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An evaluation of community care services for the elderly in Hong Kong

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Abstract

Purpose – This article analyses community care services (CCS) in terms of availability, awareness, accessibility, and acceptance (the Four A's approach), untangles the deep-seated factors underlying the CCS and provides some short-term, medium-term, and long-term recommendations.

Design/methodology/approach – A literature review was conducted, including relevant government reports, consultation papers, Legislative Council papers and articles from academic journals from 1980 to the present.

Findings – The Four A's approach shows that applicants to both centre-based services and home-based services endure lengthy waiting times because of the limited number of CCS. Furthermore, the awareness of day respite services is approximately 50 percent, which lags behind other CCS. Accessibility is contingent on a cross-district day respite service system and a lack of consistency between the quota and the proportion of older adults in the districts. Finally, the level of service provided by CCS is unsatisfactory due to inflexible service provision. Reviewing the brief history of long-term care services (LTC) reveals the deep-seated factors at the core of their heavy reliance on the subvention model, in contrast to the adoption of the 'mixed economy of care' by residential care services (RCS). An imbalance in budget allocation to RCS and CCS is also revealed.

Originality/value – Although the principle of 'ageing in place' was introduced in 1977, the institutionalisation rate (6.8 percent) of older adults remains unexpectedly high in Hong Kong, even surpassing its Asian counterparts, whereas the usage rate of CCS hovers around 0.8 percent. Thus, how to implement policy concerning LTC services for older adults must be re-evaluated.

Keywords Community care services, Ageing, Four A's approach, Publicly funded model, Unbalanced budget allocation

Paper type Research paper

Introduction

Evidence confirms that Hong Kong has already entered the era of an ageing society. First, males enjoyed an incremental increase in life expectancy at birth from 72.3 in 1981 and 78.4 in 2001 to 82.2 in 2020, while the corresponding increase for females was from 78.5 in 1981 and 84.6 in 2001 to 88.1 in 2020 (C&SD, 2012; 2020a). Another piece of persuasive information concerning the ageing society pertains to the large proportion of people aged 65 or older (18 percent) in 2019, which is projected to elevate to 36 percent in 2049 (C&SD, 2020b).

The immediate consequences of the long life expectancy are the projected increase in the old-age dependency ratio from 265 in 2019 to 653 in 2049 (C&SD, 2020b) and the projected decrease in the labour force participation rate from 59.2 percent in 2016 to 49.6 percent in 2066 (C&SD, 2017). These factors will put tremendous pressure on the Hong Kong Special Administrative Region (HKSAR) government not only to ease the demands on healthcare, housing, social security, and elderly services but also to promote active ageing, which refers to "the process of optimizing opportunities for health, participation, and security in order to enhance quality of life as people age" (World Health Organization, 2002).

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One of the key engines of active ageing resorts to the long-term care services (LTC) (i.e., community care services (CCS) and residential care services (RCS)). The principles of LTC in Hong Kong entail 'ageing in place as the core', 'institutional care as the backup' and the 'continuum of care'. Ageing in place refers to the encouragement of the elderly to stay at home to prevent unnecessary or misplaced institutionalisation (Audit Commission, 2014). Institutional care refers to that the elderly depend on institutionalisation as a last resort and the continuum of care encourages the elders to stay at the same residential care home for the elderly (RCHE) even when their health deteriorates. The Social Welfare Department (SWD) is introducing various long-term community care services (CCS) as discussed in the following section. Subsequently, the current CCS are evaluated, and the paper concludes with some recommendations.

Literature review

Different scholars have endeavoured to investigate the LTC in Hong Kong revolving around five major themes: a) a historical account of the development of LTC in Hong Kong from 1970s onwards (Chan and Philipps, 2002); b) the problems faced by LTC in compromising ageing in place (e.g., structural constrains as exemplified by an unbalanced budget allocation to subsidised RCS over CCS (Chui, 2011), a lack of alternative funding mode apart from subsidised CCS (Leung, 2001) and a lack of LTC insurance coverage (Chi, 2001), operational constraints as illustrated by poor service coordination (Chi, 2001; Leung, 2001) and no quality control over services (Chi, 2001; Leung, 2001), cultural constraints as exemplified by declining filial virtues (Chui, 2008; Fong and Law, 2017) and a change in family structure and support (Leung, 2001); c) an exploration of the alternative arrangements to the current LTC (e.g., a proposal of voucher system on LTC in Hong Kong by putting against four preconditions of a sustainable care system (Chou *et al.*, 2005) and an introduction of an accreditation system for LTC by taking reference of models from Australia and Canada (Ng *et al.*, 2017); d) the projections on financial sustainability of LTC (Yuen, 2014) and e) how LTC (i.e., RCS and CCS) respond to the threats emanating from COVID-19 (Lum *et al.*, 2020).

