Abstracts

Part 1 Definition and Influence of Socioeconomic Factors, Gender and Health Service Provisions

Definition of Successful Ageing

Professor Ann Bowling

There is increasing interest in how to age 'successfully', and in reaching consensus over the definition of this concept. The literature on successful ageing reveals a wide range of definitions. Biomedical models emphasise physical and mental functioning; socio-psychological models emphasise social functioning, life satisfaction and psychological resources. Several studies have identified each of these factors as the precursors of successful ageing. A small number of studies have explored lay views. Most older people consider themselves to have aged successfully, while classifications based on traditional models do not. A model of successful ageing needs to be multi-dimensional, incorporate a lay perspective for social significance, and use a continuum rather than dichotomous cut-offs for 'success'.

The Hong Kong Chinese Perspective

Professor Ng Sik-hung

Aims: To develop a model of ageing that differentiates between personal (self-centred) and social (other-centred) aspects, and to explain ageing success in terms of psychological (sense of humour) and social network variables. The latter include network density (number of close family, kins, neighbours and friends) and quality (being loved and respected).

Method: Data were from a near-random sample of over 1,000 ethnic Chinese in Hong Kong aged 15 to 79 years. Young and middle-aged people were included in addition to older adults in order to provide a life-course perspective on ageing. They were interviewed individually on personal and social aspects of ageing, psychological and network variables, demographical background and other various items.

Results: Personal ageing (health and functional independence) was more successful than social ageing (caring for others and contributing to family and society). After controlling for age and sex, it was found that humour and network quality enhanced the success of both personal and social ageing, whereas the number of close others produced mixed effects.

Conclusion: Ageing well is not simply a matter of maintaining personal health and functional independence, but also helping and caring for others throughout one's life course. Success can be improved significantly by having a sense of humour and quality networks. In Hong Kong, ethnic Chinese are less successful in social than in personal ageing. Consistent with this, other results from the study show a very low level of social participation and volunteering. These findings call for policy emphasis on participatory and active ageing, while retaining the importance of healthy ageing.

Influence of Socioeconomic Factors, Gender and Health Service Provisions

Professor Shah Ebrahim

Successful ageing is dependent on survival which is determined strongly by gender and socioeconomic factors. The survival advantage of women over men is explained by differences in adverse health behaviours, in particular smoking. These same health behaviours that influence survival also have effects on disability, which markedly reduce the chances of successful ageing. Socioeconomic factors have complex relationships with survival and with disability which depend on the indicator of socioeconomic position studied, the level of measurement (individual or population) and how the outcome is defined. A life course perspective enables the effects of a range of environmental exposures relevant to socioeconomic and gender differences to be studied and data from long-term cohort studies demonstrate the ways in which early life exposures can result in differences in ability and survival in old age. In the Boyd Orr cohort

we found wide variation in time to do a 6-metre walk from a seated position (Get up and Go test) (mean: 9.8 seconds; range: 5.5 - 60.5s) and this was strongly associated with age (Figure 1). Weekly household income in childhood (range: > £1 in 7% of participants to < £0.5 in 61%) was positively associated with walking speed in adulthood (3.2% faster walking time for each higher income category (Figure 2). Social class in adulthood was associated with a 4.9% reduction in walking time per social class category. These findings demonstrate that socioeconomic influences across the life course have long-term effects on walking speed, an important indicator of future disability in old age.

Health services, together with social support, provide one of the means by which societies can mitigate some of the adverse effects increasing incidence and prevalence of common disabling diseases in old age. Findings from a meta-analysis of 89 trials, including 97,984 people, mean age at least 65 years, and who had been living at home with at least six months of follow-up show that complex interventions reduced nursing-home admissions by 13%, risk of hospital admissions by 6%, occurrence of falls by 10%, and also improved physical function. However mortality was the same whether complex interventions were used or not. Benefit in trials was particularly evident in studies started before 1993 – suggesting that modification of care practices after that date has achieved little additional value. Further, there was not a benefit noted for any specific type or intensity of intervention – as such, the possibility might exist to tailor different formats of care to the needs and preferences of the individual – which could in turn lead to better uptake and adherence of care without compromising potential benefit.

