolutely developed. The ratio of elderly within the whole specific vulnerable group (SVG) stands at about 80% - so this is the most important target of social assistance services.

Group of people with disabilities in general have to tackle the same kind of problems. So again most of the persons with a disability do not have family or any statutory caregivers. They have no income, no possibility to be employed due to their disability and sometimes their age. They have never been trained, and also they live in very poor living conditions. The ratio of persons with a disability within the overall specific vulnerable group (SVG) stands at 17%.

Groups of children under age of 16[9]. There are four categories of children who need to be encompassed with the social assistance system (1) children deprived of parental care (among them orphans) (2) children with special needs (with a disability, with health problem or orphans) (3) children of a trouble family (disabled, parents alcohol addicted or in prisoned), (4) neglected, abused or living in vulnerable families. The ratio of children in need within the overall whole specific vulnerable group (SVG) stands at 3%.

Although some regulations and actions have been already undertaken by the Chinese authorities the results are not satisfactory as the recipients did not receive adequate support and provided care is not systematic and nor organised in a coherent way. In addition there are huge disparities in the provinces as far as living conditions go and local resources are restricted which affects those who are now in the most difficult situation even more.

The policy recommendations go very much in line with the recently published “Guidance on Further Improvement of the Social Assistance and Support for SVG” which recommends to:

[9] According to Chinese regulations children up the age of 16 are under legal protection.

1) clarify the definition, standards for targeting groups and procedures,
2) involve the government in service delivery such as food, clothing, housing, daily care and medical care, increase the Governments' financial input and
3) involve and reinforce social participation.

These could be regarded as very good political terms to introduce new proposals aiming at improving the living condition of the most vulnerable groups.

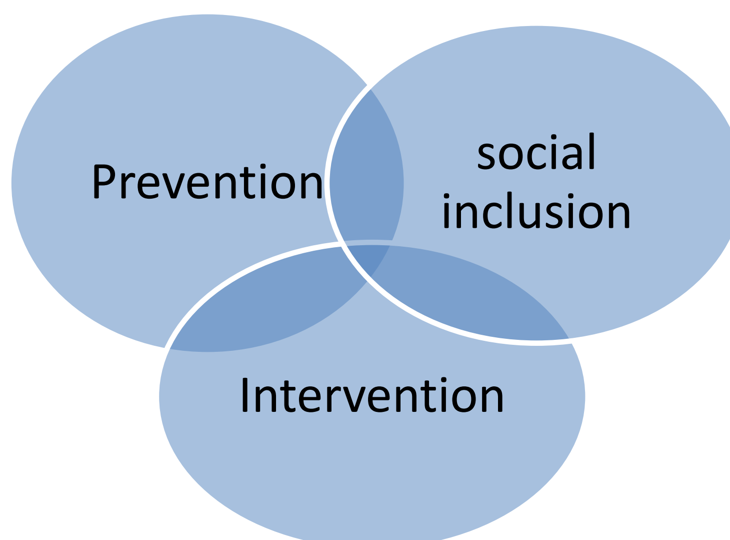
The follow-up proposals would relate to the presented assessment of the situation in China as well as to policy recommendations

2. Directions of EU social policy towards vulnerable groups –

2.1 General approach

As far as services towards the most vulnerable groups are regarded some main principles of European policy need to be kept in mind:

1) All commitments of Member States arise from EU legislation[10] agreed at European and international levels, e.g.: the Charter of the Fundamental Rights of the European Union, the UN Convention on the Rights of Persons with Disabilities, the UN Convention on the Rights of the Child, Europe 2020 Strategy, European Disability Strategy 2010–2020, European Charter of Rights and Responsibilities of Older People in need of Long-Term Care and others;
2) The European social assistance system is built upon the subsidiarity idea. This assumes the engagement and participation of social forces in the process of establishing social care policy; (
3) The role of social assistance is to support people so that they could use their potential to fulfil independent and appropriate living - the idea of empowerment;
4) The preference is for a community-based model over an institution-based models
5) The role of social policy should be broader than just intervention in difficult situations. It should concern prevention and active social integration as well.



Three main tasks of social policy

[10] http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf, http://www.age-platform.eu/images/stories/Final_European_Charter.pdf

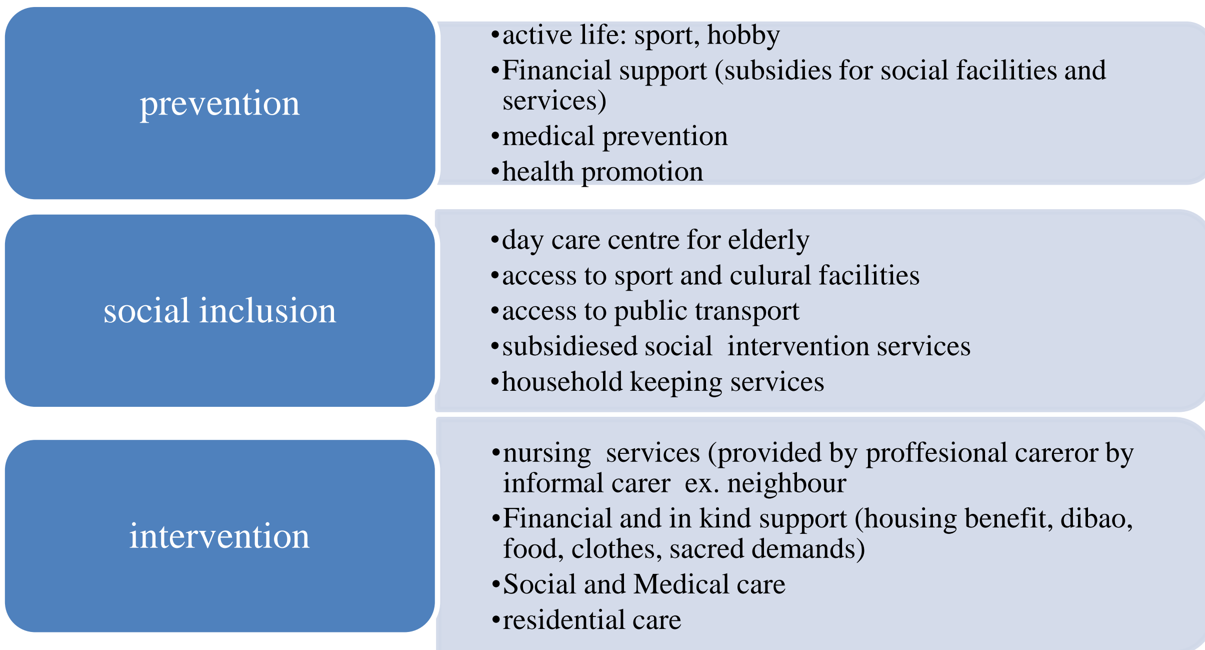
For many years the European social assistance system has been developed on an institution–based model. The new approach of European Union to social care now prefers a community-based model over an institution-based model. But the transition can only be achieved under certain conditions. To establish a system which is community-based requires the presence of available resources.

