CHAPTER 8

IMPLICATIONS AND CONCLUSIONS

8.1 The current formative and outcome evaluation of the CCSV Pilot Scheme adopts a multi-method approach of data collection and analysis, inclusive of SWD existing data, COA survey data, in-depth interviews with current, rejected, and withdrawers, as well as focus groups with RWs and RSPs. This body of research has generated a number of preliminary findings to inform and enhance the future development of the CCSV Scheme, which at present are targeted specifically at elderly persons who are on the central waiting list for LTC services and have been assessed by SWD's SCNAMES as moderately impaired.

Summary of all Findings

8.2 First, findings from SWD existing data (n = 4 734) show that that elders who had lower household income, were more educated, are living with main caregivers, require early ADL and IADL assistance, or residing in private rental housing were more likely to accept the CCSV Pilot Scheme. Advice and recommendations from RWs, having RSPs within ones' neighbourhood, and the willingness and ability to afford co-payment are also importance factors contributing to CCSV acceptance. Surprisingly, our findings reveal that health and functional conditions do not seem to affect CCSV acceptance among our participants. However, the absence of pain, as well as the presence of dressing and hygienic care needs are three unique health factors positively associated with CCSV utilization.

8.3 Conversely, our findings reveal elders who were living in public rental housing, dependent on social welfare or other social security programs, or having higher household income were more likely to refuse CCSV. Also, those who were already receiving care from their family and/or domestic helpers, unwilling to provide co-payment, or unable to identify appropriate service package or appropriate service providers were more likely to refuse CCSV. Preliminary service utilisation data further shows that the inaccessibility of RSPs can delay and potentially cause a detrimental effect on CCSV usage.

8.4 Findings from COA cross-sectional survey data (N = 60) show that a greater percentage of current users than withdrawn users found CCSV to be useful in elevating their self-perceived health and quality of life, while reducing their caregivers' burden. Current users who retrospectively evaluated the above three dimensions before and after the

CCSV participation supported the CCSV's efficacy in health alleviation and stress reduction. Moreover, results from thematic analysis show that the recommendations from RWs and family members, as well as the geographical location of service providers are robust factors that greatly influence the choices and preferences of services among CCSV users.

8.5 For withdrawn users (N = 38), although a good portion of them found CCSV to be helpful in elevating their overall health as well as reducing their caregivers' burden, the major reason that led to their departure were the lack of appropriate and attractive service packages that met their individual care needs. Health deterioration was another major reason of CCSV withdrawal. In addition, the reported unwillingness to provide co-payment was another critical factor for service withdrawal though unwillingness to co-pay does not mean necessarily unaffordability. These findings pinpoint that the future provision of CCSV needs to expand and enhance service scope, improve service quality and choices and match the voucher value with the participants' service need. Participants should also be clearly explained that there is similar arrangement under conventional CCS service for co-payment from service users.

8.6 Prospective investigation of service use and outcomes was conducted for 32 new users, among which 23 continued participating in the CCSV. Most of the elders opted for day care services, in particular rehabilitation exercise and meals. Escort service to day centre was extensively used, implying its importance in maintaining the CCSV. In general, they maintained a good impression on the CCSV Scheme. Despite the good impression among new users, the follow-up survey data did not suggest a positive change in self-perceived health, quality of life, life satisfaction, caregiver burden, and intention of ageing-in-place. The interRAI-HC 9.1 outcomes of ADL, depression, and cognition remained stable at 6 months**.** Further investigation is needed to examine whether the CCSV Scheme can delay health deterioration in the longer run.

8.7 In-depth interviews with withdrawers (n =14) and refused cases (n=10) of the CCSV Pilot Scheme revealed that inadequate service volume, lack of service options and flexibility to addresses the individual care needs of withdrawers, unwillingness to co-pay, limited understanding of CCSV whereby the interviewees lacked adequate knowledge and literacy on the pilot program, as well as service inaccessibility were all critical barriers to CCSV utilisation. In light of these challenges, our participants proposed that the SWD need to take a more active role in service planning and service coordination, while RSPs needed to expand and enhance the scope, accessibility and affordability of their top-up services. Our participants further suggested that RWs must

assume greater responsibilities in supporting and helping older people and their family caregivers to make more informed decisions on community care that best fit their needs. All of these undertakings would ultimately serve to augment the provision and utilisation of CCSV.

