

Strategies of Hong Kong's Healthcare System in Aging Population

Angie Ho Yan Lam, The University of Hong Kong, Hong Kong

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Abstract

The aging population creates challenges for the healthcare system in Hong Kong. This paper examines the challenges facing and an acceptable delivery system amid Hong Kong's rapidly ageing population.

Challenges

The elderly population is expected to increase to "one in four" in 2033. The elderly inpatient ratio is expected to be 62% in 2029. Aging people highly rely on the public healthcare service, resulting in long waiting queue in popular healthcare service.

The healthcare system over-emphasizes curative care. Aging people seek primary care for cure rather than health maintenance. Even the government provides Elderly Health vouchers, only people aged 70 or above are eligible. Besides, only 16.1% claimed to use the subsidies in the preventive care.

Strategies

Healthcare policy should emphasise disease prevention and active aging. Primary care with multidisciplinary approach should be implemented to address the holistic care. Integrative Elderly Care Centre should be developed to link up all healthcare providers to promote seamless transfer of elders to different levels of care.

Public-private partnership combines the resources in the public and private sectors. The public sector can purchase from the private sector some elderly healthcare services in high demand, such as dialysis, to shorten the waiting queue.

Elderly Health Care Voucher Scheme should offer to the older people aged 65 or above. Elderly Health Care Voucher Scheme specified on preventive care and health screening could promote the preventive care. Lifelong financial planning and compulsory social health insurance scheme should be implemented to promote the financial sustainability of health systems.

Keywords: healthcare, health system, Hong Kong, aging

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Introduction

Healthcare system in Hong Kong is facing significant challenges, including the public-private imbalance, over-reliance on the public sectors, increasing health expenditure and ineffective governing structure. The aging population will further impose stress on the healthcare system. There is an urgent call for healthcare reform to maintain service quality and a sustainable healthcare system. This article aims to analyze the current healthcare challenges and put forth potential implementation strategies. The suggestions will focus on the reforms of service delivery, leadership and governance, health financing and health informatics.

Challenges facing Hong Kong's healthcare system

Aging population and early onset of chronic illnesses

The demand for healthcare is upsurging because of the aging population and the early onset of chronic diseases. There is a rapid increase of lifestyle related diseases such as hypertension, diabetes and coronary heart disease (Food and Health Bureau, 2008). The HA estimates the demand for the healthcare services in relation to the lifestyle related diseases will constantly increase, further burdening the healthcare system (Hospital Authority, 2012). In addition, the elderly population is expected to increase by over 100% to "one in four" in 2033 (Hong Kong Golden 50, 2012). The hospitalization demand of the elderly has been over six times that of the non-elderly; the elderly inpatient ratio is expected to increase from 42% in 2009 to 62% in 2029 (Hong Kong Golden 50, 2012). The aging population will also boost the demand for healthcare services such as nursing homes and short-stay hospitals (Alemayehu & Warner, 2004). In such circumstances, Hong Kong will see an unprecedented surge in demand for healthcare services in the next 25 years.

Limited primary and integrative care

The current healthcare system over-emphasizes curative care on an episodic basis (Food and Health Bureau, 2008). The public sector provides limited outpatient care while the private sector predominates in primary care. People habitually seek primary care for cure rather than health maintenance. Due to the scarcity of the primary care services, specialist doctors seldom refer patients back to the level of primary care for follow up treatment. Without a gatekeeping system, the patients are allowed to visit practitioners of all healthcare levels. The system encourages doctor shopping behaviors and unnecessary use of specialist and hospital care (Healthcare Policy Forum, 2008).

The system does not emphasize the importance of preventive and holistic care (Food and Health Bureau, 2008). Preventive care requires out-of-pocket payments which discourages individual responsibility in maintaining personal health. People seldom seek preventive care such as health assessment and screening (Food and Health Bureau, 2008). The health promotion and preventive schemes available in the market are disorganized and not recognized by the general public. As there are no channels for liaison with the medical practitioners, the patients can only rely on the medical follow-up appointments for curative healthcare after their discharge (Food and Health Bureau, 2008). The absence of an

organized network has caused the failure to transfer patients between different healthcare levels to achieve better health outcome (Food and Health Bureau, 2008).

