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Barriers to an effective voucher programme for community-based aged care: a professional perspective

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Abstract

Long-term care for older people is increasingly turning to consumer-directed approaches. As a case in point, the Hong Kong Government recently implemented a new voucher programme for community-based aged care based on a consumer-directed approach: the Community Care Service Voucher for the Elderly (CCSV). The objectives of this study were to explore the lived experience of professional workers *vis-à-vis* the new programme and to identify barriers to effective voucher use by older people in Hong Kong. In-depth individual interviews were conducted with 16 professionals who had primary responsibility for the voucher programme for community-based aged care. The interview guide covered five main areas: (a) professional's perception and experience on the voucher programme; (b) the decision-making process around the voucher programme; (c) personal capacities of older people; (d) family support and social networks; and (e) institutional support. Findings indicate several barriers to effective use of the CCSV including: lack of self-awareness of service needs, lower education level, poor health condition, lack of financial resources, lack of family support, inadequate family involvement in decision-making, lack of peer and professional support, lack of available services and poor service accessibility. Suggestions for strengthening the voucher programme include institution of a case management model and public education. Different factors or elements are required to facilitate older people to make sound and informed choices, and a case manager can assist in combining different resources and forms of support towards effective use of the CCSV.

Keywords: ageing; case management; consumer-directed care; empowerment; decision-making; informed choice; long-term care; voucher

Introduction

Consumer-directed care (CDC) for long-term care (LTC) for older persons has become a growing trend worldwide, including in the United States of America (USA), the United Kingdom (UK), Australia, the Netherlands, France and

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Germany; and in Asia, the nations of China, Japan and Korea (Alakeson, 2010, 2016; Friedman *et al.*, 2015; Mosca *et al.*, 2017; Moore, 2021). There is no generally agreed upon definition of CDC, which is an umbrella term that refers to an approach or a model that gives consumers (*i.e.* service users) the right, opportunity, choice and control to choose the services that best meet their needs (Crisp *et al.*, 2009; Kietzman and Benjamin, 2016). As an alternative to agency-directed services, CDC offers clients greater independence, freedom, choice, flexibility, autonomy and control (Harrison *et al.*, 2014). In other words, CDC is a person-centred approach since control over service selection and acquisition is shifted away from service providers to service recipients.

The CDC approach views consumers as being knowledgeable about their own needs and preferences, as well as capable of selecting services that best meet their needs (Crisp *et al.*, 2009; Kietzman and Benjamin, 2016). Furthermore, CDC is supported by an economic rationale and applied within a liberal market model, usually involving privatisation (increasing the role of private providers and reducing the public services) and marketisation (purchasing aged care services in the market instead of providing aged care services by government organisations) in LTC (Timonen *et al.*, 2006; Fine and Davidson, 2018). The economic theory behind CDC proposes that, through market competition amongst service providers, service quality would be enhanced (Trottmann *et al.*, 2012), resulting in cost savings (Bulamu *et al.*, 2020).

There is no single model of CDC, and different CDC programmes have been operating in different countries with various forms of assessment, fund allocation, service package, degree of choice and control. Duffy *et al.* (2010) view the idea of personalised budgets for social care as a 'conditional resource entitlement' that lies somewhere between the continuum between direct provision of services and direct budget adjustment. Notable examples of CDC programmes include Consumer-Directed Personal Assistance Services (CDPAS) and Cash and Counselling Demonstration programmes in the USA, Individual Budgets and Direct Payments in the UK, and the Commonwealth Home Support Program (CHSP), National Disability Insurance Scheme (NDIS) and Home Care Packages (HCP) in Australia (Russi, 2014; Laragy and Allen, 2015; Cash *et al.*, 2017; Moore, 2021). CDC programmes offer cash or vouchers to those people who need care so they can choose for themselves appropriate LTC services in the community (Organisation for Economic Co-operation and Development (OECD), 2005; Timonen *et al.*, 2006).

Insights from the international literature on the experience of older people with CDC are varied (Ottmann *et al.*, 2013). Increasing choice, control and independence for older people have led to the improvement of consumer satisfaction in the USA (Simon-Rusinowitz *et al.*, 2014), the UK (Glendinning *et al.*, 2008) and Australia (Bulamu *et al.*, 2017). However, both US and UK studies suggest that older people may sometimes experience extra burdens in planning and managing CDC programmes (Glendinning *et al.*, 2008; Ottmann *et al.*, 2013). Older people in Australia have faced some difficulties with using the new CDC model (Moore, 2021). Furthermore, studies from the UK also underscore that only those older people with greater resources and better education can really effectively exercise choice (Moran *et al.*, 2013).