In the context of China, serious efforts to improve ways of life in urban and rural populations are needed with a particular emphasis on tobacco control and maintenance of physical activity. Investment in health services for elderly people is worthwhile as the complex interventions these services offer can help elderly people to live safely and independently, and can be tailored to meet individuals' needs and preferences.

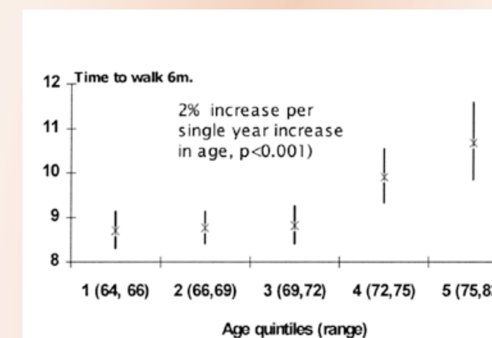

Figure 1: Age distribution of walking time, Boyd Orr cohort, 2002.

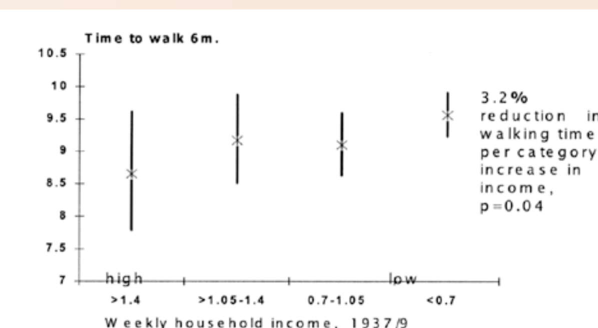

Figure 2: Household income in childhood and walking time, 2002

Well-being Indicators: How Does Hong Kong Compare with Other Countries

Dr Pui-hing Chau

While much ageing research has focused on negative outcomes such as morbidity and disability in the late stage of life, we adopt a positive outlook along the lines of the active ageing framework advocated by the World Health Organization. Accordingly, in the selection of well-being indicators, we highlight aspects that contribute to successful and productive ageing such as healthy lifestyle and active social engagement. In addition, international comparisons with economically developed countries in both the East and the West are made to reflect how well seniors in Hong Kong are doing with reference to these countries. The well-being indicators showed that the senior population in Hong Kong generally live a healthy and active life. The statistics also suggested that the senior population's well-being in physical, social and economical terms is of a comparable level to other well developed economies, including Japan, Singapore, Australia, the United States and the United Kingdom.

Part 2 An Elder Friendly Environment

Bridging the Gaps in Service Provision

Dr Fung Hong

Introduction

In Hong Kong, the service providers for elderly include Hospital Authority, Department of Health, Social Welfare Department, Non-Government Organizations and the private doctors. Greater collaboration and strengthening of networks are necessary to meet the diverse needs of the elderly population that involve physical and psychosocial health.

Medical Needs of Elderly

Elderly are common users of medical services in Hong Kong. In New Territories East Cluster (NTEC), the estimated elderly population (>65 years old) is around 130,000 in 2007. A review of the utilisation of existing services in the public hospitals and clinics in 2007 illustrates some of the healthcare needs of elderly in Hong Kong:

(a) 26-29% of General Outpatient Clinic (GOPC) patients and 29% of the Specialist Outpatient Clinic (SOPC) patients were elderly patients.

(b) The general and specialist outpatient clinics were seeing 50-55% of the elderly population as patients in NTEC.

(c) Major problems of elderly patients at seen at GOPCs included uncomplicated hypertension (50%), diabetes (10%), upper respiratory tract infection (URTI), stroke, hyperlipidemia, COPD, ischemic heart disease, osteoarthritis and gout.

(d) Around 50% of GOPC elderly patients attended Accident & Emergency departments (AED) at least once in 2007. The AED attendance ratio was also high among the SOPC elderly patients.