Over-reliance on public healthcare sector

There has been an over-reliance on the public sector in respect of secondary and tertiary care (Hospital Authority, 2008). The public healthcare sector provides over 90% of the total in-patient services which are highly subsidized, resulting in significant price differences between the public and private sectors. The price differences have caused excessive stress in the public sector and obstacles in the integration of the two sectors (Hospital Authority, 2008). Patients have to wait over 100 weeks for public healthcare such as cataract surgeries and services of orthopedic and medical outpatient clinics (LegCo Affair, 2014). Mobile canvas beds are set at the corridors in hospitals to meet the increasing demands these years (Food and Health Bureau, 2008).

Ineffective governing

The healthcare services are currently compartmentalized between different levels of care (primary, secondary and tertiary) and between different sectors (private and public sectors) (Healthcare Policy Forum, 2008). As there is no formal communication networking between the two sectors, the compartmentalization results in duplicated services and discontinuity of care (Healthcare Policy Forum, 2008). In addition, the vision of both the DH and the HA are vague and broad which cannot reflect their values. Both authorities also failed to identify their core competencies and strategic directions, resulting in disorganized development of healthcare beyond their capacity. Furthermore, the private sector is not effectively regulated in the system, as reflected by non-standardized consultation fees, varied standards of care and recurrent medical blunders (Healthcare Policy Forum, 2008). The managerial positions of the healthcare entities are taken by medical professionals, which may cause exacerbation of the medical dominance and over-protection to the medical professionals. Professional bodies responsible for regulating professionals' conduct tend to protect their reputation (Yau, 2014). Medical blunders are usually handled non-transparently and unfairly (Healthcare Policy Forum, 2008).

Unsustainable healthcare expenditure

The public sector's healthcare system is mainly financed by general tax revenue and the private sector by out-of-pocket payments. While Hong Kong's health expenditure to GDP ratio (5.5%) is low compared with some other countries such as South Korea (7.8%), Finland (9.4%) and Germany (11.3%), Hong Kong's total health expenditure increased at an average annual rate of 5.8% in the last decade, higher than the corresponding growth of GDP (4.0%) (Hong Kong's Domestic Health Accounts, 2012).

At present, Hong Kong's public health expenditure relies on a narrow tax based financing system. The government allocates block grants for public health expenditures on a yearly basis. In the public sector, patients are highly subsidized in most of healthcare services under the 'patients follow money' principle. This practice encourages abuse of public healthcare resources. Some of the service providers in the public sector would even manipulate their workload with a view to getting extra resources from the government. Due to lack of financial incentives, the current system actually discourages efficiency and

high performance (Healthcare Policy Forum, 2008). Public health expenditure rose by over 2.8 times during last decade (Food and Health Bureau, 2008).

Out-of-pocket payment accounts for a large proportion of the finance of the private health expenditure. Low income groups avoid accessing private primary care due to financial difficulties. Statistics show that the low income groups tend to utilize inpatient and specialist care (Health Policy Forum, 2008). The health financing system fails to achieve an equitable access to primary health services and leads to inferior health choices and outcomes for the low income groups (Health policy forum, 2008).

In the future, health expenditure is expected to surge in consideration of the increase in the aged population and the prevalence of chronic diseases (Alemayehu & Warner, 2004). The health expenditure on the elderly (aged 65 or above) is five times that on people in their early teens (Alemayehu & Warner, 2004). Healthcare costs continue to rise also because of the costly new technologies, new drugs and devices, healthcare goods, increasing administrative costs and physician fees (Food and Health Bureau, 2008). The total health expenditure to GDP ratio and the public health expenditure to GDP ratio are expected to rise to 9.2% and 5.5% respectively in year 2033. With the number of taxpayers in the aged population reducing, the existing health financing system will not be sustainable (Food and Health Bureau, 2008).

