Executive Summary

1. The Social Welfare Department of the HKSAR Government (SWD) implemented the First Phase (Phase I) of the Pilot Scheme on Community Care Service Voucher (CCSV) for the Elderly (the Pilot Scheme) in September 2013. The Pilot Scheme adopted the 'money-following-the-user' approach and the 'affordable users pay' principle, where the proportion of co-payment is conditional on the elderly's household income. It aims to introduce a more flexible and diverse mode of home and community support services to community dwelling frail elderly persons. The evaluation study of the Phase I Pilot Scheme was completed by the Sau Po Centre on Ageing of the University of Hong Kong (COA).

2. The Second Phase (Phase II) of the Pilot Scheme was rolled out in October 2016, with a number of enhancements to provide more personalized choices for elderly persons to meet their diverse needs. The major enhanced features include: choice of full-time/part-time mode for day care/home care; choice of 5 levels of voucher values; CSSA category of co-payment; inclusion of elderly persons of severe impairment as target beneficiary; and introduction of Centralised Team.

3. COA was commissioned by the SWD to conduct an evaluation study of the Phase II Pilot Scheme in February 2017. The objectives of the study are:
   - To evaluate the effectiveness of the Pilot Scheme in promoting health and quality of life of CCSV users and their caregivers, and in users' ageing in place (AIP) intention;
   - To examine the implication of the Pilot Scheme on users' application for subsidised Long Term Care (LTC) services;
   - To assess the effectiveness of the Phase II enhanced features in attracting elderly persons to join the Pilot Scheme and in meeting their LTC needs; and
   - To provide recommendations on further enhancement of the Pilot Scheme to be implemented as a sustainable mode of LTC services.

4. To achieve these objectives, we adopted a mixed-methods approach to collect data through survey and focus groups. Furthermore, the SWD provided us with the administrative data of 28,067 eligible elderly persons and 7,822 of them joined Phase I and/or Phase II Pilot Schemes as of May 29, 2018. These data included the eligible elderly persons' Central Waiting List status, voucher status, the voucher value, the co-payment category, their reason for case closure, and their impairment level. The SWD also provided us with the impairment levels and service mode of the 205 CCSV users who have participated in our baseline survey and their status during the follow-up period. The SWD also provided the most updated record on users' centre-based and home-based service usage as at 30 September 2017 as well as the latest information of the service provision as at 30 December 2019. However,

this report is largely based on the survey and focus group findings and information provided by the SWD before October 2018.

5. Survey participants were recruited by direct phone calls from the research team or referrals from Recognised Service Providers (RSPs) or Responsible Workers (RWs). At baseline, our trained interviewers conducted face-to-face interviews with 205 Phase II users and their carers between April and June 2017. Among the baseline sample, 84 survey participants were transferred from the Phase I Pilot Scheme to the Phase II (the Phase I-II group) while 121 participants were new CCSV users in the Phase II Pilot Scheme (the Phase II only group). The retention rates was 82.9% at follow-up interview (86.9% for the Phase I-II group and 80.2% for the Phase II only group. We also conducted 15 focus groups with the Centralised Team (two groups, 14 participants), Responsible Workers (RWs, four groups, 26 participants), and frontline and management staff of the Recognised Service Providers (RSPs, nine groups, 72 participants) between May and June of 2017 and in January of 2018.

6. All survey data collected were entered in the Statistical Package for the Social Science (SPSS) software for analysis. All focus group data were audiotaped and transcribed, and reviewed by two senior research team members to ensure data reliability. The transcribed data were used for data analysis. The major themes pertinent to the evaluation of Phase II were identified and presented in this report.

7. **Effect of the Pilot Scheme on users' outcomes:** We found that the Pilot Scheme had a moderate positive effect on users' health and quality of life (QoL) and on reducing carers' burden, particularly among the long term users. The Phase I-II users reported a significantly higher self-reported health and QoL than the Phase II only users in baseline survey, suggesting that longer term users had better outcomes than users who just joined the Pilot Scheme. Users reported no changes in their health and QoL between the baseline and follow-up surveys, indicating that they had a relatively stable health and QoL after joining the Pilot Scheme. However, Phase I-II carers did report a drop in both users' health and QoL between the two surveys for the Phase I-II group, but not for the Phase II group. The qualitative results indicated that the Pilot Scheme increased aging-in-place intention of its users, particularly among those with moderate impairment.