2.2 Examples of a variety of social services supplied to vulnerable groups

2.2.1. Support to Elderly People

Europe and the world is aging. According to simple extrapolations based on the United Nations' medium-fertility demographic scenario, by 2050 the share of older people could reach 21 percent[11]. This demographic phenomenon is very meaningful for Member States' social policy as the elderly year to year become the biggest numerical social group who can considerably influence social welfare. Apart from the size the group, it has become the most demanding in terms covering its needs, service delivery, establishing social facilities and public financing. For many reasons it is important to keep the elderly active and involved in mainstream social activities. The more people are independent the more they enjoy their wellbeing, the less they need to be looked after and the less costly is the system of social care, broadly speaking.

Looking to the above mentioned three main streams of tasks within the social policy (prevention - active social integration - intervention), it is worth answering the question "what actions are possibly to be undertaken to meet elderly's needs". One can say there is no room for prevention as far as we consider the elderly. Especially to the most vulnerable group as pointed out in the Chinese report. But we have to remember that we can always protect a person from the decline in his/her state of health, the loss of function, and the restoration of independence and living condition in general. That is why a variety of actions could be adopted within prevention, active social integration and intervention.



The aim of the assistances provided to the elderly within the social policy framework should be to support their day-to-day living independence by providing services in relation to their possibilities.

[11] "Golden aging. Prospects for healthy, active and prosperous aging in Europe and Central Asia": https://openknowledge.worldbank.org/handle/

However now the biggest challenge for China is to cover the very basic, existential needs of almost 5 million elderly people living in rural areas in very poor living conditions. Policy makers should bear in mind that for social policy to be comprehensive it should anticipate the social phenomenon and look further into future. It means that intervention actions are urgent now, but that also prevention is needed. To propose solutions for social assistance directed to the elderly we should take a broader perspective with different possibilities. The proposal should be based on a social needs analysis, and a strategy prepared for the provision of social care for older people. It should identify the range, type and quantity of provision for each type of care required.

In most European countries the services for elderly are descripted as packages of services, starting from mainstream services through to dedicated services developed upon individual assessment:

For people in very poor health conditions, firstly the level of dependency should be assessed both from a medical and a social point of view. Then according to the assessment result, a decision is taken related to the range of assistance.

If the incapacity is severe in such cases residential care is proposed. In the case of stronger social incapacity and relatively weak medical incapacity, home-based care can be awarded.

In general, in the decision-making process the beneficiary's individual preferences are taken into consideration. Some of them want to stay at home as long as possible.

The above depends additionally upon local and family resources.

The care-giver can be:

- a local agency which provides nursing and house-keeping in a professional manner. Services; can be run by a public social service centre, or they can be commissioned to the private or NGO sector
- a member of the family who decided to interrupt his/her vocational activity to take care of dependent member of family instead,
- a non-formal carer but only in case when household services are required

Services can differ:

- Mainstream services usually cover basic nursing services, emergency care, basic existential needs (meals, clothing, security, heating, etc.) and daily support like household support (cleaning, washing, shopping) and everyday activities e.g. contact with the physician, post office, public institutions, rehabilitation, therapies.
- An optimal (developed) package of services covers in addition to those mentioned above day care centre, social intergeneration - integration activities, respite care, counselling (e.g. legal advice, psychologist), specific social services for people with mental problems

Polish references:

In Poland social services for elderly people are performed according two settled standards.

- the first of them refers to residential care,
- the second to community-based social services.
- The Residential Care Standard[155] consists of recommendations relating to the living (material conditions) model of organizing daily care and the scope of the services provided. They describe in detail the living conditions and services which are:

Residential care standard[12] consist of recommendations related to the living,(material conditions) model of organizing daily care and scope of provided services.

Standards for residential care describes in details living conditions and services which are e.g.:

- to provide shelter (single or double-bed equipped room with a minimum 6m2 per person). The building should have easy access for a disabled person without architectural barriers and be equipped with a lift. Bath rooms should be equipped with facilities for the disabled,
- to provide nutritious meals, suitable clothing, sanitation supply and service,
- to provide support in everyday activities, personal up-keep and personal affairs
- to provide support in social integration e.g. workshop therapy, rehabilitation, cultural events, sacred demands, self-advocacy, contact and co-operation with family and relatives,

services are provided by professionals on the basis of an individual support plan developed together with the resident

Community-based care services standard[13] consist of recommendations related to:

- Definition who can apply for services:
  - Anyone who is in need can apply for social services provided at the local level. For people living at the minimum subsistence level services are free of charge. Others will contribute a fee according the local regulations in relation to income
  - Who can provide services and possible sources of financing
  - Social services at the place where a person lives may be provided by a public institution or can be commissioned to the private or non-governmental sector or to informal carers.
  - Caregivers have to meet capacities according to the settled standard
  - The Scope of the services is according to the needs and demands of the beneficiary:
  - Basic package - mainstream services
  - Optimal package – developed services

Basic package services are:

  - Assistance in meeting day-to-day needs (e.g. shopping, cooking, providing food and/or feeding, cleaning, household keeping, washing, regulating compulsory payments etc.)
  - Assistance in fulfilling hygiene issues (e.g. nursing for people

[12] Based on the Regulation of the Minister of Labor and Social Policy (Dz.U. 27.08.2012 r., poz. 964)
[13] Based on: "Standards of social services" http://ozrss.pl/wp-content/uploads/2015/04/Standardy-uslug-pomocy-spolecznej.pdf and http://www.wrzos.org.pl/projekt1.18/download/PakietUslug_osobystarsze.pdf

who are bed-ridden or chronically ill)
- Nursing recommended by a physician (according to specific medical needs)
- Assisting in participation in social life and social relationships (e.g. contacts with the physician, family)

Optimal package services are: (in addition)
- Specific assistance according to health conditions (e.g. Rehabilitation, physiotherapists)
- Respite care
- Day care centres – occupational therapy,
- Participation in social and cultural events, social and intergeneration integration
- Specific assistance for people with psychiatric problems
- Advocacy, mediations, legal advice, psychological counselling
- Shelter homes

A continuum of care for elderly people should provide a range of support and services which meet the objectives of maximising independence and providing different types of services to meet the needs of older people according to their health condition. Priority is given to family and community -based services over institutional services. But as it has been already mentioned the community-based model requires the presence of available resources at the community level. In establishing the model for the services local resources and needs have to be considered. If there is a lack of nursing services in the field, residential care can be sometimes be the trigger for a range of different services. In many EU countries residential care homes provide a number of other important care services such as meals on wheels, respite care, day care, day centre. They provide a base for home care organizers and the out of hours home care service. Residential care will have an important role but there will also be a wider range of services including home care, support for carers, preventative and rehabilitative intermediate care and respite care.

Aging as a social and demographic phenomenon is an issue of concern for the State Government as well. Since the task of Ministry of Family, Labour and Social Policy is to launch Poland wide programs[14], for almost two years already the State Government has subsidised Local Governments in performing actions and assistance aimed at preventing the elderly people from loss of function and promoting active aging.

EU references[15]

In most European countries the responsibility for organizing services for elderly people and providing the assistance to improve the living conditions of senior citizens rests at the local level.

The Netherlands

Care for the elderly includes:

Integrated service areas - services and care at the level of a neighbourhood or village. The goal is to integrate care services in regular housing areas, to strengthen self-supportiveness of citizens and to improve the quality of life as a whole.

[14] State Program for Active Life and social inclusion of Elderly "ASOS" (2014-2020) and Multiannual Program „Senior-WIGOR" na lata 2015-2020. http://www.mpips.gov.pl/seniorzyaktywne-starzenie/rzadowy-program-asos/

[15] Based on: Living in Old Age in Europe - Current Developments and Challenges http://www.sociopolitical-observatory.eu/uploads/tx_aebgppublications/AP_7_EN.pdf

Residential care: with the preferences to sheltered homes the so-called “living in a protected environment”.

Other services in place where the elderly live are: advice and information on public transport provision through to assistance and provisions available in the home (e.g. household assistance, adaptation of living space, provision of wheelchairs, driving services for those with limited mobility)

Denmark

The social and health services in Denmark are organised on a decentralised basis through local authorities. The municipalities are responsible for outpatient and inpatient care as well as for housing, support and social services including in the provision of social services by private providers. In residential places social services cover a broad area and include a broad range of simple support in performing household services through to medical and nursing care. Danish citizens who are aged 75 and above with specific care needs are entitled to flats for senior citizens that are barrier-free and equipped with an emergency call system. For those who cannot live independently services in a nursing flat or a nursing home are provided.

United Kingdom

To organise services for the elderly is the obligation of the municipality. The provision of services is offered by private providers, local authorities, housing associations and charitable providers. Services for the elderly are organized on the basis of a multilevel concept depending upon the differing levels of need for care of the senior citizens. For the most independent the offer is to provide independent housing units - barrier free and some of them have emergency call systems. In addition there is domestic help in the residential area, community facilities, guest rooms and laundry facilities. Very sheltered housing represents the next level of support between sheltered housing and a nursing home. A majority of occupants require medium to intense nursing and receive additional care and full meal services.