Strategies and implementation plans

New philosophy

The present health care policies emphasize the government's responsibility in providing medical treatment but overlook the individual responsibility in health maintenance. Under the philosophy of the authorities, medical treatment means entire healthcare. It is time to promote individuals' responsibility in the healthcare system. Harvard Proposal put forth a new philosophy that every resident should have access to affordable healthcare of reasonable quality; and the responsibility should be shared by both the government and residents (Liu, E., & Yue, S. Y., 1999). Although Harvard Proposal is not widely accepted, it at least introduced the concept of personal responsibility on one's own health. It also highlights the importance of holistic healthcare over passive treatment. This philosophy is applicable to Hong Kong's present healthcare system.

Reform of primary care

Research findings show that enhanced primary care can improve the health status of the general population and reduce the demand for expensive tertiary care (School of Public Health, 2008). Primary care entails provision of lifelong, holistic, first-contact and coordinated healthcare (School of Public Health, 2008). Primary care practitioners should serve as the first contact point for patients and as gate-keepers for the higher levels (Healthcare Policy Forum, 2008). Patients should be allowed to access specialist care only with the gate-keepers' referrals (Healthcare Policy Forum, 2008). Official referral guidelines directing the transfer of clinical responsibility have to be drawn up to impose the consistency, safety and quality of the primary care. These guidelines can also ensure cost effective referrals are given without delaying treatment (Docherty, Sharma, Littlejohns, Garner, Naidoo & Choudhury, 2011). In the initial phase, the government

should provide high subsidies in order to promote the new health practice to the general public. Health vouchers can be provided as extra subsidies to encourage the use of the new services. More financial subsidies should be provided to special population groups such as low income groups, patients with chronic disease, children and the elderly (Department of Community and Family Medicine, 2008).

Primary care is not identical to primary medical care (Chan, 2008). Primary care include multi-disciplinary healthcare professionals such as primary care physicians, nurse practitioners, pharmacists, optometrists and Chinese medicine practitioners. (Saskatchewan Medical Association, 2011). These health professionals provide a wide range of services such as health promotion, disease prevention, health risk assessment, treatment and healthcare (Department of Health, 2015). This team-based approach improves health outcomes by provision of care by the most appropriate team member working to the full scope of the competence and capability (Saskatchewan Medical Association, 2011). Different health professionals utilize their capabilities to address different needs of the population in bio-psychosocial dimensions, achieving patient-centered and community-focused care (Saskatchewan Medical Association, 2011). In Hong Kong, the Primary Care Directory has implemented since 2012 to facilitate the transparency of the healthcare system. Primary care providers are encouraged to register in the directory. Unfortunately, currently only doctors, dentists and Chinese Medical Practitioners can enroll in the directory. While electronic health informatics aims to facilitate the public to select their healthcare providers' according to one's health needs, the pool of health professionals should not limit to medical professionals but other healthcare professionals addressing biopsychosocial approach and holistic care (Healthcare Policy Forum, 2008).

Public-private partnership

Public-private partnership combines the resources and expertise available in the public and private sectors to promote quality, efficient and cost-effective care. It can relieve the public healthcare burden and ensure the sustainability of the system (Food and Health Bureau, 2008). Serving as a safety net under the health financing reform, the public sector can purchase from the private sector some healthcare services in high demand, such as dialysis services, labor and maternity services and elective surgeries. The public sector can therefore centralize the resources on the acute, intensive and costly hospital care (Food and Health Bureau, 2008). This approach can relieve public service demand and encourage expansion of private healthcare (Food and Health Bureau, 2008). Patients can be subsidized to use the private healthcare services so as to promote health equity in the community (Food and Health Bureau, 2008).

The growth of secondary and tertiary care does not keep up with the surging demand. While the government declines to increase public in-patient services, the growth of private hospitals is also stunted by the constrictive government policies (Hong Kong Golden 50, 2012). Besides, private hospitals are unevenly distributed in the community. Health policies should turn to expand the existing private facilitates and build up new private hospitals in badly undersupplied districts (Food and Health Bureau, 2008). To carry out a macro-level planning in respect of provision of secondary and tertiary care to the entire community, a statutory authority should be set up to coordinate all healthcare matters of both the private and public sectors. The authority should adopt the private-public

partnership to formulate long-term plans for secondary and tertiary care in the community. This also facilitates the sharing of healthcare resources and expertise between the public and private sectors (Food and Health Bureau, 2008).