According to Milton Friedman (1962: 96), a voucher system is ‘a state-funded demand-side subsidy’ to purchase social goods ‘as an alternative to pure public provision of such goods in a competitive market’. Building on this idea, the voucher was more explicitly defined as

a tied demand-side subsidy, where public dollars follow consumers rather than suppliers, with the objective of fostering competition on the supply-side and choice on the demand-side in order to improve efficiency in the delivery of classes of social goods and services. (Daniels and Trebilcock, 2005: 14–15)

In other words, consumers (service users) are given the choice to purchase services, and service providers compete for the ‘voucher dollars’ by providing higher-quality services. A key to the concept behind a voucher is that, as a policy instrument, it works *autonomously*, i.e. by simply creating a flexible voucher, users and providers automatically adjust their choices and offerings, respectively, to optimise the matching of demand and supply. This has the potential to reduce the institutional apparatus and ‘red tape’ associated with a programme (Friedman, 1962). Generally, a voucher system has the following characteristics: (a) consumers receive vouchers at different levels from the government according to their class or income; (b) consumers are given the freedom to choose services from their preferred providers using the voucher; and (c) service providers honouring these vouchers receive reimbursement from a government fund (Perri, 2003).

A voucher is a type of bottom-up funding system (Besharov, 2014) also referred to as a consumer-directed, self-directed or participant-directed instrument (Alakeson, 2010, 2016; Friedman *et al.*, 2015; Kietzman and Benjamin, 2016), which has been adopted worldwide in the provision of education, social services, health care and housing (OECD, 2005; Timonen *et al.*, 2006). This kind of approach simply places purchasing power in the hands of consumers, that is, service users, directly in order to expand the degree of choice, freedom, flexibility, self-determination, control and autonomy over services (Tilly and Rees, 2007; Crisp *et al.*, 2009; Ottmann and Mohebbi, 2014). Some literature suggests that older people with cognitive or physical disabilities have shown positive health outcomes under the consumer-direction approach, especially when support from families or social workers is provided (Tilly and Rees, 2007; Glendinning *et al.*, 2008; KPMG, 2012; Moran *et al.*, 2012; Besharov, 2014; Simon-Rusinowitz *et al.*, 2014).

A voucher system can bring a number of benefits, like (a) increasing consumer choice, purchasing power and independence; (b) sharing responsibility with users and reducing administrative burdens; and (c) improving service quality while shortening service waiting time (Elderly Commission, 2009; KPMG, 2012; Chui *et al.*, 2016). Consumer choice can improve an individual’s satisfaction, self-determination, dignity and quality of life (Benjamin and Matthias, 2000; OECD, 2005; Rostgaard, 2011). Moreover, care recipients can have positive health outcomes by gaining more knowledge, skills and confidence in managing their own health (Donald *et al.*, 2011; Greene and Hibbard, 2012). We should be open to the possibility that no single voucher programme can achieve all these multiple objectives to a great degree and, moreover, different programmes may emphasise some of these objectives more than others. Which objectives are treated as the

primary ones, and which are achieved, depends on context. How an agency defines programme success likewise depends on context.

Some scholars argue that vouchers are not suitable for older people as they may lack certain capabilities to exercise their choices and decisions (Timonen *et al.*, 2006). Some critiques reflect a view of older people, especially those with dementia, as a frail and vulnerable group who are unable to make choices in the voucher programmes (National Association of State Unions on Aging (NASUA) and National Council on Aging (NCOA), 2005; Putnam *et al.*, 2010; Ruggiano, 2012). Nevertheless, older people with mild to moderate cognitive impairment still can express their preferences and choices, and they can participate in the decision-making process with the help of care-givers or professionals (Feinberg *et al.*, 2000). To facilitate the development of a voucher system, professionals have to give up a degree of decision-making authority (KPMG, 2012), and they need to educate and advocate for older people to make their own choices and decisions over their care services (Ruggiano, 2012; Fotoukian *et al.*, 2014). Furthermore, care-givers may overlook the particular needs and desires of older individuals, and limit the service options based on their personal views and preferences about appropriate care and services (Pecchioni, 2001; Radina *et al.*, 2009; Reamy *et al.*, 2011; Yeandle *et al.*, 2012). To promote older people's self-determination and autonomy, a case management approach has been recommended, in which a professional worker, such as a social worker or a nurse, can communicate with older clients and their care-givers, co-ordinate resources and services, and facilitate their decision-making (Moore, 1992; Ruggiano, 2012; Case Management Society of Australia and New Zealand, 2015).