While the previous research focused on the structural perspectives to analyse CCS (Chan and Philipps, 2002; Chi, 2001; Chou *et al.*, 2005; Chui, 2008; Fong and Law, 2017; Leung, 2001), this study will conduct an evaluation research of CCS based on the perspective of target participants (i.e., elders). A stepwise evaluation research consists of five steps, including needs assessment, programme theory and design, programme implementation, programme outcomes, and programme efficiency. The current study focuses on the first stage by examining elders' needs assessment of the CCS with the Four A's approach (i.e., availability, accessibility, awareness and acceptance).

Synopsis of CCS

Community care and support services can be classified as centre-based services and home-based services. The former category includes District Elderly Community Centres (DECCs), Support Teams for the Elderly (STE), Neighbourhood Elderly Centres (NECs), Social Centres for the Elderly (S/E) and Day Care Centres/Units for the Elderly (DEs/DCUs). Home-based care services include Enhanced Home and Community Care Services (EHCCS), Integrated Home Care Services (IHCS) and Home Help Service (HHS).

Centre-based services

DECCs (at the district level) and NECs (at the neighbourhood level) provide health education, counselling services, educational and developmental activities, provision of information on community resources and referral services, volunteer development, carer support services,

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educational and supportive programmes on dementia, reaching out and networking, meal and laundry services, drop-in service and social and recreational activities. The S/Es offer social and recreational activities for the elders by helping them make constructive use of their leisure time, build social networks and participate in community affairs. Both DECCs and NECs operate from 9 am to 5 pm from Mondays to Saturdays by charging the elders annual membership fee.

The elders aged 60 or more who are frail or suffering from moderate or severe levels of impairment and who are not receiving any residential care, elderly people with low self-care abilities and no daytime family care usually attend D/Es or DCUs full time (4 days or more per week). Those elders with higher self-care abilities or partial family daytime care usually attend D/Es or DCUs part time (fewer than 4 days per week). In addition, a respite care service, which is a temporary day care service from 8 am to 6 pm from Mondays to Saturdays, is available for frail people aged 60 or more to give temporary relief to the carers; this service is provided by D/Es and DCUs at a charge of HK$41.5 per day.

Home-based services

As an alternative to centre-based services, the services provided by EHCCS and IHCS cover care management, basic and special nursing care, personal care, rehabilitation exercises, day care services, carer support services, day respite services, counselling services, 24-hour emergency support, environmental risk assessment, home modifications, cooking and meal delivery services, transportation and attendant services. Eligibility criteria for EHCCS and IHCS differ: EHCCS caters to the nursing and caring needs for elderly people aged 65 or over suffering from moderate or severe impairment, whereas IHCS caters to a broader group, targeting both frail cases (frail elders aged 60 or more suffering from moderate or severe impairment) and ordinary cases (elders aged 60 or more with mild or no impairment).

Evaluation of CCS: the Four A's approach

The Four A's approach is a useful tool for conducting needs assessment and evaluating social policy effectiveness, which was first introduced as "Seven A's" approach by Krout (1986, 1994) and Williams *et al.* (1991). These "Seven A's" identify availability, accessibility, awareness, acceptability, affordability, appropriateness, and adequacy as the key elements of an effective social policy. Hence, the Seven A's approach represents an analytical framework to evaluate community-based services provided to the elders in the United States (Krout, 1986, 1994), in-home services for elders in rural America (Williams *et al.*, 1991), and community resource needs among the elders (Truglio-Londrigan and Gallagher, 2003).

Royse *et al.* (2016) further highlighted four out of seven key elements that cover awareness (whether those who would benefit from a service are aware of the service), availability (the number of services provided), accessibility (whether a service is convenient to reach and any transportation cost involved in reaching the service) and acceptance (the satisfaction level with a service) for evaluating the needs assessment of a social policy. Therefore, with focus on the four key factors, the Four A's approach will be adopted in this paper as an evaluation tool for evaluating the CCS in Hong Kong.

Availability

The typical waiting period (on the Central Waiting List) for home care services, including EHCCS and IHCS (frail cases), increased from 2.5 to 6 months between 2010 and 2021, with the peak hovering between 11 and 20 months from 2017 to 2020, as Figure 1 shows. Similarly, the typical waiting period for centre-based services increased from 6.8 months to 13 months between 2010 and 2020 although it has shortened to 7 months in 2021. The long waiting period for CCS can be attributed to the demand which is outweighing the supply. Figure 2

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clearly shows that the rate of increase in subsidised places for CCS (117 percent) is incompatible with that of waitlisted cases (356 percent) over the 10 years between 2010 and 2020.