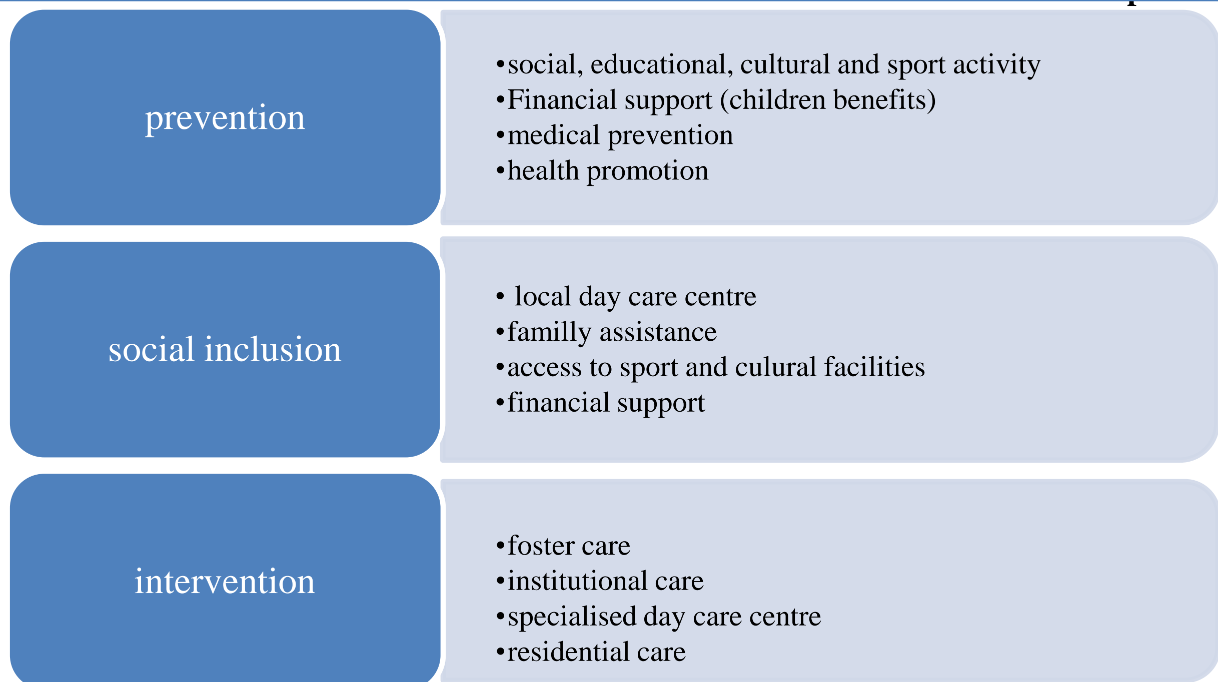
France

According to the tradition of the French, the care system for the elderly is based on family support. The priority was to enable senior citizens to live as long as possible in their own home. Therefore various models, such as respite or day care, meals on wheels or home help have been expanded. Today there are many partners: the State, social insurance providers, the social economy and the family. The care system is based on the national strategy "Ageing Well" which is implemented locally by municipalities. The goal is to allow a free choice between care at home and living in a nursing home.

2.2.2. Alternative child care

It is a cliché to say that a child’s upbringing should be in the family as that is the natural place for him or her to be growing up and to prepare for an independent life in the future. Consistently in the case of children deprived of parental care, a compensating solution should be provided within an alternative child care within the scope of the social policy system.

The responsibilities within the Polish care policy in Poland are divided between Local and Regional Governments. Social Centre Services at the community level are responsible for services delivered to biological families in need as well as for cooperation with other institution delivering services to family. The task of the community in general is prevention. The Social Centre at county level is responsible for institutional and foster care and Social Centre at regional level is responsible for adoption.



The main aim of the services for this vulnerable group will be: counteracting intergenerational poverty and providing support to protect a child from parental care deprivation. The task of social care towards the family will be then divided into two main areas: support provided to families struggling with poverty and the so-called troubled families.

There are big disparities in Poland between the urban and rural areas. There is much less of a possibility in the countryside for developing the same sort conditions that are in the urban area. The status of parents and the family household has very big influence on the educational perspective of a child and their future life. In general we can say that in rural areas social assistance is focused more on the financial and day to day needs whereas in towns social assistance is concerned more with parental obligations.

Polish references

As far as the poverty of children under 16 in rural areas is concerned it has to be highlighted that children and youngsters living in the post collective agricultural holdings, especially in the late nineties in Poland, during the period of economic transition were faced with a very difficult economic problem.

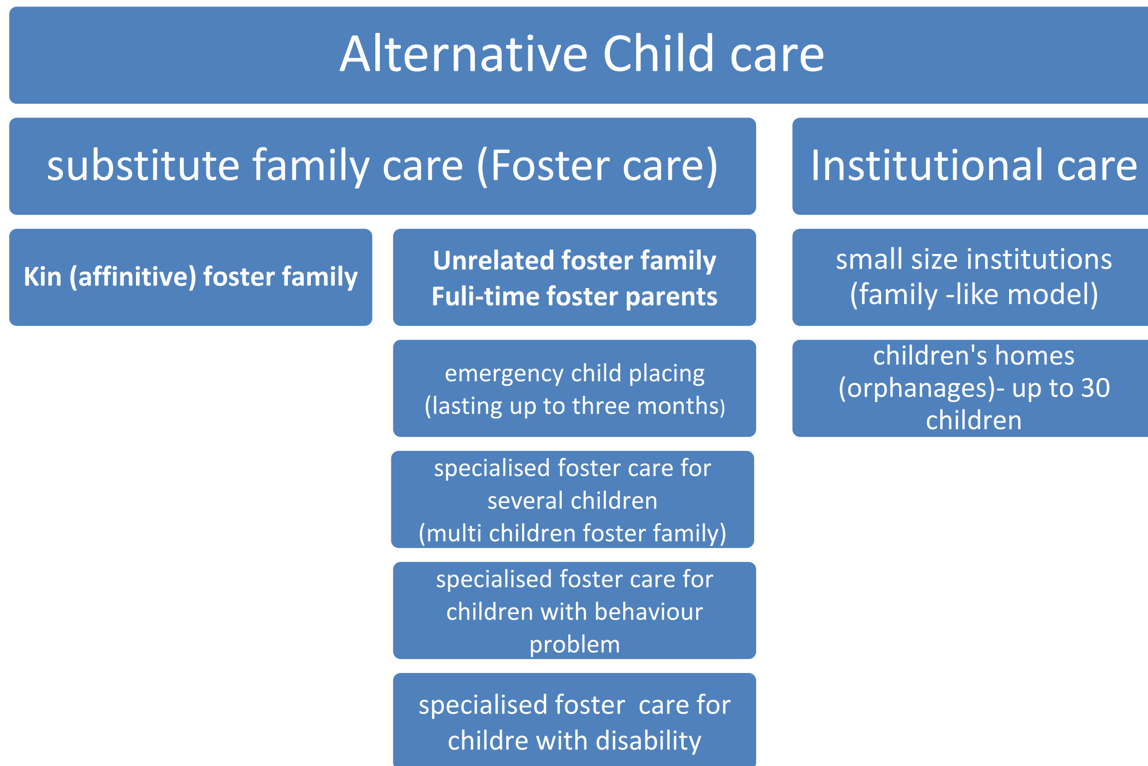
According to the survey launched under the international project "Social History of Poverty in Central Europe"[16] the most dominant causes of poverty in post collective agricultural areas are: unemployment, low standards of living, varied educational barriers, (mostly financial), poor levels of education of the parents, low local cultural and social capital, inhibitions and co- related/links to poor self-esteem and lack of resourcefulness. The evidence showed that within the process of growing up, young people from this social environment just replicated the patterns of their parents and what is more, the poverty in those families was like an intergenerational problem. The young generation received in succession from their families poor jobs, poor houses and an unsuccessful life model.