(e) 25% of the elderly population was admitted at least once into the hospitals. On average, each elderly patient required 2.4 admissions in 2007.

(f) The common reasons of elderly patients attending AED were dizziness, chest pain, URTI, gastroenteritis, low back pain and abdominal pain

(g) The common reasons of admission through AED are fever, chest pain, deteriorating general condition, abdominal pain, dizziness, COPD and congestive heart failure. The top diagnoses were COPD, pneumonia, congestive heart failure, ischaemic heart disease, fracture hip and stroke.

What are the Gaps? How to bridge the Gaps?

As the elderly population relies heavily on the public hospital system for medical care, the effectiveness of the system in addressing their needs is in doubt, especially for the taking care of their chronic illnesses. On one hand, there are overlaps and high utilisation of services, including GOPC, SOPC and AED. On the other hand, many elderly patients attend AED or seek medical advice from hospital settings for common ailments which could be handled by primary care practitioners in the community. It may be due to lack of support for elderly in managing minor acute complaints and lack of training for carers in helping elderly to keep them away from AED/hospitals.

In the past yeas, the NTEC hospitals, like all other hospitals in the Hospital Authority, had made much effort to train and provide support to elderly care workers in the Old Aged Homes (OAH) and elderly centres. These initiatives include reserved quota at GOPCs, phone consultation service, video consultation, after hour's home visit by community out-reaching teams and private visiting doctors, all with a view to enhance the capability of care in the community to avoid unnecessary AED consultation or hospital re-admission. The newly developed concept of Primary and Community Health Centre aims to further strengthen such networks, to empower the community and to create an elder friendly environment to take care of the elders in the community.

As many elderly persons receive medical services from the private sector, networking with private doctors is another important strategy. Since 2007, NTEC had established the Primary Care Coordinating Committee with local private doctor groups in order to enhance collaboration between the private doctors and the public sector. Through the committee, systematic management guidelines are promulgated to facilitate standardized protocols and referrals of patients. With the support of information technology, patient records can be shared among private and public sectors.

Finally, prevention of diseases, social deprivation, domestic violence, elderly abuse and mental health promotion among elderly are areas requiring improvement within the society. A collaborative and joint approach among various sectors will provide a better care for our elderly in Hong Kong.

Telemedicine and Group Supportive Programmes (CDMSP, Chronic Disease, Fall Prevention)

Dr Elsie Hui

Telegeriatrics

With an ageing population, there are over 80,000 residential care places for older persons in Hong Kong. Many of these homes are privately-owned, for profit establishments, with little primary care support. The Community Geriatric Assessment Team (CGAT) was set up in 1994 to provide multidisciplinary support to residential care homes for the elderly (RCHEs), but with increasing numbers of homes and no additional resources, utilisation of hospital services by RCHE residents remained high. A decade ago, we pioneered the use of teleconferencing to provide geriatric care to a residential care home.

In a pilot study to assess the extent to which telemedicine could replace previous outreach services, CGAT members, including the geriatrician, nurse specialist, physical and occupational therapists, and podiatrist were asked to use the facility. The quality and acceptability of all types of consultations via telemedicine was evaluated. End-users' (staff and elderly clients of a 200-bed RCHE) satisfaction was surveyed. A site-visit would be conducted whenever telemedicine was considered inadequate for decision-making or delivery of appropriate treatment.

After one year, telemedicine was found to be adequate for the majority (over 90%) of CGAT activities. Moreover, members were able to see more clients and respond more promptly to consultations. The system was user-friendly and particularly good for assessment of wounds. Modest reductions (10%) were seen in emergency room attendance and admissions to acute hospital beds.

In conclusion, telemedicine was a useful tool for delivery of various medical and allied health services to RCHE residents. Following our findings telemedicine has been adopted by numerous geriatric units in the territory.