Given the limited capacity, another pressing concern is service overlap. A close examination of EHCCS and IHCS reveals the similarities in realms of coverage, target users and services provided (Audit Commission, 2014). Both schemes provide care management, basic and special nursing care, personal care, rehabilitation exercises, day respite services and carer support, and both schemes serve elderly people across 18 districts in Hong Kong assessed to be moderately or severely impaired (Audit Commission, 2014). The overlap between EHCCS and IHCS gives rise to the question of whether the already limited resources have been too widely distributed (Audit Commission, 2014). It is plausible that integrating limited resources would be a more efficient way of accommodating the growing needs of the

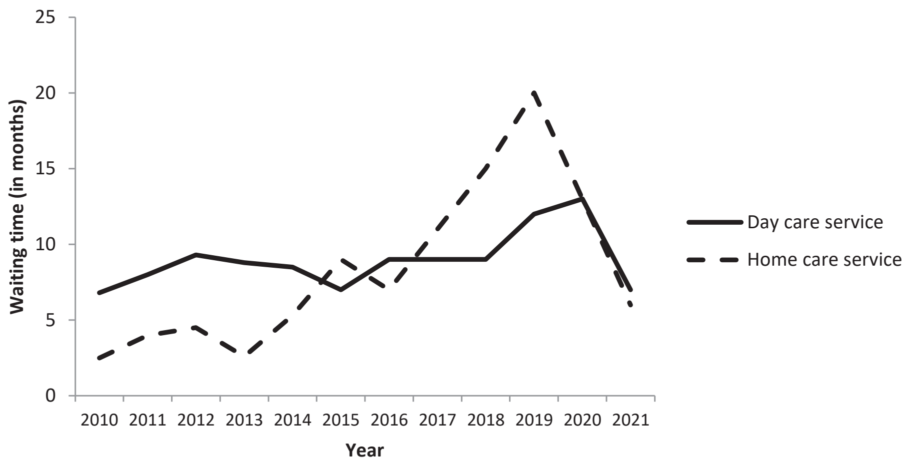

Figure 1. Waiting time (in months) of community care service, 2010-2021
Sources: Audit Commission Hong Kong (2014), Social Welfare Department (2021d) and HKSARG (2019)

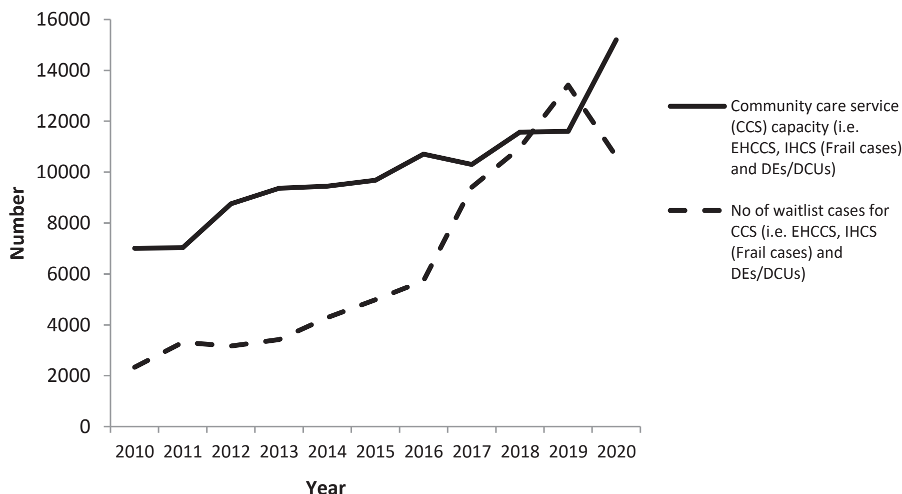

Figure 2. Demand and supply of community care service, 2010-2020
Sources: Audit Commission Hong Kong (2014), Social Welfare Department (2021f), Social Welfare Department (2021g)

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elderly (Audit Commission, 2014). Given that both schemes have been operating for over 17 years, it is perhaps the right time to consider adopting a more pragmatic strategy by integrating duplicate services (Audit Commission, 2014).

Awareness

Carers' awareness of the services is different across different services. Whereas 76.3 percent of carers were aware of IHCS, only 53.2 percent of carers were aware of respite care services and 20.5 percent of carers did not know how to apply for respite services (Society for Community Organization, 2017).

Differences in awareness can be attributed to two factors, namely the availability of channels through which to learn about services and the scope of the Standardised Care Need Assessment Mechanism for Elderly Services (SCNAMES). The SCNAMES is a mechanism implemented by the SWD since 2000 to provide assessment and registration for subsidised LTC services (i.e., CCS and RCS).