Families with poor upbringing skills are assisted with educational, financial and care services to

[16] E. Tarkowska, red.: Zrozumieć biednego. O dawnej i obecnej biedzie w Polsce, pod red., Warszawa, Typografika, 2000; źródło:http://irss.pl/wpcontent/uploads/2013/11/R%C3%B3%C5%BCne%20wymiary%20skuteczno%C5%9Bci%20w%20pomocy%20spo%C5%82ecznej.pdf

enable them to fulfil their parental obligations. In case this is not sufficient or a family doesn't co-operate the social worker will put the issue to a court. Then upon the grounds of a court order, the child will provided with substitute child care.

Scheme of child care in Poland:



In general as far as child care is concerned, the preference is adopt go family-like care over institution-like care. By family- like care we mean arrangements whereby children are cared for in small groups in a manner that resembles those of an autonomous family, with one or more specific parental figures as caregivers, but not in those persons' usual domestic environment.

Family - based care is both a short- or long-term care arrangement agreed with, but not ordered by, a competent authority. In this case the child is placed in the domestic environment of a family whose head(s) have been selected and are prepared to provide such care, and who are financially and non-financially supported in doing so.[17]

Overall characteristic of child care in Poland:

- The general framework for child care is based on a legislative act.
- Child care is financed by county Local Governments supported by State Government subsidies.
- Service could be provided by public institutions or social institutions (NGO's)
- An affinitive foster family receives a financial benefit related to its monthly expenses for the child (this is fixed and can be revalorized over the year)
- Unrelated foster parents provide their care under contract as they are regarded as full-time employed professionals and they receive salary as well as financial benefits per child to seems to be crucial.

Weaknesses and threats of the system:

[17] Common European Guidelines on the Transition from Institutional to Community-based Care www.deinstitutionalisationguide.eu_co

Limited number of approved candidates to perform foster care

Shortage of financial resources (to meet standards and investments)

Shortage of professionals

Insufficient co-operation among partners

Lack of unified evaluation procedures for assessing achieved results

In the Guidelines [18], the term ‘community-based services’, or ‘community-based care’, refers to the spectrum of services that enables individuals to live in the community and, in the case of children, to grow up in a family environment as opposed to an institution. It encompasses mainstream services, such as housing, healthcare, education, employment, culture and leisure, which should be accessible to everyone regardless of the nature of their impairment or their required level of support. It also refers to specialised services, such as personal assistance for persons with disabilities, respite care and others. In addition, the term includes family-based and family-like care for children, including substitute family care and preventative measures for early intervention and family support.

Review of EU child care systems[19]

qualification of the future foster parents as the service cannot be provided by random/casual persons. This is why the procedure is complex, gradual and lasting. In general, foster family care has priority over institutional care and even then the preference is for the child to be placed in small institutions which employ a “family like” model. Yet within the framework of foster care some countries have developed different forms, i.e. long or short term foster care. Within the short term there could be periodical foster care (only during the day or after school or during the weekend)

Good practices

The general approach of all European countries is to provide family–and community- based child care. Nevertheless nowadays institutional care still dominates. On average 11 children in every 10,000 are placed in residential care. In some countries the ratio is even higher. e.g. Spain 24 children in every 10,000, France 29 children in every 10,000, Romania 45 children in every 10,000.

However where for some reason there is still a need to provide institutional care it should be in small, family-like institutions. Some countries e.g. Slovenia, Norway, Great Britain and Iceland went even further and stated that no child under the age of eight can be placed in any substitute care or in an institution.

Great Britain’s system is based on family-based foster care solutions with preferences to affinitive families. Care-givers are regarded as professionals and they are paid as being employed. Small children are placed in the foster care or they go to adoption. Institutions are preserved mostly for children displaying difficult behaviours.

In Germany the system is very much similar. Institutional care is mostly reserved for those who cannot adopt themselves to foster families or there is no possibility due to a lack of proposed carers. In general institutions are small - up to 30 children. Children aged 16 or older are placed in a supervised independent living arrangement where they can be trained in household keeping, and encouraged and enabled to acquire the necessary independent living skills.

[18] Common European Guidelines on the Transition from Institutional to Community-based Care www.deinstitutionalisationguide.eu_co