Population ageing has been spurring a significant increase in the demand for LTC in Hong Kong, which is adding to a structural deficit in public-sector spending since most of these services are subsidised by the government (Chui and Law, 2016). To increase the efficiency and reduce costs of LTC, a new funding mechanism in the form of a voucher programme, the Pilot Scheme on Community Care Service Voucher for the Elderly (CCSV), was introduced by the Hong Kong Government in September 2013 (Social Welfare Department, 2021). It adopts the 'money-follows-the-user' approach, which gives the service user control over service choice. The CCSV is used for community-based aged care, including day care and home care services.

In Hong Kong, vouchers have been adopted in the education, health-care and social welfare sectors (Li *et al.*, 2010; Yam *et al.*, 2011; Chui *et al.*, 2016). This article presents the findings on the First Phase of the CCSV, which was implemented from September 2013 to August 2017. The CCSV was aimed at 'testing the viability of a new funding mode' (Audit Commission, 2014: 75), which adopts a consumer-centred approach with a means-tested co-payment provision to facilitate ageing-in-place (Chui, 2011; Chui and Law, 2016). Eligible older people, who are on the waiting list for subsidised LTC services, are given a voucher with values that were adjusted annually (HKD 5,800 in 2014–2014; HKD 6,000 in 2014–2015; HKD 6,250 in 2015–2016; HKD 6,500 in 2016–2017; HKD 6,680 in 2017–2018), with five levels of co-payment (HKD 500; HKD 750; HKD 1,000; HKD 1,500; HKD 2,500) based on the recipient's household income, to select and purchase services from service providers (Social Welfare Department, 2021). In the

First Phase of the CCSV, older people were allowed to select either a mixed mode with part-time day care and home care services, or a single mode of part-time day care services from any of 62 service providers. A responsible worker (normally a social worker) is assigned to eligible older people to assist them in comprehending and signing up for the CCSV programme while another professional from the service provider interacts with the clients to create a plan of care using the voucher (Sau Po Centre on Ageing, 2015; Social Welfare Department, 2021).

Evaluation of the CCSV scheme suggested, however, that utilisation among Hong Kong's older population was uneven, with many either not joining or dropping out of the programme (Sau Po Centre on Ageing, 2015). In this article, we present research that helps explain these patterns by probing into their experiences of professionals around the process of voucher use.

Policy instruments for CDC, like vouchers, are a growing trend in the area of LTC (Ungerson and Yeandle, 2007; Laragy and Naughtin, 2009; Alakeson, 2010, 2016; Friedman *et al.*, 2015). However, some policy makers have expressed concern about the capabilities of older people to exercise their choices and decisions in the consumer-direction approach (Batavia, 2003; Coleman, 2003; Putnam *et al.*, 2010). Informed choice is the main principle underlying the voucher; however, there may be barriers that hinder informed choice, *e.g.* lack of service accessibility, programme flexibility, service information and transport (Boyle, 2013). Most of the literature on the use of vouchers for CDC has focused on outcome evaluation (San Antonio *et al.*, 2010; KPMG, 2012; Moran *et al.*, 2012). Much less attention has been paid to the *process* of voucher utilisation. The voucher system in LTC is a new mode in Hong Kong, and there is lack of local research on it, especially on the users' decision-making process. To fill this knowledge gap, there is a need for a process evaluation focusing on the barriers of voucher utilisation amongst older people. This study probes into the experience of the professional, who is best positioned to observe all the different factors that promote or impede the older client's use of the voucher. The qualitative findings presented in this paper analysed the individual interview data from professional workers, which was part of a bigger research project. The aim of this paper is to examine the lived experience of professionals *vis-à-vis* the barriers to the voucher system for community care in Hong Kong. The specific research questions being answered herein are:

- (1) What is the experience of professionals *vis-à-vis* implementation of the CCSV?
- (2) As professionals observe the choice and decision-making process around the CCSV, what insights do they have regarding how older people and/or their family members exercise choice within the CCSV?
- (3) What are the barriers to effective CCSV in terms of older people's personal capacities, social support and institutional support, from the professionals' point of view?

Methods

Study design

A qualitative research study was used to identify the factors which affect older people to make informed choices in the utilisation of the CCSV from the perspectives of

professionals. A qualitative approach was appropriate to explore the complicated decision-making process of the older people in the service utilisation, especially for the relatively new voucher programme in Hong Kong which needs an interpretive approach to investigate the limitations and obstacles experienced by participants (Creswell, 2003; Yin, 2011).