The elders usually participate in activities in DECCs or NECs, which may bring opportunities for them to approach the IHCS or EHCCS provided by DECCs or NECs (SWD, 2021a). Furthermore, when elderly individuals are hospitalised for any reason, medical social workers will refer them to home care services after they are discharged to meet their needs during their recovery. This increases the chances of elderly individuals and/or their carers learning about home/community care services.

In contrast, respite care service requires self-arrangement. Elderly individuals in need and/or their carers have to contact the service provider to submit an application. Moreover, the service providers are not DECCs or NECs, but DEs/DCUs (SWD, 2021b). DEs/DCUs are not open facilities. Carers are generally unlikely to encounter these units in their daily lives or to be familiar with the services they provide.

When seeking elderly services, the elderly/their carers first have to take the SCNAMES conducted by the SWD before applying, to assess which types of services are suitable for them (SWD, 2021c). The subsidised CCS covered by the SCNAMES include IHCS (Frail Cases), EHCCS and DEs/DCUs. As EHCCS and IHCS (Frial Cases) are covered by the assessment, applicants are likely to be more aware of these services when seeking assistance. In contrast, day respite services are not covered by the SCNAMES, so applicants are likely to be less exposed to and thus less aware of these services.

Accessibility

In general, the accessibility of CCS depends on strict requirements set by the SWD. To determine the care needs of elderly individuals, the comprehensive assessments under the SCNAMES are conducted by accredited assessors (i.e., social workers, nurses, occupational therapists and physiotherapists) according to the physical functioning, abilities in activities of daily living, social support and living environment of the elders by putting against the assessment tool, interRAI-Home Care (SWD, 2021c). Of the applicants who apply for CCS, only elderly individuals who are assessed as having moderate or severe physical impairments are eligible to access such services while their counterparts who are assessed as having no impairment or mild impairment are not eligible for any subsidised CCS. This results in a low CCS utilisation rate in Hong Kong. For example, only 14.8 percent of the carers used EHCCS, and only 6.3 percent of the carers used the Day Care Centre Service (Society for Community Organization, 2017).

Apart from the strict requirements, accessibility also differs across various on-site support services and respite care services. On-site support services are handled by the Support Teams for the Elderly associated with the DECCs. According to the SWD's 2021 figures, Hong Kong has 41 DECCs distributed across 18 districts, each with one Support

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Team for the Elderly. On average, each district has at least two teams. Those in need can apply for services at the DECC in their area of residence. This shows that the coverage of on-site support services is broad and easy to reach. Therefore, its accessibility is high.

However, respite care services adopt a non-regional division model to provide services (The Hong Kong Council of Social Service, 2018). Despite there being 90 units providing services in Hong Kong (SWD, 2021d), the services available for appointment may not be in the same community as the service users. The cross-district system is further complicated by the number of spots available for day respite services. According to the latest Vacancy Position number of Day Respite Services for Elderly Persons (as of September 2021) (SWD, 2021e), only 47 out of 90 respite service units can be reserved, and there are only 78 vacancies in total. This greatly increases the difficulty for carers to find services. Therefore, accessibility of day respite service is low due to location and vacancy issues.

The allocation of services is also disproportionate to the ratio of elderly people across the different districts. Despite Kwun Tong (9.6 percent), Shatin (9 percent) and Yuen Long districts (8 percent) having the largest proportions of elderly citizens to Hong Kong's total elderly population out of the 18 districts in Hong Kong (C&SD, 2018), the percentages of the total day respite services allocated to them were 17 percent, 12 percent and 6 percent, respectively. The percentage of the total day respite services allocated to Yuen Long is even the same as that of the Central and Western District (6 percent), which only had 3.3 percent of total elderly population in Hong Kong (C&SD, 2018; SWD, 2021e). Furthermore, the percentages of actual vacancies in those three districts were 36 percent, 16 percent and 38 percent respectively (SWD, 2021e). This greatly increases the difficulty for carers to find services.

Acceptance

Acceptance varies across different CCS. In the survey conducted by Sau Po Centre on Ageing (2011), 10.8 percent of subsidised CCS users suggested increasing service hours and flexibility of services. Currently, meal delivery services under EHCCS are not provided on Sundays and public holidays (Elderly Rights League H.K. and Society for Community Organization, 2012). To accommodate staff members' commuting time, lunch and dinner are delivered at 11:00 am and 4:30 pm, which may not align with the normal living habits of all elderly service users (ERL, 2012). The household cleaning and rehabilitation services under the programme also performed poorly. Cleaning staff usually visit older adults only once per month for 1 hour each visit, while physical therapists may only visit them once every 6 months (ERL, 2012).