[19] upon the assesstment made by ngo: http://www.mikolaj.org.pl

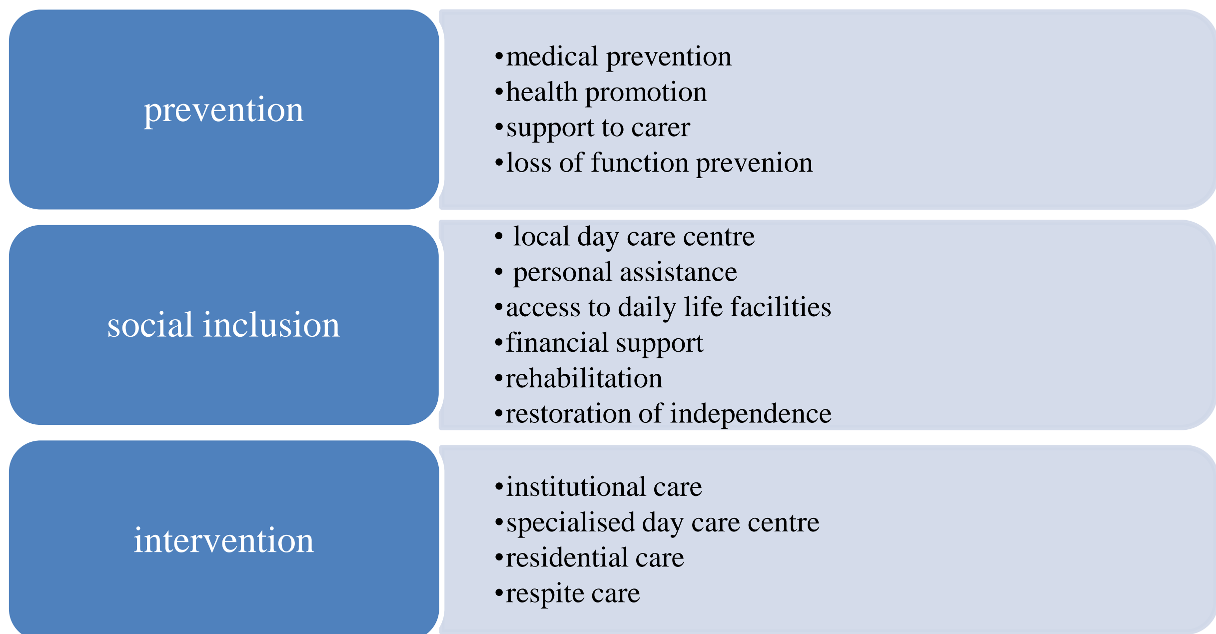
In Sweden the child care system includes institutional care but in most of the cases it is for children with special needs. The policy is focused on family-based care with a preference for adoption.

2.2.3. Support to Persons with a Disability

The UN Convention on the Rights [20] of Persons with Disabilities defines 'persons with disabilities' as including "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

In Poland social assistance towards persons with a disability is organised on a legal basis which is the Law on "Social and Vocational Rehabilitation of Disabled People". Social Assistance for the disabled is financed by the State Government via the Rehabilitation Fund and by local governments. To benefit from the assistance system an adult person should be examined for the purpose of being assigned his/her level of disability. People with severe impairment are assigned as significantly disabled. In sequence there are people with a moderate disability and a slight disability. According to the level of disability different kind of benefits and assistance can be provided. In general all financial benefits paid on account of disability are higher than those paid to an able-bodied person. Assistance is provided to the individual person or to his family as services should enable individual users and families to participate in the community on an equal basis with others.

The main goal of social assistance for persons with a disability is to support their independent living and their social integration.



The range of services may differ according to the individual's needs. It can encompass mainstream services, such as housing, healthcare, education, employment, culture and leisure. It also refers to specialised services, such as personal assistance for the person with a disability, respite care, counselling and others.

Community-based services - examples:

- sheltered–living arrangements organised in a manner that resemble autonomous accommodation where people with a disability may live independently with the support of

[20] United Nations Convention on the Rights of the Child, Article 1.

professionals which is not permanent but casual. People are trained and prepared for day-to day activities.

- Day care centres – a range of centres which provide social activity, where disabled people can improve their skills in self–assistance, can participate in cultural, sport and leisure activities and are provided with meals and other facilities
- Sheltered workshops – day care where persons with a disability are prepared and trained for supported employment in protected work conditions
- Sheltered employment – special employment organised in the open labour market in protected work conditions;
- Nursing services – for disabled people with an impairment which limits their functional independence and possibilities
- Personal assistance – services of professionals who assist in everyday living activities and enable a disabled person to be more independent. The assistant should respond to the disabled person's wishes. Respite care – short or longer term but temporary services provided by local residential care institutions to enable to members of a family to have rest from caring.
- Residential – institutional care – long term assistance for people who have no family or whose family cannot perform the assistance themselves.

3. Cooperation between stakeholders

As it appears from the policy recommendations of the Chinese experts, co-operation among stakeholders is very much required as it influences strongly the efficiency and effectiveness of the performed services. This issue is also considered in all European social system policies as the need for co-operation is crucial everywhere but is not efficient everywhere. Firstly it is related to the subsidiarity idea and secondly to the idea of empowerment. Both are fundamental to the European understanding of the policy of setting up services. These should be placed and organised as close to the needy persons as possible. Within the new approached launched recently in Europe concerning the preference for community-based assistance over institution-based asssitance, co-operation and co-ordination within the process of delivering services should guarantee the stability, and the permanence, of the assistance. In addition to this, in Poland and in other countries of the EU, there is a new direction promoting services provision organizations – the preferences to go to outsourcing services (commissioning the services to different partners - social and private) over keeping them being delivered by the public sector. But as usual there are arguments for and against which have to be taken into consideration. Commissioning is not always cheaper. To guarantee the required standard, services should be monitored and this will be the obligation of the public sector – this will be an additional cost as well that of tendering procedures and monitoring contract compliance. The next issue which has to be taken into consideration is that by commissioning we do not always cover all the needs – commissioning frequently fragments the service instead of creating joined-up services. It could happen that the services could be more casualised, not planned and not permanent. So again it seems like the best solution is to differentiate the supply of services according to needs, demands and possibilities at the local level.