Leadership/governance

New management structure can strengthen its capacity in steering the healthcare system (Healthcare Policy Forum, 2008). While Food and Health Bureau is responsible for formulating health policy and allocate resources, there should be a new authority, a statutory body, to execute the health policies and manage the primary, secondary and tertiary healthcare levels. The authority should review and revise the relevant ordinances to ensure the quality and accessibility of the healthcare services in the community (Fig. 1). The new authority can also serve to advise Food and Health Bureau on the provision of healthcare services and establish a registration system to ensure the transparency and accountability of both the healthcare sectors (Balabanova, Oliveira-Cruz & Hanson, 2008). The existing healthcare facilities Department of Health therefore can therefore focus on its core competence in public health protection and policies to tackle various health issues such as infectious and chronic diseases, injuries, food and water safety, environmental hazards and occupational safety.

There is an urgent need to integrate the existing services to promotes proper use of healthcare services (Food and Health Bureau, 2008). The integration facilitates the coordination and connections for service providers at all healthcare levels in every district. The new department can be set up to link up all healthcare providers in each district including public and private hospitals, primary healthcare providers, community healthcare providers, rehabilitation centers and nursing homes (Fig. 2). It develops inter-district networking to facilitate efficient use of health resources. This inter-sector collaboration will induce one-stop, highly accessible and integrative care in every district. This integrative approach can reduce fragmentation of services and promote seamless transfer of patients to different levels of care. This department takes responsibility to assess health needs and provide subsequent implementation strategies to promote health at district level. A respective health centre should be erected in every district to execute the implementation plans and support the district's health needs.

To minimize the medical dominance and tackle manpower shortage, healthcare administration training should be introduced to Hong Kong's tertiary education institutes. The USA and the UK started hiring non physicians as the hospitals' senior managers in the last century. Hong Kong's healthcare system, however, is still superintended by physicians. A healthcare administrator is a unique professional who have both healthcare knowledge and management skills to direct a healthcare organization towards its vision (Public Health Online, 2015). Healthcare administrators would establish healthcare standards, develop strategic policies and budget plans, and coordinate healthcare services (Public health online, 2015). They play a role in achieving professional autonomy and at the same time maintaining cooperation of diverse interest groups, so as to protect the best interests of the patients (Public health online, 2015). Health administrators are employed by various organizations including hospitals, healthcare and social care organizations and rehabilitation institutions. This approach relieves frontline healthcare professionals from administrative duties (Public health online, 2015).

Health Financing

While achieving universal coverage, the reform should also include effective cost control. A review should be undertaken on the share of responsibilities between the government and the residents on health expenditure.

It is recommended to introduce a compulsory social health insurance scheme (Liu, E., & Yue, S. Y., 1999). All citizens should contribute a certain percentage of their income to fund the healthcare system. Determination of contribution level is based on one's ability to pay. It demonstrates a role in wealth redistribution to ensure equitable access of healthcare for the low-income and underprivileged groups.

Mandatory medical savings accounts should be created for payment of personal healthcare expenses. Both employers and employees are required to contribute a certain percentage of salaries. All contributors can voluntarily contribute additional monies for better benefits and coverage. The medical savings account can be combined with one's existing private health insurance to maximize the coverage. Coverage can also be extended to family members. The contributions should be eligible for tax deduction.

The administrators of the current healthcare system play multiple roles – budget controller, healthcare provider and healthcare quality assurer. This arrangement has brought questions about the healthcare providers' accountability in respect of the quality and the cost-effectiveness of services. The new system should compartmentalize the financing functions (e.g. revenue collection, pooling and purchasing) and service provision. The mechanism should emphasize on accountability of different stakeholders to ensure the healthcare quality and cost-effectiveness. Health Security Fund should be set up to ensure effective use of health revenues (Liu, E., & Yue, S. Y., 1999). It should aim to protect the public's equal rights to access the healthcare, and prevent failure to obtain essential health services because of financial difficulties. By revenue collection and pooling, Health Security Fund can achieve redistribution of wealth and constantly protect the public on health spending.