Participants

Formal invitation letters were sent to all 62 service provider organisations which joined the first phase of the CCSV in October 2013, of whom 16 agreed to participate. In a type of purposive sampling (Gabor and Ing, 2001), each of the participating service providers were asked to identify a staff member with extensive contact with clients and close knowledge of the CCSV (either in the role of caseworker or service provider), who agreed to be interviewed. Informed consent was obtained before data collection.

Data collection

Semi-structured face-to-face in-depth interviews with professionals were used to examine their views and perceptions on the CCSV utilisation of older people. Data collection was conducted by the author from March 2014 to September 2015. The author is both an academic and professional in the field of social work, specialising in aged care. All interviews took place in private rooms at each service unit and lasted from 45 to 90 minutes. Before the interview, the author contacted each participant by phone to introduce the general background of study. At the start of each interview, the author introduced her professional background and, during the interview, endeavoured to build a good rapport with participants (Tong *et al.*, 2007). An interview guide was developed with the following areas: (a) the professional's perceptions and experiences of the CCSV; (b) observations of the process of choice and decision-making around the CCSV; (c) personal capacities of older people; (d) family support and social networks; and (e) institutional support, while allowing the respondent to share her or his other views on all other aspects related to the CCSV. Interviews were partly semi-structured, with common questions asked of all respondents, and open-ended, where respondents were encouraged to tell whatever story they wanted to share. Sample interview questions are shown in Table 1.

Data analysis

All interviews were conducted by the author in Cantonese. The audio-recordings of interviews were transcribed into Chinese by a research assistant. For data analysis, the transcriptions were translated into English by the author. Back translation was carried out for the adequacy of the translated interview transcripts. Discrepancies were resolved in discussion with the research team. Analysis of interview transcripts was carried out with NVivo and based on a thematic analysis (Braun and Clarke, 2006). The first step was to gain familiarity with the data by reading and re-reading all the transcripts to form initial impressions. In the second step, initial codes and

Table 1. Sample questions for the semi-structured interviews

| Areas | Sample of in-depth interview questions |
|--|--|
| Professional's perceptions and experiences of CCSV | What were your thoughts when you learned about the CCSV? |
| | Any changes on your impressions of the CCSV from the very beginning up to the present? Why and how? |
| The decision-making process around the CCSV | How do your service users (older people) and/or their family members make the decision to participate in the CCSV? |
| | How do your service users (older people) and/or their family members select appropriate services within the CCSV? |
| Personal capacities of older people | What is your opinion about your service users' (older people) ability to select appropriate services for themselves in the CCSV? |
| Family support and social networks | What kind of help do your service users (older people) need in order to select the appropriate services in the CCSV? |
| Institutional support | What is your role/responsibility in the CCSV? |
| | How has your organisation responded to the changes led by the CCSV? |

Note: CCSV: Community Care Service Voucher for the Elderly.

patterns were generated by line-by-line coding of each interview (Johnson and Christensen, 2004). In the third step, codes were combined into different potential themes and sub-themes. In the fourth step, all potential themes and sub-themes were reviewed by the research team through peer debriefing. In the fifth step, all themes and sub-themes were defined and operationalised clearly. Associations, similarities and differences amongst various themes and sub-themes across the sample were examined. Transcript text was coded by theme. In the final step of analysis, results and conclusions were drawn based on the proposed associations amongst categories, themes and sub-themes, and samples of quotations utilised to vividly illustrate each general finding.

To enhance reliability of the coding process, an outside reviewer was asked to code a selection of text independently, and this showed sufficient consistency with the author's coding. The outside reviewer is a professor from New York University, whose expertise lies in qualitative research, including analysis of textual data. About a third of all the interview transcripts were shared with the outside reviewer, who then independently coded the transcripts thematically. The coding was then compared between the researcher and reviewer, and it was judged that they were largely consistent with each other and that differences were minor. The sub-themes were generated during the coding process. At the same time, the study was predisposed to search for different factors that influenced or hindered use of the CCSV. Unlike a completely open-ended coding strategy, the author was guided by the study's central aim, which is that different factors aid or hinder voucher utilisation.