Telehealth in chronic disease management and maintenance

Subsequently, we identified a service gap in the management of chronic debilitating conditions (e.g., diabetes (DM), stroke, dementia, osteoarthrosis (OA) and urinary incontinence (UI)), namely community-based rehabilitation. The feasibility and efficacy of tele-rehabiliation was studied. Each programme comprised of three core components: exercise training, education and group interaction. Small groups of patients congregated at social centres for up to 12 weekly sessions. Research staff located at the hospital used a tele-link to deliver the programme content. Outcome measures included assessments specific to individual conditions (e.g., DM group - blood glucose levels, diabetic knowledge test, Diabetes Quality of Life Questionnaire), as well as measurements of well-being (e.g., Medical Outcomes Study Short Form (SF-36), Geriatric Depression Scale) and satisfaction. A quasi-experimental design with pre- and post-intervention assessment was used for DM, stroke and UI groups. Randomised controlled trials were conducted for dementia and UI to compare tele-rehabilitation with face-to-face intervention.

133 clients completed 5 rehabilitation programmes. In the DM programme, for example, statistically significant improvements were seen in the SF-36, diabetic knowledge and patient satisfaction. Subjects with normal 2-hour post-prandial blood glucose rose from 9% to 50% following intervention. Overall compliance was over 90%, and the majority of subjects were satisfied with teleconferencing as the mode of care delivery.

In summary, community-based group rehabilitation programmes via teleconferencing improved physical and psychological outcomes in various common chronic diseases.

Technological Innovations: Optimizing the Living Environment and Aids - New initiative for Primary Health: Mobile Integrative Health Centre for Older Adults

Professor Joanne Chung

At present, health services provided in hospitals are tertiary care with acute patients while clinics' are disease-oriented and both of them seldom include preventive care service. Based on the Government statistics, in the year 2003, there is about 11.7% of the Hong Kong population, totaling 795,413 people, was aged 65 or above. The figure would climb up yearly and the burden of the Government and other organizations must be aggravated. Thus, the Government sees preventive health care as equally critical and should be highly encouraged to the primary health care sectors since early detection of the onset of an illness is vital to prevent it from becoming a chronic or deteriorating condition. The medical burden can also be relieved.

Currently, health care services are delivered to senior citizens in hospitals, clinics and community centres of which locations are mostly fixed. When seniors need health care service, they have to travel to these locations, which can present a challenge and danger to them because of their immobility and the inaccessibility of the facilities. Now, it is the high time to provide a mobile channel to deliver health care service to needy people, especially elderly near their residential area.

To this end, with a generous donation from philanthropist Mr Edwin S H Leong, The Polytechnic University of Hong Kong (PolyU) has started its first PolyU-Henry G Leong Mobile Integrative Health Centre (MIHC) in Hong Kong in December 2007. The Centre is a brand-new service concept that offers free health checks and monitoring services within a vehicular clinic that tours around selected districts of Hong Kong. The Centre is directly improving the health and quality of life of many of the city's aged, as well as proactively addressing long-term problems associated with Hong Kong's ageing population. Recognising that integrated health and social care are essential for treating each client holistically as an individual, the Centre is staffed by an interdisciplinary team of health care professionals such as Advanced Practice Nurses, traditional Chinese medicine practitioners, and nutritionists, and is fitted with advanced health-check and training equipment such as a Telehealth System, heart rate variability meters, and Bodyblade exercise equipment. The holistic treatment of clients also extends to examining their happiness, nutritional status and prevalence of pain to monitor their physical, mental and emotional health as well as aiding research efforts in furthering evidence-based health and social care for the aged. The Centre has been received enthusiastically by its target users, the needy elderly.

It is believed that the MIHC would achieve unprecedented success that not only seniors can enjoy a quality health care service, but undergraduates of the Faculty of Health and Social Sciences of the University are able to assimilate precious experience from training in the Centre and apply it in real life. In addition, research students can utilize the rich and practical data base for their research in the continuous pursuit of new discovery and inventions.

Part 3 Public Health Aspects of Population Ageing

Ageing Populations: Implications for Hong Kong

Professor Jean Woo

This presentation covers two broad themes: 'desired outcomes' for people who are ageing, and how health and social services could adapt to this demographic change.