In stark contrast, 100 percent of the caregivers were satisfied with the day respite services and only 6.1 percent of the interviewees were worried about the service cost (Society for Community Organization, 2017). In this regard, acceptability is quite high and the service fee is not a burden for carers.

Discussion

The aforesaid Four A's approach shows that applicants to both centre-based services and home-based services perceive availability, awareness, accessibility, and acceptance as unsatisfactory. It represents an initial attempt to evaluate the needs assessment of CCS from the perspective of target participants. It adds new knowledge to existing literature, which identified the structural barriers and operational constraints based on the organisational perspectives.

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Overview of long-term care policy: deep-seated causes of the lagged development of CCS

Until the 1970s, economic development was prioritised over welfare programmes, which mainly arose as by-products of economic development and the remedial and reactive actions of departments (Chan and Phillips, 2002). In other words, there was no specific LTC policy to address the ageing population. In response to the increase in the population aged 65 or above from 4.5 percent in 1971 to 5.5 percent in 1976 (C&SD, 1997), the government issued the first White Paper on ageing and services and the Programme Plan on elderly services in 1973 and 1976, respectively. Although these early initiatives highlighted the shortcomings of the services provided to this high-risk group and acknowledged the need for coordination among government departments, they both succumbed to unfavourable economic conditions (Chan and Phillips, 2002). In 1977, the needs identified by professionals were recognised via the issuance of the Green Paper on Services for the Elderly, which upheld the principles of ageing in place (Chan and Phillips, 2002). Ageing in place is defined as allowing the elderly to live in a familiar place for as long as they wish (Fisk, 1986; Pastalen, 1990), which aligns with the five major principles (i.e., independence, participation, care, dignity and self-fulfilment) of social policy for older adults identified by the United Nations Principles for Older Persons (United Nations, 2008). Subsequent adherence to the principles of ageing in place was addressed in the 1980 White Paper on Social Welfare and the 1991 White Paper - Social Welfare into the 1990s and Beyond (Social Welfare Department, 1980; The University of Hong Kong, 2009). Hong Kong's first Chief Executive, Tung Chee-hwa, set care for the elderly as a strategic policy objective in 1997 (Audit Commission, 2014). Ageing in place and the continuum of care were adopted as two guiding principles to promote a sense of security, a sense of belonging and a sense of health and worthiness among the elderly (Tung, 2000).

Ageing in place is, however, constrained by both structural and cultural barriers. The structural barriers consist of the funding mode of LTC (Chan and Phillips, 2002; Chou *et al.*, 2005; Chui, 2011) and the imbalanced budget allocation to RCS and CCS (Hong Kong Policy Research Institute and Hong Kong Vision, 2017; Sau Po Centre on Ageing, 2011). The cultural barriers are caused by the decline in the traditional Chinese values of filial piety (Chui, 2008; Leung, 2001).

Structural barriers

First, inherited from the British model, the financing mode of LTC services before 1999 was predominantly based on the subvention model supported by tax revenue, in which subventions were provided to nongovernmental organisations for service provision (Chan and Phillips, 2002). The SWD played a statutory role in ensuring services providers in accordance with service quality standards and funding and service agreements. After 1999, the predominant subvention model transformed into a mixed model of public, private and voluntary providers (i.e., a mixed economy of care; Walker *et al.*, 1998), as the SWD contracted out home help and home care services (1999), introduced competitive bidding among contractors to run contract homes (2001) and allowed nongovernmental organisations to run self-financed homes by charging higher fees without seeking government funding (Chan and Philipps, 2002; Chui, 2011). Salient differences, however, can still be identified between RCS and CCS. Due to the unique history of residential care homes, private residential homes became alternatives in coping with the escalating ageing population and prolonged bureaucratic procedures in the 1980s (Lam, 2022).

In contrast, the private market of CCS is relatively underdeveloped, constrained by its labour-intensive nature. High-touch services (Wilber *et al.*, 1997) appear unattractive and unprofitable to private service providers, resulting in a reliance on government support for nongovernmental organisations in providing CCS (Chi, 2011). As solely relying on the public

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sector restricts service providers' options, introducing a voucher system that advocates consumer-oriented LTC should be considered (Chou *et al.*, 2005; Leung, 2001). Hence, in 2013 the Pilot Scheme on Community Care Service Voucher for the Elderly, based on the 'money-follows-the-user' approach, and the co-payment scheme, based on a sliding scale of users' ability to pay, were introduced. The pilot scheme has attracted more service providers, the number rising from 62 in 2013 to 227 in 2020, with one third of the new entrants coming from the private sector (Legislative Council Secretariat, 2021).