Table 2. Characteristics of research subjects – professional staff

| Name | Gender | Profession | Stakeholder role | Years of service |
|------|--------|------------------------|--------------------|------------------|
| Lau | Female | Social worker | Responsible worker | 7 |
| Liu | Male | Social worker | Responsible worker | 25 |
| Yip | Female | Social worker | Responsible worker | 9 |
| Ho | Female | Social worker | Responsible worker | 14 |
| Wong | Male | Social worker | Responsible worker | 17 |
| Tong | Female | Social worker | Responsible worker | 15 |
| Wang | Female | Social worker | Responsible worker | 7 |
| Siu | Female | Social worker | Responsible worker | 9 |
| Kwok | Female | Nurse | Service provider | 35 |
| Li | Female | Nurse | Service provider | 26 |
| Dai | Female | Social worker | Service provider | 9 |
| Chow | Female | Social worker | Service provider | 14 |
| Woo | Female | Social worker | Service provider | 15 |
| Tang | Female | Social worker | Service provider | 2 |
| Chan | Male | Occupational therapist | Service provider | 13 |
| Chau | Female | Nurse | Service provider | 15 |

Notes: N = 16. Pseudonyms are used to ensure confidentiality.

Results

Sixteen individual face-to-face in-depth interviews were conducted with the professionals, which included eight responsible workers (the term referring to social workers who are responsible for older people's LTC arrangements) and eight service providers. Of the group of responsible workers, two were male while six were female, and all were social workers with length of service ranging from 7 to 25 years. The sub-group of service providers consisted of one male and seven females: three were nurses, four were social workers and one was an occupational therapist, with length of service ranging from 2 to 35 years. The characteristics of the professionals are shown in Table 2. In the following discussion, pseudonyms are assigned to each respondent.

Two core main themes emerged from thematic analysis: (a) barriers to effective implementation of the voucher programme and (b) suggestions for a more effective voucher programme. From two main themes, 12 sub-themes were generated: self-awareness of service needs, education level, health condition, affordability, family support, collective family decision-making, peer influence, professional support, service availability, service accessibility, case management, and public education and promotion. The summary of overall findings is shown in Table 3.

Table 3. Summary of the findings

| Themes | Sub-themes | Main findings |
|--|-----------------------------------|---|
| Barriers to effective implementation of the voucher programme: | | |
| Personal capability | Self-awareness of service needs | Lack of self-awareness of own needs |
| | Education level | Lower education level of older people |
| | Health condition | Poor health condition of older people |
| | Affordability | Financial difficulties of older people |
| Social network | Family support | Lack of family support – emotional support, physical assistance, information and advice, and financial resources |
| | Collective family decision-making | Lack of family involvement in decision-making |
| | Peer influence | Lack of advice from peers |
| Institutional effectiveness | Professional support | Lack of professional support – information, explanation, suggestions, recommendations and other resources from social workers |
| | Service availability | Lack of available services for meeting the needs of older people |
| | Service accessibility | Difficulty in accessing services |
| Suggestions for a more effective voucher programme: | | |
| Suggestions | Case management model | A case manager to assess the needs of older people, develop care plans and co-ordinate services for them |
| | Public education | Public education to increase people's understanding of the CCSV |

Note: CCSV: Community Care Service Voucher for the Elderly.

Theme 1: Barriers to effective implementation of the voucher programme

Participants pointed out that there were some personal, social and institutional factors which could hinder older people from making choices and decisions over the CCSV scheme in Hong Kong.

Personal capability

This category includes personal factors that affect older people to exercise their choices, controls and decisions over the CCSV. Four sub-themes were generated, including *self-awareness of service needs*, *education level*, *health condition* and *affordability*. Most participants pointed out that *self-awareness of service needs* was an important factor which could affect decision-making amongst older people on the CCSV:

Some older people get used to their current living and caring arrangements, they prefer not to use the voucher services to avoid any trouble from it, they think they don't need the CCSV services. (Ho, female, social worker, responsible worker)

The CCSV scheme is quite a new service delivery model in Hong Kong, and it is difficult for many users to understand the service content and service mechanism. Many participants expressed that a lower *education level* could hinder older people from informed choice and decision-making with regard to the voucher. In this study, the term 'lower education level' refers to a level of education not exceeding primary school:

The concept of the voucher is good since it gives service users choices. However, this new mode of service selection is quite difficult for the current cohort of older people since they are not educated. Many older people said to me that they don't understand the voucher scheme and they don't know how to choose voucher services ... the voucher scheme will be more suitable for the next cohort of older people who are more educated. (Lau, female, social worker, responsible worker)

Moreover, some participants mentioned that *health condition* can be a factor that affects the utilisation of the voucher scheme since some older people with deteriorating health could not visit different service units to compare the service options before making the best choice and decision:

Older people don't know how to shop around different voucher service units if their family care-givers don't have time to help them ... it is quite exhausting or even impossible for older people to visit all the service units by themselves, especially for those with physical and/or cognitive problems. (Chau, female, nurse, service provider)

