PolyU THE HONG KONG POLYTECHNIC UNIVERSITY 香港理工大學

COLLEGE OF PROFESSIONAL AND CONTINUING EDUCATION 專業及持續教育學院

School of Professional Education and Executive Development 專業進修學院 SPEED

HONG KONG COMMUNITY COLLEGE 香港專上學院

CPCE Health Conference 2017

HEALTHCARE DELIVERY AND FINANCING REFORM

Implications for Business, Healthcare Providers and Patients

醫護服務及融資改革：對商界、醫護人員及病人的影響

Date:
16 January 2017 (Monday)

Time:
9:00 am – 5:30 pm

Venue:
UG06, PolyU Hung Hom Bay Campus
8 Hung Lok Road, Hung Hom
Kowloon, Hong Kong

Co-Organisers:

Sponsors:

Associate Organisations:

Introduction

The College of Professional and Continuing Education (CPCE) of The Hong Kong Polytechnic University (PolyU), incorporating the School of Professional Education and Executive Development (SPEED) and the Hong Kong Community College (HKCC), is currently the largest self-financing tertiary education provider in Hong Kong. It has over 10,000 full time students. It offers a range of programmes in many different disciplines including health related programmes at Associate Degree, and Honours Bachelor's Degree levels. The Academic Discipline of Health and Life Sciences of CPCE was commissioned to organise this Conference with the aim to share research and scholarly work pertinent to healthcare delivery and financing reform. It also takes the opportunity to promote interdisciplinary education and research on the topics related to the theme of this Conference -- "HEALTHCARE DELIVERY AND FINANCING REFORM: Implications for Business, Service Providers and Patients".

Speakers for the Plenary Sessions include: (1) **Professor David Briggs**, Adjunct Professor, College of Health Systems Management, Naresuan University of Thailand, to speak on "*Health Reform: Critical Challenges for Health Systems Management - Australian Perspectives*", (2) **Professor Toshihiko Hasegawa**, President, Future Health Research Institute, to speak on "*Historical Overview of Health Sector Reform of Japan and its Future Perspective*", (3) **Professor Tomonori Hasegawa**, Professor and Chair, Division of Health Policy and Health Service Research Department of Social Medicine, Toho University School of Medicine of Japan, to speak on "*Health Sector Reform – Japan's experience*", (4) **Dr Phudit Tejativaddhana**, Assistant to the President, Comprehensive Operations, Naresuan University (NU), Assistant Professor, College of Health Systems Management, Naresuan University, to speak on "*Health Reform: Perspectives from the Thai Experience"*, (5) **Professor Jui-fen Rachel Lu**, Professor, Graduate Institute of Business and Management and Department of Health Care Management of the College of Management, Chang Gung University, to speak on "*Beyond a 20-Year Journey of Universal Health Coverage in Taiwan: Challenges ahead"*, (6) **Dr Zhang Hui (Vivienne)**, Assistant Professor, Department of Health Policy and Management, Sun Yat-sen University, to speak on "*Health Care System in China and Recent Reform Initiatives*", as well as (7) **Professor Peter P. Yuen**, Dean of CPCE, The Hong Kong Polytechnic University, to present on "*The Lack of Progress in Health Systems Reform in Hong Kong: Reasons, Implications, and The Way Forward"*.

There are five parallel sessions containing a wide range of important topics pertinent to healthcare delivery and financing reform that are not only crucial to Hong Kong and also to other international communities. We are delighted to report that contributors to these parallel sessions include scholars and practitioners from Australia, Canada, Hong Kong, Indonesia, Japan, Chinese Mainland, Taiwan, Thailand, and the United States. These contributors from the region and other parts of the world share their perspectives about challenges and opportunities in healthcare delivery and financing reform.

