Executive Summary

1. Publicly funded community care services that are provided as cash payments or service vouchers are increasingly adopted by different parts of the world. This funding model empowers users to direct their use of services. Recommended by the Elderly Commission, the Social Welfare Department (SWD) adopted this "money-following-the-users" approach by introducing the Pilot Scheme on Community Care Service Voucher for the Elderly (CCSV) in September 2013. Instead of providing the subsidies to service providers, the Government provides direct subsidies to service users in the form of a service voucher of single monthly value. The CCSV Pilot Scheme is guided by the principles of empowerment and "user participatory care". Service users are expected to take shared responsibility for their own community care costs, and at the same time, they are given greater flexibility in their community care choices. The Pilot Scheme also aims to foster diversity and competition among service providers in uplifting the responsiveness and quality of their healthcare services. Commissioned by the SWD, the Sau Po Centre on Ageing (COA) of the University of Hong Kong has been conducting a formative evaluation of the first phase of the pilot scheme.

2. In September 2013, 62 recognized service providers (RSPs) participated in the first phase of the CCSV in eight districts across Hong Kong, including Eastern, Wong Tai Sin, Kwun Tong, Sham Shui Po, Shatin, Tai Po, Tsuen Wan, and Tuen Mun. The CCSV are valued at around HKD$6,000 per month in 2014-15 (value adjusted annually based on the Composite Consumer Price Index). Voucher users are required to make a co-payment, where the amount of co-payment, ranging from $500 to $2,500, is determined by means testing.

3. This formative evaluation aims to assess its feasibility and efficacy for program enhancement and refinement before launching the second phase of CCSV. This mid-term evaluation report presented findings from four major sources. First, SWD data of the socio-demographic and health related information of elders eligible for CCSV and their service were analysed. Preliminary findings of the service utilization were also presented. Second, structured interviews with current voucher users and withdrawn voucher users (who had accepted but later quitted the CCSV) were conducted to explore their reasons of accepting/withdrawing from CCSV and criteria for choosing RSPs and to examine their subjective perception of the CCSV efficacy in self-perceived health, quality of life, and caregiver burden. Third, in-depth qualitative interviews were conducted to elicit views from withdrawn users and their family caregivers on the CCSV and reasons for withdrawing from the CCSV. Fourth, two rounds of focus groups were

conducted to elicit RSPs' and responsible workers' (RWs) experiences during the initial implementation of the CCSV and to collect their feedback on program enhancement.

4. All elders eligible for CCSV were asked to complete a questionnaire which collected their socio-demographic, health, and service utilization information. By December 31st, 2013, 4 734 elders returned the questionnaires and out of which 504 accepted the CCSV and the remaining 4 230 refused. Elders who were living with main caregivers, living in rented private housing, having higher levels of education, or needed help with dressing and hygiene were more likely to accept CCSV. Elders who had higher household income or suffered from pain were less likely to accept CCSV.

5. According to the 504 elders who accepted CCSV, they accepted mainly because of the advice from a social worker, the close geographical location of the RSP, and reasonable fee for CCSV services. On the contrary, the 4 230 elders refused CCSV mainly because of the adequate care provided by their families or helpers and the lack of appropriate service package.

6. Another questionnaire collected information from 1 201 voucher holders between August 26th, 2013 and May 29th, 2014. Voucher holders from Shatin, Eastern, Kwun Tong, and Wong Tai Sin districts constituted the majority of the group. However, the percent of CCSV utilisation was the highest in Sham Shui Po and Tai Po (both >80%) whereas the lowest level of utilisation was found in Kowloon City and Yau Tsim Mong (both <50%).

7. By September 2014, the COA researchers interviewed 60 current users and 37 withdrawn users. Among the withdrawn users, 24 were withdrawn users (who quitted CCSV after using it) and 13 were withdrawers (who quitted CCSV without using it). A greater percentage of current users were female, had lower levels of education and income, resided alone in either their own properties or public housing, and had the longest RCS waiting time. Majority of the current users (70-80%) subjectively felt that the CCSV Pilot Scheme was either helpful or very helpful in improving their general health, quality of life, and reducing the caregivers' burden. The findings coincided with their self-ratings that they perceived to have better general health, quality of life, and reduced caregivers' burden as compared with the condition 3 months ago. Although withdrawn users generally felt more negative towards the CCSV, a considerable proportion of them still subjectively felt that the CCSV was helpful in improving the above outcomes. Both current users, withdrawn users, and withdrawers generally agreed that they would be highly likely living in the community in the forthcoming year from the time of the interview.

8. These current users were further asked about their service utilisation and preference. Over 80% of the current users had a co-payment of $500. Majority of them accepted CCSV because of the recommendation from the RW and family. In terms of the criteria for choosing RSPs, many of them considered location and recommendation from the RW and family as the most important criteria. For the withdrawn users, the most frequently expressed reason for withdrawal was that the service was not meeting their needs. More withdrawn users expressed satisfaction with regard to the service provider, service quality, service accessibility, and application process. However, they showed stronger dissatisfaction with the service flexibility, co-payment amount, service package as well as top-up service fee.

9. To elucidating the various challenges of the CCSV Pilot Scheme, 2 withdrawers and 12 family caregivers of the withdrawers participated in an individual in-depth interview conducted by trained COA interviewers between June and September 2014. Three major themes were elicited from the interviews: 1) CCSV service limitations, 2) CCSV utilization constraints, and 3) CCSV improvement needs. Specific concerns surrounding service limitations included inadequate service volume, service inflexibility, and limited service option. Utilization was also limited by the inadequate understanding of the CCSV, financial concerns, and service inaccessibility. They suggested that greater flexibility of the program, more support from RWs, and better service planning and coordination would help improve the CCSV.

10. Perspectives from RSPs and RWs were elicited during the initial implementation of CCSV (at 4^{th} and 10^{th} month). A total of 33 RSPs and 22 RWs participated in these two rounds of focus groups. Many of them expressed that the implementation was challenging because of the additional workload, limited manpower and resources, staff's inadequate understanding and readiness, and the potential role conflict. The utilisation of CCSV was limited by the inflexible service mode, service inaccessibility, users' financial concerns, their inadequate understanding of the CCSV, unmet user needs, and unsupported decision-making. Despite the drawbacks, many participants found that the Pilot Scheme helped promote choices, empower families, promote health improvement, and reduce caregiver stress. To further improve the scheme, they suggested that improved program flexibility, service coordination, and infrastructure transparency would be needed. A care management system with independent care managers would facilitate the formulation of care plan for the elders.

11. This formal evaluation has generated a number of preliminary findings to inform and enhance the future development of CCSV pilot 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. Based on the current findings, the COA project team has made five recommendations according to three principles: accessibility, accountability, and affordability. To make CCSV more accessible to elders, greater flexibility of the voucher budgets will empower users to decide what services to use and at what volume. The SWD should consider ways to encourage more NGOs, social enterprises, self-finance service providers, and private organizations, to become RSPs. Expansion of the number of service providers will increase the accessibility and diversity of services. The SWD should continue and reinforce the training provided to RWs and RSPs on CCSV and consider creating an easily accessible communication platform to provide most updated information to all stakeholders. Accountability concerns about the involvement of District Offices under SWD, which should take a greater role in the development of programs that best fit their communities. To enhance the affordability of CCSV, the SWD should consider setting different voucher values based on the casemix (i.e., pattern of care and resource utilization) of service users with co-payment rates based on means test.

12. This mid-term report has summarized the preliminary findings for further enhancement of the CCSV Pilot Scheme. The evaluation is still in progress and more findings will be reported in the final report.