In the new system, there will be insurance options, and cost-effective and high quality healthcare services can be purchased from healthcare providers. National/territory insurance scheme can be formulated for both public and private sectors (Health Policy Forum, 2008). The scheme requires patients to share the responsibility of supporting healthcare. Patients are required to make "small-proportion" co-payment (e.g. 30%) when paying medical fees and the best part of the health expenditure (e.g. 70%) will be borne by the insurance scheme (Health Policy Forum, 2008). Patients who make additional contributions to their medical savings accounts will be entitled to a lower proportion of co-payment.

The 'money follows patient' principle should apply in both the public and private healthcare sectors (Health Policy Forum, 2008). Under the national/territory insurance scheme, the healthcare sectors will receive standard fees which include the co-payment from the patients (Health Policy Forum, 2008). The medical fees will be the major source of their health revenue. This approach reduces the price differences between the public and private sectors, thus reducing the reliance on public health services. The co-payment practice and limitation of insurance claims can also prevent misuse and abuse of the healthcare services (Health Policy Forum, 2008). It is clear that financial incentives are

positively linked to the work performance (Health Policy Forum, 2008). Since patients would choose the healthcare services in consideration of service quality, use of financial incentives can bring more effective allocation of resources and healthy competition among the healthcare providers (Health Policy Forum, 2008). The system can therefore ensure the quality of healthcare and equitable access to the healthcare services (Health Policy Forum, 2008).

Level of protection

Health Security Fund serves as a safety net to ensure that no one will fail to access essential healthcare services due to financial difficulties. At present, the Samaritan Fund and the CSSA Scheme serve the same purpose. The Samaritan Fund can be combined with Health Security Fund to streamline the management and maximize the cost-effectiveness. The government should inject capital into the fund to enhance financial assistance.

The safety net should procure different levels of protection to support different groups with financial difficulties. For example, at the first level, subsidies can be paid for 90% of the medical fees after the patient has fully claimed his/her insurance. This helps the patient to deal with the expensive hospitalization and treatments, such as chemotherapy or intensive care. In the second level of protection, co-payment can be exempted for vulnerable groups such as low income households, children, the elderly or the disabled.

Health informatics – Electronic health record system

There is a social consensus to develop a system with territory-wide electronic health records to enable all relevant healthcare providers and patients to access patients' health records. The electronic health records facilitate the implementation of the proposed healthcare reform measures such as enhancement of primary care, private-public partnership, integrative care and health financing reforms (Healthcare Policy Forum, 2008). It improves efficiency by minimizing duplicate investigations and treatments (Food and Health Bureau, 2008). The records include data for disease surveillance, which facilitates the monitoring of health outcomes and formulating healthcare policies (OECD, 2013). Patients can access the records of their preferred health providers, which facilitates conduct of peer review and promotes self-regulation of the profession (Healthcare Policy Forum, 2008).

At present, different healthcare providers create patients' medical records in different formats (eHealth Record Office, 2015). eHR Office of Food and Health Bureau is now developing a platform containing individuals' health-related data stored and retrieved by different healthcare providers (eHealth Record Office, 2015). However, the system does not support data sharing in different electronic formats (Poon, 2012). The program is based on voluntary participation, and private doctors are not interested in participating in the program because it involves new technical skills and extra costs (Poon, 2012; Legislative Council, 2012).

The eHR system pursues the vision that every Hong Kong citizen have only one health record (OECD, 2013). The vision supports sharing health records among different healthcare providers, and building a health database for monitoring the public health status (OECD, 2013). In this regard, implementation of eHR should be included in the administrative region's policies. Many countries such as Korea and Singapore drew up

national policies to protect personal privacy while advocating legal liability on ‘duty to share’ (OECD, 2013). Data protection act is essential to protect patients’ privacy by limiting data collection, restricting data accessibility and regulating security issues. In addition, the act should also stipulate that authorization is required for certain data retrieval in order to protect the public’s and patients’ interests (OECD, 2013). Financial incentives (or penalties) can be introduced at the initial phase to promote the use of the electronic health records. For example, the US Health Information Technology for Economic and Clinical Health Act introduced incentive payment to promote the use of interoperable health information system. Healthcare providers may be penalized if they do not use the electronic health records (Centers for Medicare & Medicaid Services, 2011).