In contrast to the traditional subvented services (with fixed and equal service payments across all service users), the CCSV adopts a sliding scale co-payment approach in which voucher users are assigned differing amounts of payment according to their monthly household income. In addition, voucher services and the traditional subvented services cannot be used at the same time; in other words, the older people cannot select traditional services as well as voucher services together. Our findings revealed that *affordability* of co-payment affected the choice and decision of older people over the voucher scheme:

I have some cases, because of the amount of co-payment is too expensive, thus, they don't use the voucher services ... as we know that it ranges from \$500 to \$2,500 ... for older people living with their children, they may need to pay \$2,500 just for 3 days of voucher services which is more expensive than traditional subvented full-time day care services. (Liu, male, social worker, responsible worker)

In some cases, without family or other support, the amount of co-payment proved unaffordable to older people, hindering them from using the voucher:

Some older people don't use the voucher because in the CCSV, service users need to pay for services. Payments range from \$500 to \$2,000 each month ... some

older people without others' support may not be able to afford this co-payment amount. (Chow, female, social worker, service provider)

According to professionals' experience and observation, deficits in certain personal factors could hinder people from making sound decisions regarding the voucher. Furthermore, participants also emphasised that social factors, such as support from family and friends, can empower older people to effectively utilise the voucher.

Social network

This category refers to the social factors, which can assist older people in making their choices and decisions over the voucher scheme. In other words, it helps to examine how the lack of certain kinds of social factors can hinder older people from making informed choices. Three sub-themes were generated which included *family support*, *collective family decision-making* and *peer influence*.

Family support includes different kinds of support that are provided by the family, like emotional support, physical assistance, information and financial resources, and all these play an important role in facilitating older people to participate in the CCSV. Normally, older people deal with different kinds of disabilities and need assistance from family. Almost all participants expressed that, without *family support*, it is impossible for older people to exercise informed choice within the voucher scheme:

Most of our voucher cases have family support, thus, we mainly contact the family care-givers and explain the voucher services to them ... older people living alone without family support have rejected the voucher scheme. (Yip, female, social worker, responsible worker)

Furthermore, family members can assist older people during the decision-making process through *collective family decision-making*. *Collective family decision-making* is essential to voucher utilisation. Family members can be involved directly in the decision-making process, or they can be partly involved by supporting older people's capability to exercise their own choices:

In our centre, almost all the voucher cases are supported by family. Family care-givers accompany older people to visit our centre. I know that family care-givers discuss whether to join our voucher services with older people afterwards. Most of them respect older people's preferences. (Dai, female, social worker, service provider)

It was evident that even when the older person had some cognitive impairment, family members still respected their needs, wishes, preferences and choices, and let them make their own choices regarding the voucher scheme:

Older people with dementia still can express their preferences by saying simple words, like 'yes' or 'no', 'like' or 'dislike', and/or by showing non-verbal facial expressions or behaviour, like smiling when they like the service or refuse to

walk when they don't like the service ... I can see some families of older people with dementia visit our centre with the older people, and respect the preference of older people before making the decision to join our CCSV services. The family care-givers always say 'will see whether he/she [the older person] wants to use the services [CCSV], if he/she likes it, we will join'. (Kwok, female, nurse, service provider)

In short, support from the family can compensate for the lack of personal capabilities, such as the lack of education, deteriorating health conditions and limited financial resources, that can facilitate older persons' participation:

All my voucher cases have family support, for those older people or older couple living alone without family support, first of all, it is very difficult for them to understand the voucher scheme, secondly, they are not willing to pay for it. But for those with family support, their family care-givers help them in service selection and also help them to pay the co-payment fee. (Tong, female, social worker, responsible worker)

These patterns extend to the older person's wider social network. Our findings support the idea that positive *peer influence* can support older people to make decisions and encourage them to use the voucher scheme:

Some of the cases [CCSV users] are recommended by their friends to use our CCSV services, and then they approach the social workers for details since they want to use the voucher services as well. (Chau, female, nurse, service provider)

In short, a person's social network (family members, but also one's peer group) can be seen as a resource that enhances one's capabilities.