Moreover, an over-reliance on the public market is further compromised by an unbalanced budget allocation to RCS and CCS. Figure 3 presents the recurrent expenditure on the provision of subsidised RCS and CCS from 2004 to 2020. It shows that from 2003 to 2015 the recurrent expenditure on subsidised RCS was on average 3.35 times greater than that on CCS (Figure 3), and the capacity of subsidised RCS was on average 3 times greater than that of CCS (Figure 4). Although the recurrent expenditure of CCS in 2020 was triple that in 2014, the recurrent expenditure of RCS remained 1.8 times that of CCS (Figure 3). The budget imbalance runs in tandem with the service imbalance between RCS and CCS (Elderly Commission, 2017). From 2013 to 2015, approximately 65 percent of the new applications were for CCS, whereas only 35 percent were assessed as having care needs that could only be met by RCS. However, over 95 percent of the applicants applied for subsidised RCS because of the dual option of CCS and RCS (Elderly Commission, 2017).

The imbalance is intricately intertwined with the non-means-tested mechanism (universal rather than targeted) and nuances in the subsidised modes of RCS and CCS, supplemented with the social insurance system (Chui, 2011). A Standard Care Need Assessment Mechanism was established in 2000 as a centralised screening mechanism to determine the care needs of elderly individuals according to their impairment levels, rather than a means-tested or needs-related mechanism (Legislative Council Secretariat, 2021; Leung, 2001). In 2021, RCHE-subsidised places accounted for 40 percent of residential homes, including 27 percent subvented homes (i.e., nursing homes and care and attention homes), self-financed homes, and contract homes, and 13 percent Enhanced Bought Place Scheme (EBPS) homes. The remaining 60 percent of residential care homes were private. However, the government still indirectly subsidises private homes (i.e., it subsidises older adults to live in private homes via

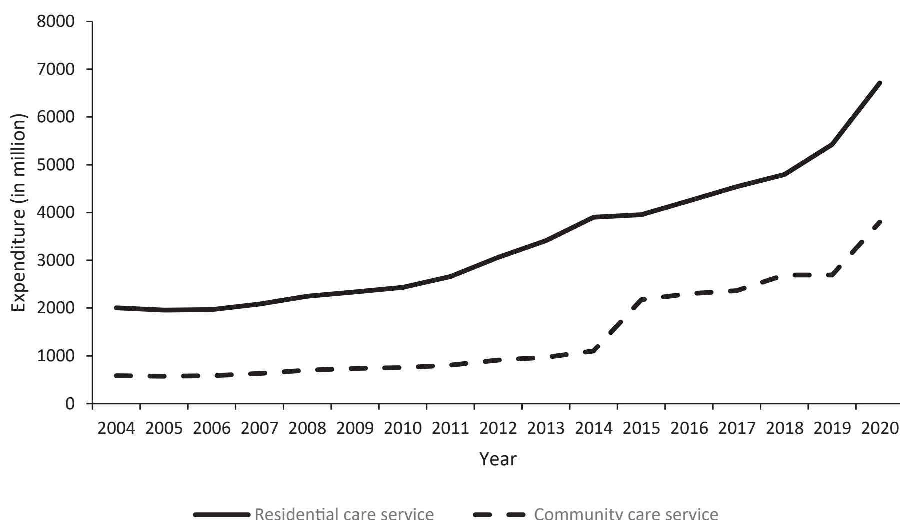

Figure 3. Recurrent expenditure on subsidised community care services and residential care services, 2004-2020

Sources: Audit Commission Hong Kong (2014), Legislative Council Secretariat (2019) and Sau Po Centre on Ageing (2011)

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Comprehensive Social Security Assistance (CSSA) once they pass the income and assets tests; Elderly Commission, 2011). Figure 5 presents the ratio of CSSA recipients living in private homes to the total number of subsidised places, which hovered around 50 percent from 2008 to 2017.

In contrast, CCS are publicly financed, with the government subsidising 90 percent and 96 percent of the unit cost of centre-based and home-based CCS, respectively (Legislative Council Secretariat, 2021). As CCS and RCS are complementary, it is not surprising that the institutionalisation rate was as high as 6.8 percent in 2008, surpassing that in Asian counterparts, such as Japan (2.9 percent), Singapore (2.9 percent), Taiwan (1.9 percent) and China (1.7 percent), whereas the utilisation rate of CCS accounted for only 0.8 percent in Hong Kong in 2010, lagging behind Japan (5.5 percent), Taiwan (1 percent) and China (i.e., Shenzhen: 19 percent) (Hong Kong Policy Research Institute and Hong Kong Vision, 2017). The high