8. **The Effect of the Pilot Scheme on Users' Application for LTC Services**: We found that the Pilot Scheme had a positive effect on reducing the demand for traditional LTC services. Compared with eligible non-users, a higher percentage of Pilot Scheme users were inactive on the CWL for CCS and RCS, indicating a positive effect of the Pilot Scheme to promote aging-in-place and potentially to cut down the CWL. The effect was even larger among those who were currently using the Pilot Scheme services. Among those who left the Pilot Scheme,

about 43% went to other LTC services, including 9.9% went to subvented RCS and 13.6 went to private RCS.

9. **Findings on the Enhanced Features of the Second Phase of the Pilot Scheme:** The Phase II introduced several new features into the Pilot Scheme, including (1) residential respite service; (2) flexible service mode; (3) five levels of voucher values; (4) CSSA-specific co-payment category; (5) inclusion of elderly persons with severe impairment as targeted beneficiaries; and (6) the Centralised Team. Majority of our survey participants (58% in baseline survey and 55% in the follow-up survey) reported that the enhanced features met their needs.

10. **Residential respite service:** Although our survey participants wanted residential respite service, only 18 (10.7%) had applied for it and eight (4.7%) successfully obtained the services. Among these eight respondents, six found that the residential respite service helped reduce their caregiving burden. The low utilization reflects unavailable residential respite service places.

11. **The flexible services mode:** The Phase II of the Pilot Scheme provided users more choices of full time or part-time modes, and could use day care only, home care only, or mixed mode of day care and home care. Most users in the Phase I-II group used day care only (59.4%), followed by mixed mode (37.3%). However, among the Phase II group, less than half of them (43.6%) used day care only, and about the same number of users used either home care (28.9%) or mixed mode (27.5%). The Phase II users also used less services than phase I-II users, except meal services. The focus group participants revealed that the flexible service mode had attracted more elderly persons to use home care. It also allowed smooth transition from one mode to another mode to meet the changing needs of older people. However, this flexibility created more financial and operational pressures on RSPs.

12. **New five pre-set voucher values:** Our survey respondents were satisfied with the new five pre-set voucher values. According to the SWD data, most users chose $5,340 (30.9%), followed by $8,830 (22.4%), $3,700 (19.0%), $6,680 (14.7%), and $7,500 (13.1%). Most Phase II users chose the voucher values at the lower end (HK$3700, 46.3%; HK$5,340, 24.2%). In our focus group interviews, we found that the new five pre-set voucher values were attractive to users as they offered more flexible service coverage. However, the matching and negotiation of the voucher values with users and their carers created significant challenges to RSP.

13. **CSSA co-payment category:** The new CSSA co-payment category has simplified the reimbursement procedure for CSSA recipients. Respondents expressed that a separate co-payment category for CSSA recipients benefited both recipients and RSPs.

14. **Persons with severe impairment:** Persons with severe impairment were eligible for the Pilot Scheme in the Phase II. However, only a small number (9.9%) of all users were assessed as having severely impairment. Furthermore, a significant number of those with severe impairment chose the lowest voucher value of $3,700 (56.2%), followed by $5,340 (18.0%). Only 17.4% chose the highest value of $8,830 (17.4%). The focus group participants voiced that a higher service intensity needed by elderly persons with severe impairment posed greater manpower challenges to RSP.

15. **Centraliszed team:** The Centralised Team was set up in Phase II and served as the point of contact for potential users who needed support to decide whether they should apply for the Pilot Scheme. For voucher users, the team assisted them to identify a suitable RSP and found a service package that fit their needs. The team also supported Pilot Scheme users to transfer to another RSP when necessary. Respondents were generally satisfied with the Centralised Team.

16. **Recommendations:** Finally based on our qualitative and quantitative findings, we made several recommendations to the SWD, including: (1) to review the funding level for RSPs regularly to make joining the Scheme a financially viable and sustainable option, particularly for potential providers who are not already traditional CCS providers; (2) to consider setting of minimum and maximum voucher values to allow the use of any voucher value in between for purchase of voucher services to achieve greater flexibility to cater for various service needs of individual CCSV users and minimise the administration cost of RSPs in formulating the service packages for CCSV users that confined to 5 pre-set voucher values ; (3) to expand the RSP pool and to consider including (i) other service operator (not limited to the elderly services operators) such as medical and rehabilitation services operator with relevant experience in providing CCSV services, and (ii) informal helpers such as neighbours, friends, family members, or even foreign domestic helpers as potential RSPs; (4) to allow the use of voucher in more than one RSPs simultaneously; (5) to develop an advanced computerised system for voucher users' better access to the information of the RSPs and the CCSV Scheme and to minimise administrative workload of RSPs as well as to make information sharing among RSPs and Centralised Team more efficient via IT means; (6) to further enhance the collaboration of the Centralized Team and the RWs; and (7) to explore ways to enhance the use of available residential respite service places.