8.8 The in-depth interviews with 12 current users discussed the CCSV efficacy attributes and improvement needs. They agreed that the Scheme promoted individual choices which gave them greater power in the negotiation with RSPs. Their positive impression on CCSV also resulted from the self-perceived health and wellbeing enhancement among elders and reduction of caregiver burden. They suggested that the programme could be improved with greater service choices, more RSPs, greater support from RWs, and more resources allocated to enhance service content. Irrespective of the positive attributes, the CCSV might not be competitive enough for full-time users because of the expensive top-up fees. Service options and packages of the CCSV would need to be improved which will therefore be comparable with the self-financing and full-time day care service, considering that self-finance services were comparatively more flexible and sometimes, reasonably-priced.

8.9 Two rounds of focus group with RWs and RSPs conducted in January and July 2014 reveal comparable findings across time. Specifically, although most RWs and RSPs expressed concerns and frustration in program implementation due to a series of administrative, resources, and manpower limitations; most participants had expressed a deep appreciation for the work that they do because they were able to observe the many positive changes among CCSV users and their family caregivers, particularly those related to choice promotion, empowerment, health elevation and stress reduction. However, they also saw many barriers preventing elders from taking up CCSV, and these included users' understanding of CCSV, service inflexibility, inaccessibility and unwillingness to co-pay. Thus, many had suggested that the SWD together with all of its district offices need to take a more active role in promoting the Pilot scheme by establishing a much more transparent, user-friendly and accessible infrastructure to facility information exchange, service provision and service delivery. Finally, a case management approach had been claimed by many to be an essential and pivotal mean for sustaining the future development of voucher programs in Hong Kong. In sum, the overall impression of the CCSV Pilot Scheme from the perspectives of RWs and RSPs is positive and encouraging.

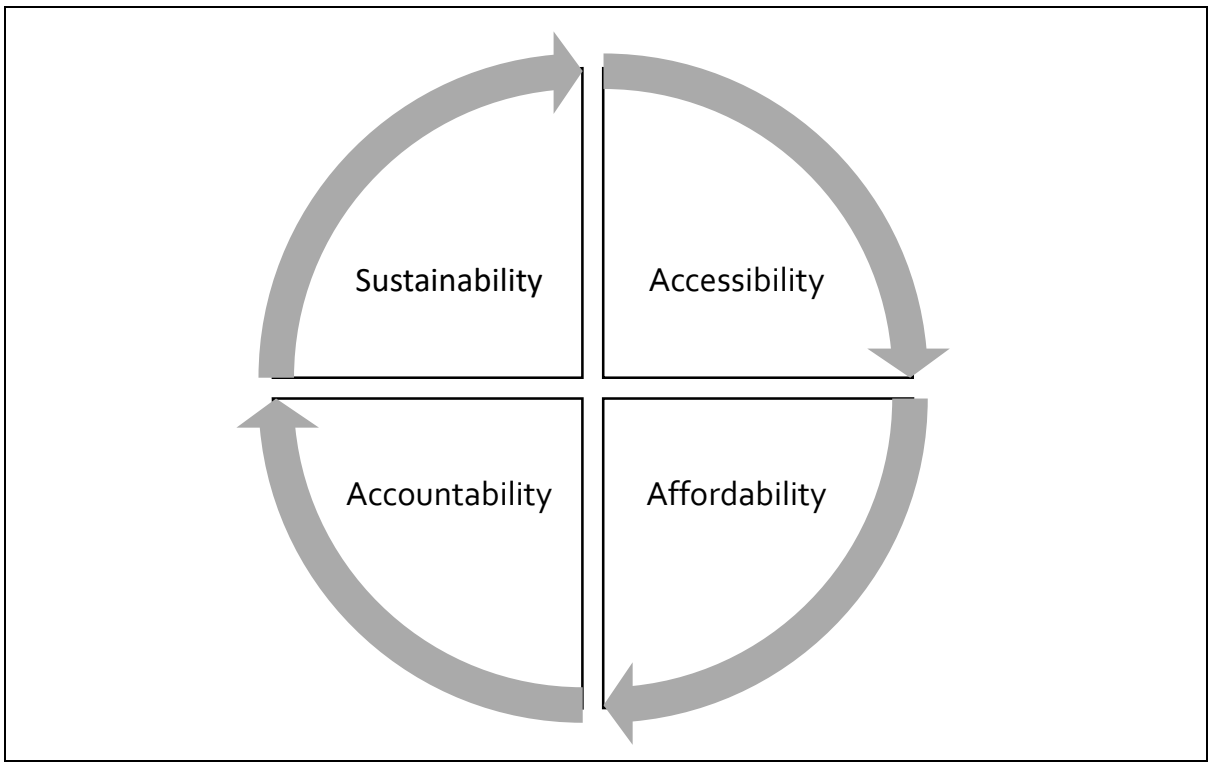
8.10 The third round of focus group with RWs and RSPs was conducted in March 2015. After one and a half year of implementation, their workload did not diminish due to the