Local studies show that the three main concerns of people as they age are health, financial security, and engagement in society, as for other countries. A survey of 2,000 people of all ages show persisting gaps in knowledge of ageing processes, coping with common chronic conditions such as dementia availability of services, and negative perceptions of ageing particularly among those age 65 and over, in spite of recent efforts in health education and promotion. There is room for greater effort in health education and promotion, with the objective of empowerment of individuals, using modern educational concepts aiming at behaviour modification, as well as social marketing techniques. There is less importance placed on psychosocial factors affecting health, although these are as important as other lifestyle factors, and little understanding of stress associated with compulsory exit from the workforce. Furthermore, the quality of dying should not be neglected.

From the point of view of health and social service providers, the content, organisation and financing of services require constant review and adaptation, based on projection of population needs informed by epidemiological and health economic studies. Results from a study of the use of hospital services in the last 3 years of life would inform the demand on services, based on future population projections of demography and life expectancy, and a trend of compression of morbidity. Current demographic trends show that the oldest-old support ratio is declining, indicating a parallel need for increasing the capacity of the informal care sector. A declining death rate without parallel decline in incidence of chronic disabling conditions would lead to an increase in the number of frail elderly with or without cognitive impairment. Health and social services would need to develop systems to cater for frail people at the end of life. Community services need to be developed that have a seamless medical and social interface, to act as an effective primary care to enable people to remain at home as long as possible. Newer models of care such as case management support for high risk elders discharged from hospital, and group management of chronic diseases emphasising empowerment have produced good outcomes, in terms of better disease control and quality of life. In spite of improving community care, it is likely that long term residential care places will need to be increased in parallel to meet these needs. A survey showed that dementia is a strong factor that precipitates the need for long term care placement. Affordability and quality of care remain a challenge for long term residential care.

Engaging the Public – Examples from Australia

Professor Helen Bartlett

The challenge of maximising ageing well has been recognised by local government in Australia, with many Councils developing ageing strategies to help address the diverse needs of a rapidly ageing population. The concept of ageing well has been variously interpreted in policy goals and in the research literature and can embrace physical, health, social and psychological needs. The broader community context in which people live has a major impact on older people's quality of life and may facilitate or hinder ageing well. This paper explores the understandings of ageing well from a policy perspective and considers how older people themselves interpret this concept at a local level. Drawing on a project funded by the Australian Research Council in partnership with two city councils, examples of community priorities for ageing well are identified and in particular those which would benefit from a collaborative community effort across multiple stakeholders. Progress from the first phase of action research in two communities is discussed, highlighting the challenges and the opportunities for engaging older members of the community in working towards ageing well at the local level.

Engaging the Public – Local Strategies

Professor Diana Lee

Successful ageing is a socially and culturally determined construction. The perceptions of ageing and the approaches to healthy practices of ageing are formed and constructed in different socio-cultural contexts. Development of culture-specific knowledge about the ageing experience will help to inform the identification and evaluation of strategies that will positively engage the public in the promotion of successful ageing. However, little is known of Chinese people's views of successful ageing and the strategies they use when striving to age successfully.

This presentation will describe the results of a study that explored the meaning of successful ageing from the perspectives of Chinese older people. A sample of 68 older people aged 65 or over was recruited from 18 community centres and specialist out-patient clinics in Hong Kong. In-depth interviews were conducted to explore their views and experiences of successful ageing. The narrative data were content analysed.

The results indicated that successful ageing for Chinese older people is about being engaged in life. It is a life course concept and experiences of earlier life stages were seen as important in shaping later life experiences. Successful ageing is achieved through striving to keep one's physical, psychological and social health. Among all these aspects, sustaining harmonious relationship with families is seen as most important. Chinese values of protecting the family's face, maintaining harmony and being thankful were found to shape older people's perceptions and approaches to practices of ageing. Implications for identification of strategies to engage the public in successful ageing initiatives will be examined.