Institutional effectiveness

This category refers to institutional factors which facilitate older people's informed choice around the CCSV. It involves three sub-themes of *professional support*, *service availability* and *service accessibility*. *Professional support* pertains to all information, explanation, suggestions, recommendations or other resources which are provided by social workers or other related professionals related to the voucher programme. All participants agreed that professionals, such as social workers, play an important role in the voucher scheme. Without *professional support*, older people could not make the informed choice for the use of the CCSV:

I heard from a case that he had received the voucher for a while but he did not use the voucher service because the older person actually did not know how to choose the service since the responsible worker [or social worker] only gave him the voucher without any follow-up actions ... so for those older people without family support, professional support is very important. (Dai, female, social worker, service provider)

In many cases, the services provided within the CCSV scheme were insufficient to meet the person's needs. Adequate service options are needed for informed choice. *Service availability* refers to whether service packages provided in the

voucher scheme can meet the various needs of older people. Participants highlighted that the service design of the CCSV scheme, including service volume and service type, could not meet the needs of some older people, and this affected their decisions and utilisation of the CCSV:

Some service users told me that they did not use the CCSV because it provides part-time day care service only [for the single mode service]. In this case, they can only either use the service on Monday, Wednesday and Friday or Tuesday, Thursday and Saturday ... the CCSV service volume and arrangement cannot meet their needs at all. (Chow, female, social worker, service provider)

More frail persons might need some special care, such as oxygen therapy or dialysis, but the CCSV service units were not equipped with the facilities or staff for older people's special needs:

For some cases with special health-care needs, such as oxygen concentrator and dialysis, the CCSV service providers cannot provide the related caring services to them, so they reject the services as their needs cannot be met. (Wong, male, social worker, responsible worker)

Service accessibility refers to both geographical accessibility (which is the physical location of service units) and administrative accessibility (which means whether transport and escort service are provided). Almost all participants expressed that older people consider the location of service units and the availability of transportation or escort services to be key factors for them:

Most of the older people and their family care-givers consider whether the voucher service units are close to their home and also whether transport is provided when making the selection and decision. (Dai, female, social worker, service provider)

Due to deteriorating physical health, some older people find it very difficult to use the CCSV if service units are too far away, or if they lacked escort and transport services:

Some older people cannot join the voucher services because service providers do not provide door-to-door escort services. Some older people really cannot go downstairs alone to take transport ... some others cannot cope with long journeys. (Ho, female, social worker, responsible worker)

Institutional resources and services can be seen as complementing the older person's own capabilities and, often, making up for decrements in the same.

Theme 2: Suggestions for a more effective voucher programme

Some suggestions were provided by the participants regarding the barriers to the voucher programme (CCSV); two sub-themes were generated: *case management model* and *public education*. All participants agreed that the existing

workloads of responsible workers were too heavy and prevented them from performing their roles well:

In order to empower older people in using the CCSV, there should be someone to facilitate their choices and decision. However, the RWs [responsible workers] are unable to take up this role due to the existing heavy workload. (Yip, female, social worker, responsible worker)

The potential benefits from a *case management model* were highlighted for service assessment, planning and coordination.

The current CCSV system really lacks a real case manager to facilitate the service utilisation. In fact, older people need someone to assess their needs, develop a care plan and co-ordinate services for them. Presently, responsible workers cannot fully achieve the role of a case manager. (Woo, female, social worker, service provider)

A majority of the participants suggested that a comprehensive case management system should be developed to facilitate CCSV utilisation:

To facilitate the CCSV utilisation, the government should consider the case management approach ... from my personal point of view, a real case management should not be undertaken by the responsible worker in NGOs [non-governmental organisations] ... there should be a group of professionals who serve the role of case managers ... the case manager should be very familiar with the overall social welfare and medical system in Hong Kong, and then co-ordinate or refer the necessary services to meet the needs of an individual older person. (Kwok, female, nurse, service provider)

Apart from the case management model, the participants further highlighted the importance of *public education* for increasing people's understanding of the voucher scheme and for facilitating people's ability to make an informed choice:

CCSV is a new concept for both service providers and service users. Only the information in the brochure is insufficient for older people and their family caregivers to understand the scheme and make choices on the service selection ... more public education is needed to increase older people and family care-givers' understanding on the CCSV scheme. (Li, female, nurse, service provider)

In this study, the views of professionals regarding the CCSV were explored. Participants highlighted the presence of some barriers to the CCSV with regard to personal capability, social support network and institutional effectiveness. In the next section, implications and recommendations will be discussed for reducing some obstacles in making informed choices and decisions around the voucher programme.

Discussion and implication

Older people are often disempowered due to the lack of income, health, education and other elements (Hafford-Letchfield, 2010; Kam, 2021). Because of ageism and political disenfranchisement, the rights and needs of older people are often taken for granted (Thompson and Thompson, 2001). Findings from thematic analysis of interviews with professionals show that different levels of factors, acting at the intrapersonal, interpersonal, organisational and policy levels, can facilitate older people to exercise their choices, controls and decisions over the voucher scheme. In other words, the lack of certain kinds of favourable factors or supportive conditions may create some obstacles to the successful utilisation of the voucher. In contrast to the conventional notion of vouchers as impersonal, market-like instruments, the research underscores how caring relationships invariably support any well-functioning programme for LTC (Rodrigues, 2020).

