COUNTRY PROFILE

Care of the older Hong Kong Chinese population

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Introduction

The Chinese population of Hong Kong is relatively young in terms of the proportion older than 65 years (9% in Hong Kong [1] compared with 18% in Sweden, 16% in the UK, 13% in the USA and 11.2% in Australia). However, at 76 years for men and 82 years for women, life expectancy is one of the highest in the world [2]. The absolute number of those aged 85 years and over will rise from 30,000 in 1995 to 75,000 by 2005 [2]. The approaches the government is taking to the care of this rapidly increasing sector of the population show how measures adopted in other populations may be examined critically and then modified for local use.

Faced with these issues later than many Caucasian populations, we have the advantage of seeing the outcome of different health care policies in other countries before making such choices ourselves. Here we report the burden of chronic disease and disability, modes of service delivery and health care financing, preventive opportunities and methods of monitoring the outcome of care, as well as considering which approaches adopted from Caucasian communities are appropriate and how they may be modified to meet local needs.

Currently the government is responsible for 12% of primary care and over 95% of hospital care, while the rest is provided by the private sector. Long-term institutional care is provided by social services and to a small extent the hospital services, the private sector providing more than half. The government and government-aided services are free for those who cannot pay the nominal charges. In 1991, Hong Kong spent only 3.7% of its gross domestic product on health, compared with 8.6% in Sweden, 6.6% in the UK, 13.4% in the USA and 8.6% in Australia [2]. In 1994, the numbers of doctors per 1000 people were 1.27 in Hong Kong, 2.69 in the USA and 1.58 in the UK, while the corresponding numbers of nurses were 5.55, 7.84 and 5.17 and the numbers of hospital beds per 1000 were 4.59, 4.33 and 4.85 [2].

Disease and disability burden

For those aged 70 years and over, the prevalence of hypertension is 48% [3], the prevalence of ischaemic heart disease is 26% for men and 27% for women [4], the incidence of stroke is around 756 per 100,000 per year [5], the incidence of hip fracture 307 per 100,000 in men and 505 per 100,000 in women [6], the prevalence of dementia is 1.6% [7] and the prevalence of diabetes mellitus is 8% in the 60–64 age group and 17% in the 75+ age group [8].

The diseases constituting the greatest burden are arthritis, hypertension, cardiac disease, peptic ulcer, osteoporotic fractures, diabetes mellitus and chronic obstructive airways disease [5]. The projected numbers affected range from 150,000 to 300,000 for the year 2001. With this information, we can estimate costs and disability burden, expressed as disability years (estimated number with disability x duration of disability). Estimates for those aged 70 years range from around 19,000 (those who cannot feed themselves) to 100,000 (those who cannot climb stairs) [9].

Service delivery

Community support

Hong Kong has a comprehensive range of medical and social services, which were originally based on the UK model. The social services provide old age allowance (not means-tested) and allowances for disability and chronic diseases, as well as comprehensive financial support below a certain level of savings for the unemployed. Community centres provide meals-on-wheels, home help, and help with clinic and hospital attendances for those without relatives. Volunteers visit the housebound and report any problems to the social services. The social welfare department also runs residential homes for elderly
people who are functionally independent and those who require <2 h of nursing care per week.

There is great emphasis on the provision of community support to enable older people to remain in their homes for as long as possible, thus reducing the demand for institutional care. This view may not be wholly applicable in Hong Kong, since a survey of older peoples' attitudes showed that the factors influencing their decision to live in an old age home are living alone and presence of disability and that few subjects would opt to remain at home with social support (Kwok et al., unpublished data). Perhaps we should provide more nursing homes rather than increase the provision of community support.

Inpatient care

The Hospital Authority is responsible for acute, convalescent/rehabilitation and infirmary beds, specialist outpatients, day hospitals and geriatric and psychogeriatric outreach teams. With inadequate primary care services, geriatricians take on more primary care activities than their UK counterparts. In accident and emergency departments 20% of attendance by people aged 65 years and over is inappropriate. These attendants tend to be younger, physically more independent, illiterate and have less family support [10]. When geriatric medicine was first recognized as a distinct subspecialty, separate wards with age-related admission criteria were created. However, with the rapid ageing of the population and the pressure on acute beds (the ratio varies from 5.8 to 1.8 beds per 1000 of the overall population depending on the region), integrated and needs-related care had to be developed, particularly in newer hospitals, while established units also face pressure to adopt this model.

In some regions with fewer acute beds, where the average duration of stay is 4 days and where there is shortage of nursing staff and cramped ward space, it has been very difficult to develop good acute geriatric care. Systems of screening elderly patients admitted to the medical wards have been set up, with early transfer to a nearby non-acute hospital as soon as the initial acute medical condition has stabilized. The average stay in the latter type of hospital is 21 days and standards of care may now reach those seen in other countries with well-established elderly services.