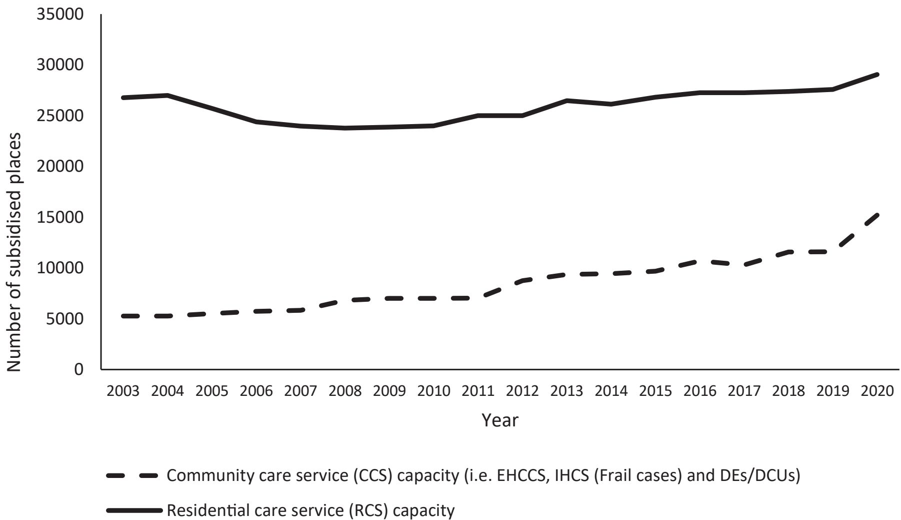

Figure 4.
Capacity on subsidised community care services and residential care services, 2003-2020
Sources: Audit Commission Hong Kong (2014), Sau Po Centre on Ageing (2011), Social Welfare Department (2021f), Social Welfare Department (2021g)

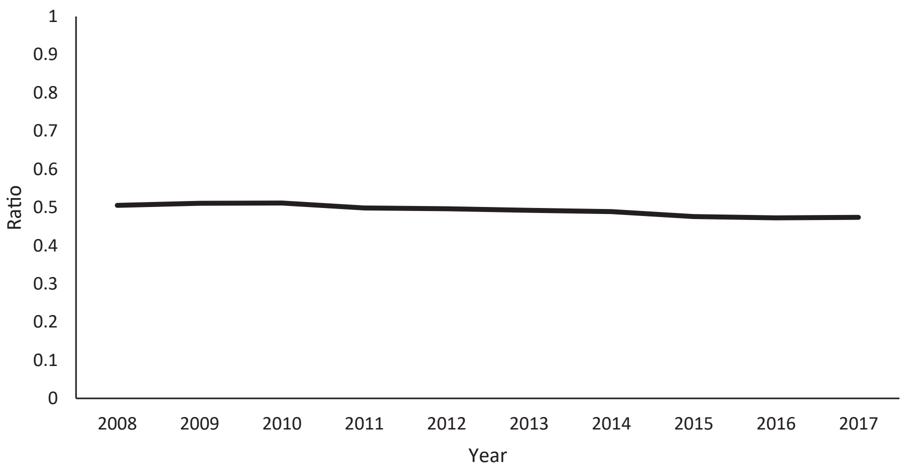

Figure 5.
Proportion of CSSA cases to total number of subsidised residential care service places, 2008-2017
Sources: Calculated from Audit Commission Hong Kong (2014), Sau Po Centre on Ageing (2011) and HKSARG (2018)

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institutionalisation rate is caused by several factors, including the decreasing co-residence rate between parents and adult children, the declining family size and flat size, the lack of transitional support after discharge from hospital and the sudden deterioration of the health status of older adults (Elderly Commission, 2009). However, underdeveloped CCS are considered to be the main cause of the high institutionalisation rate in Hong Kong (Leung, 2001). This drives a vicious cycle that violates the ageing in place principles that have been upheld since 1977. Despite the high rate of institutionalisation and underuse of CCS, 96.4 percent of elderly respondents to an official survey stated a preference not to move to a residential care home and 81.4 percent stated that they would rather remain at home even if their health worsened (C&SD, 2009). This is in accordance with the normative belief that the Chinese prefer to age in a familiar environment, with the support of their family, friends and neighbours.

Conclusion and recommendations

Underdeveloped CCS are hindered by a shortage of subsidised CCS places coupled with long waiting times of 10 months and 5 months for day care and home care services, respectively, in 2021 (Legislative Council Secretariat, 2021). The shortage has become acute, with the Elderly Commission (2017) predicting a shortage of 18,000 CCS places in 2026. The shortage is attributed to structural factors, including a publicly financed model and prioritising of the budget allocation to RCS over CCS. Enormous financial pressure puts fiscal sustainability at stake, which will result in a structural financial deficit in 2029–30 as predicted by the Working Group on Long-Term Fiscal Planning (Elderly Commission, 2017); currently, the intended objective of ageing in place cannot be achieved. The priority assigned to RCS drives a vicious cycle characterised by a shortage of CCS places, thus causing a failure to uphold ageing in place.