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Conference Chair

Professor Peter P. Yuen

Dean, College of Professional and Continuing Education (CPCE), Professor, Department of Management and Marketing, The Hong Kong Polytechnic University

Organiser

The Academic Discipline of Health and Life Sciences, College of Professional and Continuing Education (CPCE), The Hong Kong Polytechnic University

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Hong Kong Public Administration Association (HKPAA)

Professor Albert Lee

Professor (Clinical) of Jockey Club School of Public Health and Primary Care and Fellow of Wu Yee Sun College, The Chinese University of Hong Kong

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Professor of Pharmacy and Head, School of Pharmacy, Monash University Malaysia

Professor Lee Ngok

Consultant to Executive Director,
The Hong Kong Management Association (HKMA)

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Master of Wu Yee Sun College, The Chinese University of Hong Kong

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President,
Hong Kong College of Health Service Executives (HKCHSE)

Professor Warren Chiu

Associate Dean, College of Professional and Continuing Education (CPCE), The Hong Kong Polytechnic University

Dr Simon Leung

Associate Dean, College of Professional and Continuing Education (CPCE) and Director, Hong Kong Community College (HKCC), The Hong Kong Polytechnic University

Dr Jack Lo

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Under Secretary for Food and Health, The Hong Kong SAR Government

Professor Peter Y. Yuen

Dean, College of Professional and Continuing Education, The Hong Kong Polytechnic University

Speakers

Professor David Briggs, BHA(NSW) MHM(1st class Hons) PhD(UNE) DrPH(HonNU) FACHSM FHKCHSE

Adjunct Professor, College of Health Systems Management, Naresuan University of Thailand
Editor, Asia Pacific Journal of Health Management
President, Society for Health Administration Programs in Education (SHAPE)

Professor Briggs is Adjunct Professor of the College of Health Systems Management at the Naresuan University of Thailand, and Editor of Asia Pacific Journal of Health Management. He is the President of Society for Health Administration Programs in Education (SHAPE). Professor Briggs is Fellow, Life Member and Past National President of the Australasian College of Health Services Management (ACHSM), and Founding Fellow of the Hong Kong College of Health Service Executives. He was the recipient of the NSW ACHSM Presidents Award 2014 for his extensive contributions to the College and to health services in NSW.

He has had extensive senior management and governance experience in the public health sector. His consultancy, research and publications include work in the health sector, most recently in PHC, in the Asia Pacific as well as Australia. Currently he is a Director of a PHC network, HNECCPHN and Chairs the Research, Innovation, Design and Planning Sub Committee, former Chair, New England Medicare Local, former Director, HealthWise P/L, a Director of DSB Consulting A/Asia P/L and a former Director of North West Division of General Practice.

Professor Briggs was previously Head of the Health Management Program at the University of New England and has taught across the range of course units in that program both domestically, and overseas at the Chinese University of Hong Kong. His research and publications interest focus on health reform, health systems management and the potential for distributed networks of practice in the delivery of primary health care. He has presented and published extensively in relation to his work in the Asia Pacific and this detail is available at https://www.researchgate.net/profile/David_Briggs/timeline.

Professor Toshihiko HASEGAWA, MD MPH PhD

President, Future Health Research Institute

Professor Hasegawa is President of the Future Health Research Institute. He is a retired Professor of Nippon Medical School after a long career in the Japanese government, including development of elderly care policy and management of Japanese national hospitals. He graduated from Harvard School of Public Health for MPH, from Osaka University Medical School for MD, and finished General Surgical Residency in Milwaukee, Wisconsin.

He taught at many medical schools in Japan as Visiting Professor of health policy and hospital management. He did research on health policy, health sector reform, planning and evaluation of disease management program, hospital strategic management and international health. Professor Hasegawa published many papers and books about ageing society, international health, health policy, hospital management, health care delivery system and safety and quality of care including the Hospital Strategic Management in 2002 that was translated in Korean, Thai, Russian and Chinese and the International Symposium on Health Transition and Health Sector Reform in Asia in 1998.