The screening is performed by trained nurses, similar to nurse practitioners in the UK and USA. Nurse practitioners refer to the geriatric team and to the non-acute or day hospital or social services, give education on diet, drug use, inhaler techniques etc., liaise with relatives or old age home staff on premorbid condition, organize pre discharge planning and support after discharge. A nurse practitioner can screen 60–70% of all acute admissions aged 65 years and over, or approximately 8000 of the 10 000 acute admissions to the medical wards each year. Of those screened, about half require the geriatric team's input.

It is uncertain whether older patients requiring acute inpatient care in separate geriatric wards have better outcomes than those in general medical wards. No data are available in Hong Kong. In the USA, a randomized controlled trial showed that care in a specialized unit resulted in shorter length of stay and less use of nursing homes post-discharge [11]. On the other hand, the provision of geriatric consultation team does not result in better outcomes, probably because the team does not control the care [12]. Our model is a mixture of these, since the patient is initially cared for in integrated wards, and those identified by the geriatric team as likely to benefit from care by the geriatricians are then transferred to designated wards.

The concept of a nurse taking on a screening role has been adopted from the development of gerontological advanced practice nurses in USA, where they play an important role in screening, counselling and directing appropriate use of resources [13, 14].

Day hospitals

There are eight geriatric day hospitals in Hong Kong, where the emphasis is on active treatment rather than maintenance. The average duration of attendance is 8–12 weeks. Day hospitals may cover existing areas of deficiencies in service provision, such as comprehensive outpatient assessment, checking drug usage and compliance, nutritional advice, podiatry and enabling early discharge from hospitals. Day-hospital treatment is cheaper than an equivalent period of inpatient rehabilitation or outpatient therapy [15]. A team approach to the management of elderly stroke patients, allowing treatment in a geriatric day hospital, has been shown to hasten functional recovery and reduce outpatient attendance without costing more than conventional medical management [16]. There is still debate over the usefulness of day hospitals [17], but in Hong Kong there is no doubt that they provide a venue for many services which cannot be provided in any other setting.

In recent years the Hospital Authority has pioneered multidisciplinary outreach teams in geriatrics and psychogeriatrics, as a bridge between community and hospital services and to provide geriatric community care, where such expertise was largely non-existent. These teams assess which types of residential care are suitable, arrange rehabilitation and provide consultation to residential homes. Eight teams support the government-aided homes. There are not enough resources to support the privately run homes, which outnumber the subvented ones. As a result of the development of this service, there has been a fall in attendances at accident and emergency and outpatient departments as well as in acute hospital admissions.
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[18, 19]. Residential home staff now spend less time accompanying residents for consultations.

The provision of long-term residential care is by both the Hospital Authority and the Social Welfare Department, with the former catering for more dependent people. The private sector provides half of the required places, and all levels of dependency are accepted. The most neglected category are those with dementia: there is a reluctance for many organizations to look after such subjects. A prospective study of a random cohort of people aged 70 years and over (mean age 80) documenting the need for institutionalization has revealed that current number of residential places needs to be increased by at least 10% [20]. The quality of care in nursing homes is being examined, and guidelines such as those compiled in the UK by the Royal College of Physicians will be helpful [21]. Examples of models of quality assurance in the USA may also be followed since use of a Minimum Data Set Resident Assessment Instrument and the linking of these documentation to reimbursement improves quality of care in nursing homes [22, 23].

Health care financing

Hong Kong has embarked on health care reforms along the lines of UK and Australia. The never-ending quest for productivity gain may result in capping of services. The public’s expectation of free services is ever-increasing and the latest technological advances are expected to be widely available. The government must decide what it is willing to pay for, rather than promising the best and letting frontline workers carry out rationing and receive the complaints. The positive side is that political mileage can be gained from championing elderly health care issues.

Care of elderly people remains high on the agenda for the government of the new Special Autonomous Region of China. In his policy speech, the Chief Executive increased the old age allowance and announced plans to increase community and outreach care teams. However, expenditure on health and social services are fixed at a certain percentage of the gross domestic product, so that in reality increases in certain areas will probably be accompanied by cuts in funding in other areas. With the recent economic downturn in South East Asia there will be a relative reduction in funding. Ultimately, alternative sources of funding such as insurance schemes or managed care systems will be developed.

Preventive aspects

Both the prevention of disability and chronic diseases are important in minimizing use of health care resources and maintaining quality of life. Maintenance of physical activity and body weight are important in the prevention of mobility decline. A prospective study of diseases associated with functional limitation in Chinese people aged 70 years and over showed that the attributable fraction for severe functional limitation was highest for stroke, dementia and fractures [24]. Measures to reduce the incidence of these diseases will also reduce the disability burden of the population. These include control of blood pressure and diabetes mellitus and use of anti-platelet drugs or anticoagulants. Attempts at population-wide reduction in salt intake (which is higher than in Australia, for example) may reduce the prevalence of hypertension and its consequences [25-28].

Conclusion

Hong Kong has adopted many of the health and social care policies of Western countries and modified them according to local needs. If a central body were responsible for co-ordinating care, determining future policies regarding prevention, community care, hospital and institutional care and monitoring the outcomes, care for elderly people would become more coherent, enabling Hong Kong to face the challenges of a rapidly ageing population.

References

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