Since the ageing in place is compromised by the aforementioned structural barriers, CCS reform over the short, medium and long terms is urgently needed. The short-term reform should involve refining existing services, including service integration between IHCS and EHCCS, an expansion of service coverage from moderate and severe levels of impairment to mild levels of impairment. The government made the initial attempt to introduce a pilot scheme of CCS in December 2017 by extending coverage to low-income elderly persons with mild impairment waiting for IHCS (Legislative Council Secretariat, 2021). Moreover, a district-based preregistration system for respite services can be established by assigning quotas according to the proportion of elderly individuals in each district (Elderly Commission, 2017). However, refining the existing services would not suffice, as the effectiveness of CCS hinges on awareness of CCS. The Four A's approach shows that awareness of respite services is generally low among the elderly and their carers. Hence, CCS promotion should be strengthened, including the hosting of CCS promotions in DECCs and NECs, social workers sharing relevant information in hospitals or the inclusion of respite services in the SCNAMES. Emphasis should be placed on the advantages of CCS, including the enhancement of the physical and cognitive status of elderly users, the prevention of unnecessary institutionalisation and the relief of physical and mental pressure among carers.

This should be supplemented by a diversified finance system in the medium term to encourage shared responsibility among the government, individuals, nongovernmental organisations and private sectors to finance LTC (Elderly Commission, 2017). Concrete measures could include co-payment schemes, self-financed CCS offered by nongovernmental organisations and CCS offered by the private sector (Elderly Commission, 2017). The Pilot Scheme on CCSV offers a good example of a co-payment scheme between the government and the elderly population. It not only empowers the

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elderly and/or their carers (Benjamin and Matthias, 2000) but also represents an alternative financing mode and encourages public–private partnership. Attention should be paid to how to attract CCSV holders to use the vouchers by refining existing service packages.

Moreover, the effectiveness of the voucher system hinges on the availability of healthcare workers and the quality assurance system (Sau Po Centre on Ageing, 2011). The voucher system is susceptible to polarisation of service providers into 'very good' and 'very bad' (Chou, Chow and Chi, 2005). Furthermore, lessons should be learned from RCS in terms of disparate quality between subvented, self-financed and private homes for elderly people (Wong, 1995). Establishing a licensing system for CCS may prove difficult, as the spectrum of services is too wide (Sau Po Centre on Ageing, 2011). Rather, drawing on examples from Germany and Japan, a transparent and clear accreditation system covering service performance standards, independent party audits and a transparent complaint system can be set (Legislative Council Secretariat, 2021; Sau Po Centre on Ageing, 2011). Rewards can be given to private providers if they exceed the minimum performance threshold, but they may be asked to exit the market if they underperform, aligning with one of the preconditions of vouchers stated by Chou, Chow and Chi (2005).

The key precondition of public–private partnership is an incentive for the private sector to enter this unattractive market to provide high-touch services. Initial attempts could rely on non-subsidised places to offer subsidised services, such as utilising existing nonsubsidised places in the EBPS, contract homes, self-financed homes and subvented homes to provide respite and emergency placement services (Elderly Commission, 2017). However, incentives such as tax deductions should be given to the private sector.

Long-term measures should revolve around cultivating a positive elder care culture among carers, among the elderly and across generations. Subsidies, leave and flexible working hours can be provided to carers as incentives for taking care of the elderly, but the level of subsidy should not exceed their income, as excessive subsidies may discourage carers from working and thus negatively affect the labour market (Hong Kong Policy Research Institute and Hong Kong Vision, 2017; Sau Po Centre on Ageing, 2011).

In the long run, an alternative financing mode, such as an LTC insurance system, should also be considered to enhance financial sustainability (Elderly Commission, 2017). Cross-regional comparisons reveal an interconnectedness across the LTC insurance system, the health system, the pension system and the tax rate of regions (The University of Hong Kong, 2009). Whether social or private insurance is introduced depends on three preconditions (The University of Hong Kong, 2009).

First, a mechanism of co-payment between individuals, employers and employees would help prevent abuse of LTC insurance. Second, the assessment of service need should be objective and impartial. Examples from Japan demonstrate that reassessment is sometimes requested by family members or elderly individuals to decrease the contributory payment (The University of Hong Kong, 2009). Third, the problem of 'budgetary flight', referring to the tendency for insurance companies/agents to avoid users providing the costliest service, should be circumvented.

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