Professor Tomonori HASEGAWA, MD PhD

Professor and Chair, Division of Health Policy and Health Service Research
Department of Social Medicine, Toho University School of Medicine of Japan

Professor Hasegawa is Professor and Chair of the Division of Health Policy and Health Service Research Department of Social Medicine at the Toho University School of Medicine of Japan. He had his medical education at the Tokyo University School of Medicine, where also received his Doctor of Philosophy. He was previously a Resident at the Tokyo University Hospital in Internal Medicine.

He is a member of the Japanese Society of Public Health, Japanese Society of Hygiene, Japanese Society of Transplantation, Japanese Society of Hospital Administration, and Japanese Society of Healthcare Management. He also holds membership of the following specialist councils or committees: Ministry of Labour, Health and Welfare, Committee on Disclosure of Healthcare Information, Committee on the Administration of Healthcare Organizations, Cabinet Office Council for Regulatory Reform, Office for the Promotion of Regulatory Reform and Private Finance Initiative, Japan Council for Quality in Health Care Center for Medical Accident Prevention (vice-chair).

Professor Hasegawa's research background includes health policy, health economics, and quality assessment of health care.

Dr Phudit TEJATIVADDHANA, MD MPA (1st class Hons) DHSM(UNE) FCHSM

Assistant to the President, Comprehensive Operations, Naresuan University
Assistant Professor, College of Health Systems Management, Naresuan University (NU)

Dr Tejativaddhana is the Assistant to the President for Comprehensive Operations of the Naresuan University (NU) at Phitsanulok in Thailand, and Assistant Professor of the College of Health Systems Management at NU. He has been assigned to establish and manage the College of Health Systems Management at NU, which aims to create body of knowledge on health systems management and train managers and researchers in this field in order to help support Thailand and other countries in this sub-region especially in ASEAN to achieve the UN's sustainable development goals (SDGs) in 2030. He was commissioned to consider a draft of the Public Health Professional Act which was successfully enacted in 2013. He initiated the award for the best public health practitioners in Thailand and was conferred the name of the award from H.M. King Bhumipol as 'Jayanadnarendhorn' (The name of Thai prince who is the founder of Thai Public Health Ministry).

Dr Tejativaddhana is a general practitioner by background and has been in senior executive roles both in the public and private sectors for many years. He is a founding Director of the Lower-northern Region Heart Centre at NU, advisor to the Minister of Public Health, member of the Senate Standing Committee on Public Health, member of the Subcommittee on Health Services Reform, National Reform Council, former Vice President of Navamindradhiraj University, Bangkok and former Dean of the Faculty of Public Health, NU. He initiated and headed the Master of Public Health program with an emphasis on health services management at NU, a program that was funded by the National Health Security Office.

Dr Tejativaddhana's research and publications interest focus on health reform, health systems management, and primary health care. Internationally, Dr Tejativaddhana is the founding member of the South-East Asia Primary Health Care Innovations Network (SEAPIN) which is supported by the WHO SEARO. He is also the founding member of the Greater Mekong Subregion Public Health Academic Network, which includes the Deans and the Rector of 14 public health academic institutions in Cambodia, China, Laos, Myanmar, Thailand and Vietnam.

Professor Jui-fen Rachel LU Professor Jui-fen Rachel LU, BS MS ScD

Professor, Graduate Institute of Business and Management and Department of Health Care Management of the College of Management, Chang Gung University

Professor Lu is a Professor in the Graduate Institute of Business and Management and Department of Health Care Management of the College of Management at Chang Gung University in Taiwan, where she teaches comparative health systems, health economics, and health care financing and has served as Department Chair (2000-2004), Associate Dean (2009-2010), and Dean of College of Management (2010-2013). She earned her B.S. from National Taiwan University, and her M.S. and Sc.D. from Harvard University.