Part 4 Legal and Financial Aspects of Population Ageing

Enduring Powers of Attorney

Ms Alexandra Lo

Elderly care has gained an increasingly important position in public policy in recent years. The Elderly Commission was set up with specific remit on this aspect of care. In Chinese society, elderly care is not unfamiliar, as it is a moral requirement that is central to Confucian thought in the Chinese civilisation. However the role of law in elderly care has not been clearly articulated. Because of the frailty of the patient and other societal complexities, the age-old dichotomy between autonomy (freedom of choice) and paternalism (protection of the weak) in medical ethics is much more pronounced in elderly care. Thus a deeper understanding of the legal issues underlying elderly care is important for successful ageing in the Hong Kong context.

Issues in medical law that relate to elderly care can arise in a number of situations. It is trite law that a doctor commits trespass on a patient if medical treatment is administered without consent. Where elderly patients are concerned, questions can arise when a patient refuses medical treatment or requests discharge from a hospital or nursing home, and it is unclear whether the patient is legally competent to make decisions. Questions of consent can arise in relation to the use of restraints against elderly patients who may be demented. It would also relate to the prevention and detection of elder abuse. It is submitted by the author that these legal issues, while not fully expressed as such, are not new to Hong Kong's current best practices. This paper will examine several codes and guidelines of hospitals, nursing homes and residential care homes with a view to identifying and articulating their underlying legal and ethical basis. By placing better emphasis on these fundamental issues and complying with these best practices, we can together enhance an elder-friendly care environment.

Elder Abuse

Professor Catherine Tang

With rapid global ageing, there are increasing attentions to elderly people as victims of crime, abuse, and exploitation. Research has shown that violence against elderly people occurs both at home and in the community. It is argued that rapid social changes may have eroded traditional family values, and elder abuse may become a fact of life as in spouse and child abuse. Despite increasing interests in elder abuse across countries, this phenomenon is relatively unexplored in Chinese societies. Partly relating to the cultural emphasis on the preservation of family harmony and honour, elder abuse remains a hush-hush topic in Chinese societies with most cases being undetected and unreported. However, there are evidences that the younger generation of Chinese has become less respectful of traditional cultural norms about filial piety and familial responsibilities. Thus, elderly Chinese may not have the prestige, power, and care in the family and in the society as in previous decades. These challenges to traditional Chinese attitudes toward ageing and

family relationship may have their implications on elder abuse. Furthermore, caring elderly people at home and in the community residential homes can be both physically and mentally demanding for family members and care providers, which may also be related to neglectful and abusive behaviors against the elderly. Identifying various risk factors and detrimental impacts are important in designing prevention and intervention programmes to prevent the occurrence of elder abuse. It is hoped that through the concerted efforts of researchers, service providers, and policy-makers that elderly Chinese continue to live with dignity at home and in the community.

Health Insurance for Older Populations

Mr Peter Chan

The gist of the Healthcare Reform Consultation Document: "Your Health Your Life" released by the Hong Kong Government in March 2008 is on how to reform healthcare financing arrangements including public and private insurance. Out of the 7 major finance options presented in the document, five of them are very much insurance based including social health insurance, medical saving account, voluntary private health insurance, mandatory health insurance and personal healthcare reserve.

Who need health insurance? Older persons are the people likely with multiple chronic conditions that require constant healthcare and are the group of people need it most. According to a USA study, the only industrialized country which relies mainly on private insurance (The McKinsey Quarterly, June 2008), the older persons need more relevant, understandable and support to make such a complex decision of what insurance to take on. To help make such a decision, the older persons need far more criteria to consider, other than the issue of affordability. These issues include:

- Will the insurance policy covers all aspects of my health care needs? Short term hospital care, rehabilitation, continuing care in the community or in a long term care facility, support, prevention and promotion.
- Will the insurance policy covers all people regardless their health status? Will I be excluded because of a pre-existing condition?
- If I decide to move back to live in China, will the insurance cover my stay in China?
- Will I be able to access all health services close to where I live?
- Will the system be run by a public or private administration?

This presentation will benchmark other countries experience in launching their health care insurance and see how Hong Kong can learn from these countries in marketing their health insurance, either private or public, to the population including the older persons.