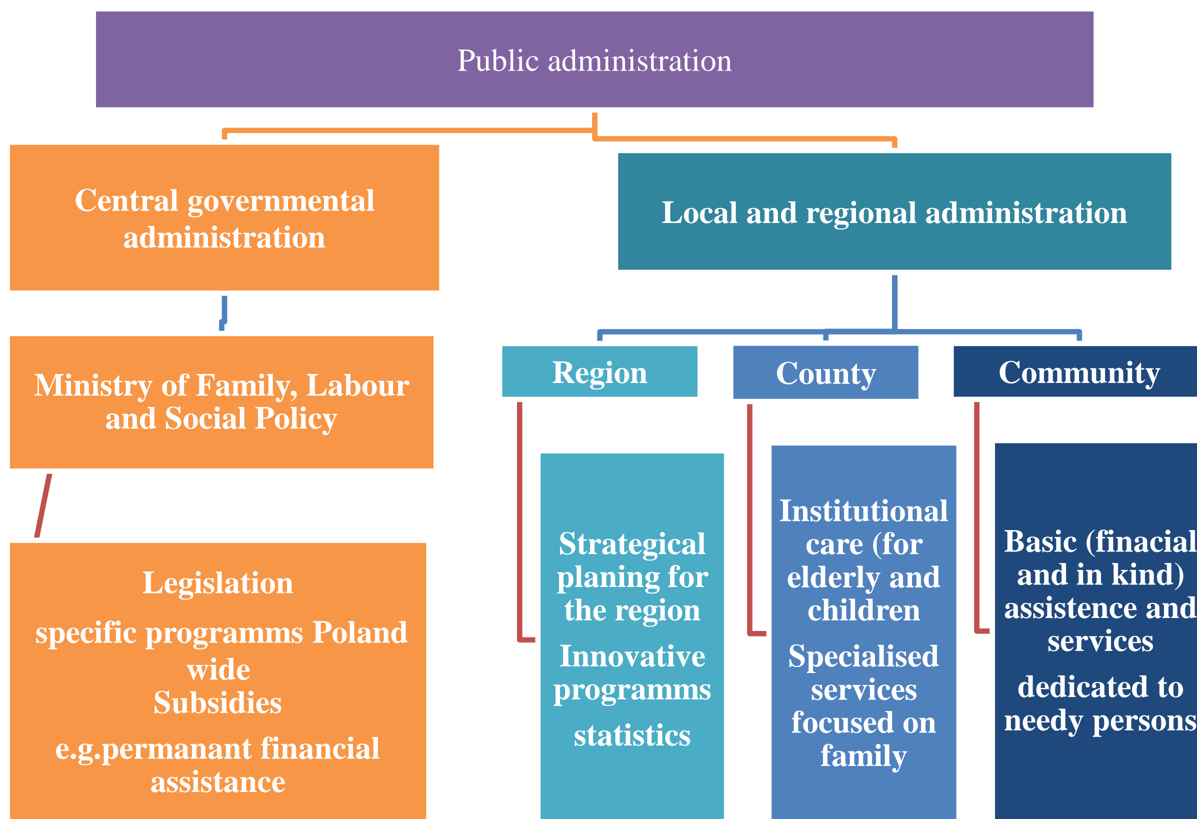
Co-operation can be regarded as collaboration between the public sector institutions which are responsible for different tasks, or in a broader perspective as an engagement of all social forces into the process. It is obvious that in the care system the many different needs of a beneficiary must be covered by different services which are placed in different institutions, e.g. nursing, medical care, lodging, meals etc. To make the co-operation more efficient, some countries have established a legal regulation to promote common performances. In some others the engagement

and common understanding is enough to fulfil the actions. From the practical point of view we can say that both are equally as important.

Polish references

Co-operation and co-ordination among stakeholders in the field of social policy and social assistance as a manner of performing social task comes directly from the legislation. Firstly from the legal framework establishing the structure of public administration and secondly from the legislation legal on social care.

Since 1999 when the reform of administration was launched, public administration in Poland has been decentralised. There is no vertical, hierarchical structure – regional and local governments have their own tasks, responsibilities and financing. Local governments have to organise and manage local institutions according the demands and needs that the citizens face in the field and according to the legal framework established at the central level.



This structure enables local governments to implement on their own rights and responsibility the necessary actions as all institutions are subjected to local government in terms of their management. This structure also enables the capacity to co-ordinate the performances of all local institutions. The main directions on management are:

1) Social care is the responsibility of both central and local governments
2) Basic needs should be covered and organised in the places where clients live – by local authorities and by providing dedicated assistance and services to the people in need
3) Specific needs and specialised services as well as financial assistance for people without income are the obligation of the Central Government. This assistance is subsidised and commissioned to local governments
4) At the local level all institutions are dependent upon local authorities not the Ministry

5) All social institutions should co-operate to solve social problems of an individual or a family in a network together with non-governmental organisations
6) Social assistance is provided by professional and qualified staff according to assessment and approved standards.

In the Polish social policy legislation there is a delegation clause which permits local governments to co-operate with local partners by commissioning social services. Mostly these are non-governmental organisations. It is presumed that as they represent the interest of people inneed so they can in a very appropriate way to fulfil their needs by delivering services. Consequently each local government has to establish a long standing programme of co-operation with the social partners where the main goals of social policy and the goal of co-operation are resolved. Thereafter, each year in the budget of local governments there is an amount of money provided for social assistance expenditures delivered by social organizations. To commission the service, a tender procedure must be applied. Social organisations may perform their services in a casual way or on the basis of a long term agreement. This depends on the task's characteristic. The provision of institutionally-based services always requires at least a 3 year agreement as it guarantees the sustainability and permanence of the services.

Apart from non-governmental organisations a partner for public administration in delivering social services can be the private sector, in the case where there is no NGO in the field which can fulfil the commitments concerning the services. But the priority must always be NGOs over private sector.