Conclusion

The healthcare system in Hong Kong is currently facing numerous challenges. In order to secure sustainable development in the next 25 years, reforms must be carried out to meet the challenges and to promote the health of individuals, families and communities.

Figure 1: Health System Reform

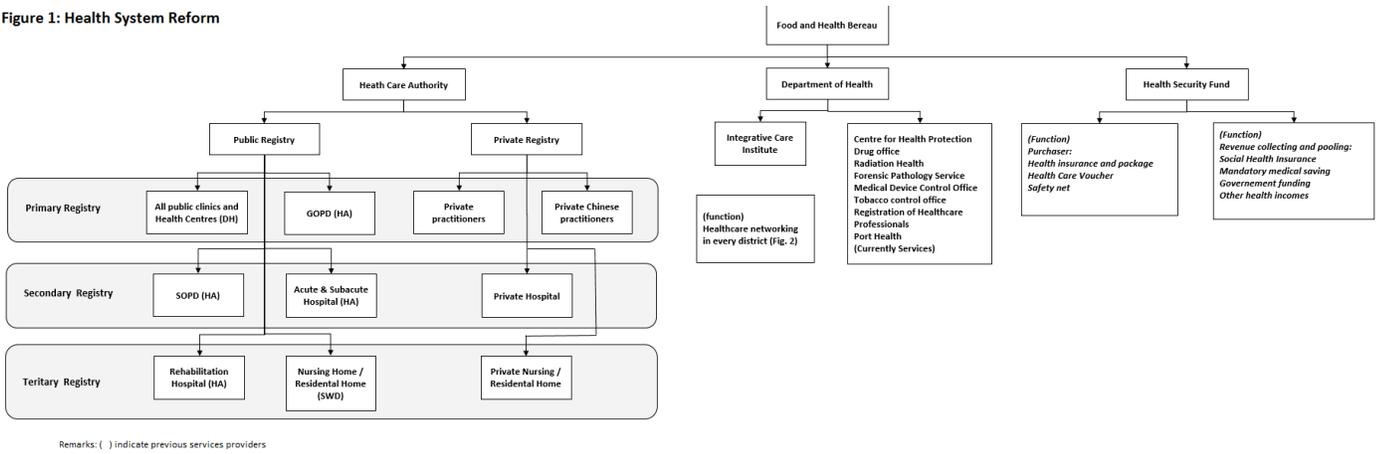
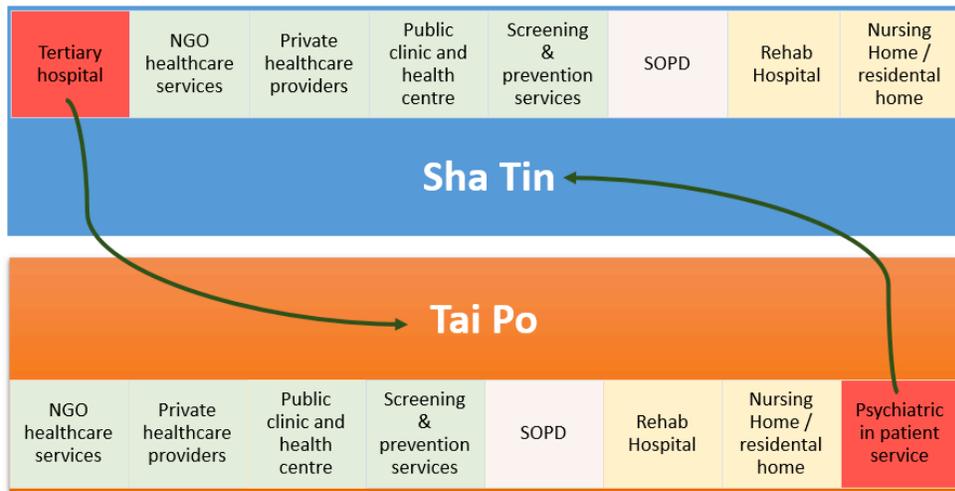


Figure 2: Example of Networking by Integrative Care Institute



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