changing administrative procedure and heavy regulatory activity. Their distress was resulted from resource limitation, especially when the users' health conditions were deteriorating. The existing service matching process was ineffective because RSPs were unable to contact potential service users directly and RWs had inadequate knowledge about the updated service plans. Similar to the last two rounds of focus group, participants criticized that the Scheme was inflexible and services were inaccessible to many elders. They expressed the difficulty in explaining the Scheme to elders and caregivers, and difficulty in developing programs that meet the needs of a wide spectrum of users. Although they agreed that the Scheme promoted choices and relieved caregiver burden, they suggested giving RSPs greater flexibility in designing the service content with less monitoring. The importance of case management was further re-iterated in this round of focus group. Strategies could be developed to promote efficient matching between users and service providers. In terms of service fee, the amount of CCSV was suggested to be determined in consideration of users' financial resources as well as care needs.

Implications for Program Enhancement

8.11 Based on all of the above findings, a number of preliminary implications can be deduced for formulating CCSV service policy, provision and delivery. In general elders who are living with caregiver, are more educated, or with family support are more likely to accept and utilise CCSV. Its promotion is heavily dependent upon in-person contact via RWs. In order to enlarge the CCSV service window and to enhance CCSV service quality, the four principles of Accessibility, Accountability, Affordability, and Sustainability should be carefully considered.

Figure 8.1 Principles for CCSV program enhancement



8.12 The CCSV Pilot Scheme needs to be fine-tuned to increase Accessibility (personalized service, more service providers and better service matching), Accountability (training to RWs and RSPs and involvement of District Offices in the implementation of CCSV), Affordability (voucher value to meet individual's service need), and Sustainability (adequate resources and manpower to provide continual care) and this translates into identifying and enhancing service activation pathways and service utilization patterns to improve greater usage. The following six variable strategies may be considered.

(i) To adopt a personalized approach in services provision: The SWD should define what is allowable and what is not allowable for voucher budgets, empowering CCSV users with the greater flexibility on what services to use and at what volume. This will allow users to decide the most suitable mix of services that best support their community living.

(ii) To expand the service providers' pool for enhancing service quality and diversity: The SWD should consider ways to encourage more NGOs, social enterprises, self-finance service providers, and private organizations, to become RSPs. This will increase the accessibility and diversity of services in all districts with a greater number of service units. This may also reduce travel distances between service providers and voucher users through expanding the

geographical space of service provision with more effective and streamlined escort services.

(iii) To provide ongoing training to RWs and RSPs: The SWD should continue and reinforce the training provided to RWs and RSPs on CCSV and to update them latest development of the program. To facilitate better service matching, the SWD should also consider creating an easily accessible communication platform to provide most updated information directly to all stakeholders.

(iv) To increase District Offices' involvement in CCSV implementation: Each district has its own unique characteristics and an one size fit all program design may not be the most appropriate model for implementing the CCSV program in each district. The SWD should set some board parameters on allowable and non-allowable items for CCSV, but allow district to develop programs that best fit their communities. The SWD headquarter should also provide the necessary technical support on program logistic and administration to District Offices to set up such services.

(v) To adopt both case-mix and means-test approach for enhance affordability: The SWD should consider setting different voucher values based on the case mix (i.e., pattern of care and resource utilisation) of service users with co-payment rates based on means test. This will make the CCSV services more affordable for elderly persons with higher needs and those with less means.

(vi) To review voucher users' need for continual support and care: The resources given to RSPs have to be regularly reviewed according to the users' changing care needs. In view of the deteriorating health of elders, their care needs would inevitably increase with time. To facilitate RSPs the provision of continual care, the SWD should consider reviewing users' care needs for re-adjusting service packages and service volume to cater for individual needs.

Concluding Comment

8.13 The First Phase of Pilot Scheme on Community Care Service Voucher for the Elderly has shown great promise in elderly health promotion and caregiver stress reduction though the cultivation of participatory care and consumer empowerment. The introduction of 'self-directed care" has also display outstanding potential in fostering diversity and competition for elevating the quality and responsiveness of community

elderly care services in Hong Kong. Now is the time to enhance and expand the true capacity of CCSV to further facilitate ageing in place for all older people in Hong Kong.

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