4. Workforce development [21]

To develop a successful social assistance system a professional staff is required. There is a strong link between the qualifications of the personnel and the quality of the services both in the institution-based and the community–based system. In most European countries the core staff are social workers employed in public or non-governmental centres for social services which are situated in communities. They are responsible for developing and delivering the range of care services and support. To perform their job, social workers apply appropriate methods and tools. They must follow agreed standards for social work. The role of social worker is first of all to assess the beneficiary's situation and to propose an adequate solution with strong co-operation between the beneficiary, his/her family and other social institutions and social forces in the field. Social workers are often the link between the person and the services and benefits to which they may be entitled. It means that, apart from social workers, many other professionals are involved in the process of delivering services depending on the scope and range of those required.

1) For nursing and household services it will be a nurse or care person which has to be trained to do their job. The scope of services can differ from very basic (simple day to day services) to para-medical services which should be provided by trained and qualified staff.
2) In institutional care the staff is more developed by functions as they provide more complex services related to daily activities - nursing, cleaning, keeping clients in good health. Consistently these institutions will employ differentiated staff to perform their task e.g. therapists, physio-therapists, occupational therapists, nurses, personal assistants, careers' coaches, psychologists, pedagogues, foster parents etc.

[21] Hussein S.: "Social Work Qualifications and Regulation in European Economic Area (EEA)"
This report provides detailed information on social work regulation, registration process, education and training. http://www.kcl.ac.uk/sspp/policy-institute/scwru/pubs/2011/hussein2011eea.pdf

The more qualified the professional staff is, the better quality of services can be performed in the community and in the institutions. The better will be the public image of social workers and social services as a whole.

Skills and knowledge required of professional staff providing services:

1) possessing skills and knowledge on methodology and social practices
2) possessing good command in the methods of social work e.g. case work, group work and community work
3) processing important and adequate events during the assistance route
4) understanding the needs and the difficulties of people in need
5) creating a long-standing emotional and confidence bond with people in need
6) ability to develop and maintain good professional relations with stakeholders, particularly counterparts and staff members in the work environment
7) ability to work in team and share knowledge relating to social policy and social work methods
8) good coordination with other partners in the team with the aim of cultivating a supportive environment
9) to keep updated on current methodologies, approaches and practices.

In all European countries a candidate to become a social worker or other professional carer employed in a social care institution - must graduate with the required level of education presumed for this profession. In the case of Poland it is bachelor's level degree in social work from a university. Under the EU Treaty, social workers who are trained and qualified in the European

Economic Area (EEA) have the right to practise anywhere in the EEA as long as they are appropriately trained and qualified[22]

5. Recommendation on services provision to the vulnerable group

1) Introduce a new model of assistance in relation to the results of an assessment. The proposal for services should be built upon an assessment of the needs of the vulnerable group in their local environment, according to local requirements for the type, range and quality of services required. It should reflect what is best for the vulnerable group in each province. An assessment always helps to ensure that the real needs and challenges are addressed and that resources are used efficiently.
2) Significant attention should be paid to improving the co-operation and co-ordination among the different institutions which are involved in the process of providing services and benefits by establishing platforms and rules for inter-communication on the exchange of appropriate information in the field of health care and of medical, functional treatment and financial benefits. Good co-operation is needed to:

- gather and exchange information and data concerning the Specific Vulnerable Groups
- give the picture of all the possible and available care systems, i.e. pension insurance for urban and rural residents, basic medical insurance, minimum subsistence guarantee, and basic living guarantee for children deprived of parental care.
- encourage Local Innovation in the FG Support System by sharing experiences and ideas

3) Develop the co-operation of partners at the local level. The input of stake holders to the local model setting public private and non-governmental partners, needy persons themselves

[22]The European Communities (Recognition of Professional Qualifications) Regulation 2007, Statutory Instrument 2007, No 278 (Directive 2005/36/EC)

and community organisations, and other social, health and housing institutions must be encouraged throughout the design and planning process.

4) Introduce the responsibility for providing services at the lowest level. The execution of services for individuals should be delegated to stakeholders as the most efficient method is the community-based and family-based model over the institution-based model. There is a need for developing self-help initiatives and voluntary movements on local level. Involve local partners as they can better respond to individual needs.
5) Provide a pilot to implement the new solution with strong attention to the evaluation and monitoring of the whole process. It should be done by using approved, prepared methods and techniques. The evaluation and monitoring process should engage people at different levels – central government, local government, service providers as well as the people using the services or their representative organisations.
6) Provide a range of support and services. A continuum of care for needy people should meet the objectives of maximising independence and providing different types of services to meet the needs and demands of the vulnerable groups according to their health and social conditions.
7) Enhance the financial support for local level institutions from the government regular budgets so as to ensure the possibility of providing services according to settled recommendations and ensuring the sustainability of the system
8) Introduce standards both for the management and the organization of social care institutions and services as well as provide scope for the tasks and responsibilities of different local governments (including training and professional staff formation) as there is a strong link between qualification of the personnel and the quality services both in institution-based and community–based systems. The more professional is the staff that is employed then the better the quality of services that can be performed in the community and in the institutions and the better the public image of social workers and social services as a whole will be.

References

Common European Guidelines on the Transition from Institutional to Community-based Care www.deinstitutionalisationguide.eu_co

Golden aging. Prospects for healthy, active and prosperouse aging in Europe and Central Asia": https://openknowledge.worldbank.org/handle/

United Nations Convention on the Rights of the Child

http://www.mikolaj.org.pl: Assesstment on alternative care in EU

Living in Old Age in Europe - Current Developments and Challenges http://www.sociopolitical-observatory.eu/uploads/tx_aebgppublications/AP_7_EN.pdf

Tarkowska E., red.: Zrozumieć biednego. O dawnej i obecnej biedzie w Polsce, pod red.,

Warszawa,Typografika,2000;

źródło:http://irss.pl/wpcontent/uploads/2013/11/R%C3%B3%C5%BCne%20wymiary%20s

kuteczno%C5%9Bci%20w%20pomocy%20spo%C5%82ecznej.pdf

http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf,

http://www.age-platform.eu/images/stories/Final_European_Charter.pdf