Older people with poor health condition and mobility problems may have difficulties in exercising their choices and decisions (Thompson and Thompson, 2001). Those people who lack support, information, funds or available services may not be able to make informed choices (Spicker, 2013; Fawcett and Plath, 2014). The current cohort of older people in Hong Kong are, on average, less educated than the general population, which may further hinder them from using the CCSV (Census and Statistics Department, 2018). Our findings imply that a person-centred approach should be adopted in the service design and implementation of the voucher programme, with particular attention paid to service availability, service accessibility and service affordability. For example, the government can enhance the service package, increase the number of service units, review the voucher value and co-payment rates, and so on.

To support older people in the exercise of their rights, choices and decisions, an empowering social and institutional context is needed (Thompson and Thompson, 2001). In Hong Kong, the care of older people is still influenced by traditional Confucian views on filial piety (Chow, 2006; Fan, 2007) and, consistent with this, our findings underscored the importance of family support as important assets to empower older people to use the voucher programme (Ahmad, 2011). However, the extent to which family can take up the role in older people's empowerment is still an open question due to structural changes in the family unit, such as changes to the nuclear family and women's increasing professional responsibilities (Ting, 2010). Furthermore, older people may simply just follow their children's decision, and ignore their own preferences and needs in accordance with traditional Chinese family values (Chow, 2006; Wang and Nolan, 2016). All these imply that the development of voucher programmes (and, more generally, LTC services) should adopt a family-centred approach, in other words, considering the strength (or lack thereof) of family factors in service planning. At the policy level, government can encourage family-friendly practices, such as flexible working hours, work-from-home and flexible family leave arrangements to enable family care-givers to take up their roles in caring for their older family members.

To further facilitate older people's choices as well as the family decision-making process, professional support and involvement are shown to be important in the study. A strength-based approach should be adopted to view older people as having

the ability to exercise their own choices. Professionals should change their roles from an authoritative one to that of a partner, a facilitator, an enabler and an advocate (Ruggiano, 2012; Li and Walker, 2017), and a representative, like a case manager, can help (Laragy and Allen, 2015). In fact, a case management model can be recommended for use in conjunction with the consumer direction approach. Case managers are needed to take up the role of planning, facilitation and advocacy of service options for older people, especially for LTC (Reilly *et al.*, 2010; Case Management Society of Australia and New Zealand, 2015).

The recommendation is to initiate a standardised, individualised case management model and include the same in the formal design of the CCSV programme. No such standardised case management model is being practised in Hong Kong at this time (Elderly Commission, 2017). Case managers can combine different forms of support, compensating for cases where the older person has no support from family or social network. The research points to the crucial role played by professionals in the implementation of the CCSV. These findings are consistent with previous literature on policy and 'street-level bureaucrats' (Lipsky, 1993). There is always an inherent ambiguity in policy at a state or municipal level (Brugnach and Ingram, 2012), which means that considerable discretion may lie in the hands of the workers who not only implement the policy but interpret and translate it to practice as well.

The relatively small-scale nature of this study must be acknowledged as a limitation. The participants in this study cannot represent the views of all professionals regarding the CCSV, and the findings cannot strictly be generalised to a broader population. However, this study provides new insights on some of the barriers hindering effective use of the voucher programme in Hong Kong. Although the experiences of older people were not discussed in this article, their perspectives as well as those of family care-givers were included in another larger study (Kan and Chui, 2021), and the professionals' perspectives studied herein complement those from previous work.

Conclusion

The findings of this study identify various barriers hindering effective utilisation of the voucher programme for community-based aged care in Hong Kong, as gleaned from interviews with professionals. This study has provided evidence that choice and decision-making around the CCSV is a complex process in which different factors or elements at different levels (personal, social and institutional) are required to facilitate older people's use of the voucher-based services. Lack of self-awareness of service needs, low education levels, poor health condition and lack of financial resources of older people hinder them from making sound decisions in using the CCSV. Social support networks are essential to effective voucher utilisation, and family support and involvement should be strengthened. This study has also underscored the importance of institutional factors, such as professional support, service availability and service accessibility. Finally, findings reinforce the need to develop a comprehensive case management model for community-based aged care in Hong Kong, and highlight the need to increase people's understanding of the voucher programme.

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