Professor Lu was a Fulbright Visiting Scholar at Stanford University (2015-2016), and a Takemi Fellow at Harvard (2004-2005), and she is also currently an Honorary Professor at Hong Kong University (2007-2017). She co-founded Taiwan Society of Health Economics (TaiSHE) in 2008 and currently serves as President of TaiSHE (2014-2017). Professor Lu is also a member of the Arrow Award Committee for International Association of Health Economics (iHEA) (2014-2016), and iHEA board director.

Her research focuses on 1) the equity issues of the health care system; 2) impact of the NHI program on health care market and household consumption patterns; 3) comparative health systems in Asia-Pacific region. She is a long-time and active member of Equitap (Equity in Asia-Pacific Health Systems) research network. Professor Lu has been appointed to serve on several advisory boards to Taiwan Ministry of Health and Welfare, National Health Insurance Administration, and Ministry of Science and Technology.

Dr ZHANG Hui (Vivienne), MSc PhD

Assistant Professor, Department of Health Policy and Management, Sun Yat-sen University

Dr Zhang is an Assistant Professor in the Department of Health Policy and Management of the Sun Yat-sen University in China. She received her PhD in health economics from The Hong Kong Polytechnic University, MSc in economics from The Hong Kong University of Science and Technology.

As a doctoral student, she spent one year as a visiting scholar at the University of California in the Los Angeles (UCLA) School of Public Health. Dr Zhang's research focus is health economics, especially health insurance reform, health care financing, health policy evaluation, and cost-effectiveness analysis.

Professor Peter P. Yuen, BA MBA(SUNY Buffalo) PhD(Birmingham) FCHSE(Aust)

Dean, College of Professional and Continuing Education (CPCE), Professor, Department of Management and Marketing, The Hong Kong Polytechnic University

Professor Peter P. Yuen is Dean of the College of Professional and Continuing Education (CPCE) of The Hong Kong Polytechnic University (PolyU). He is also Professor in the Department of Management and Marketing of PolyU.

He received his Bachelor of Arts degree in Cellular and Molecular Biology and Master in Business Administration degree from the State University of New York at Buffalo, and his Doctor of Philosophy degree in Health Economics from the University of Birmingham. Professor Yuen's research involves public policy formulation and evaluation, and health services management. He is the Co-Editor-in-Chief of Public Administration and Policy and an Editorial Committee member of Asia Pacific Journal of Health Management. He is also a consultant for the Hong Kong SAR Government and the Bauhinia Foundation on a number of public policy related projects including the West Kowloon Cultural District, Sustainable Built Environment, Subsidized Homeownership, Managed Care, and Health Systems Reform.

Professor Yuen is currently the Chairman of the Federation for Self-financing Tertiary Education (Hong Kong). He is a founding Fellow of the Hong Kong College of Health Services Executives, and an Honorary Fellow of the Australian College of Health Services Management. He once served as Vice-President of the Chinese National Institute of Health Care Management Education, and President of the Hong Kong Public Administration Association.

Moderators of Plenary Sessions

Plenary Session I

Dr S. H. Liu
President, Hong Kong College of Health Service Executives

Dr Ben Y. F. Fong
Senior Lecturer, SPEED, The Hong Kong Polytechnic University

Plenary Session II

Prof. Maurice Yap
Dean, Faculty of Health and Social Sciences, The Hong Kong Polytechnic University

Prof. Warren Chiu
Associate Dean, CPCE, The Hong Kong Polytechnic University

Chairs of Parallel Sessions

Session A: Healthcare Reform

Prof. Lee Ngok
Consultant to Executive Director, The Hong Kong Management Association

Dr Artie W. Ng
Deputy Director, SPEED, The Hong Kong Polytechnic University

Session B: Financing and Management

Dr Fowie Ng
Academic Convenor, Hong Kong College of Health Service Executives

Dr Tiffany C. H. Leung
Lecturer, SPEED, The Hong Kong Polytechnic University

Session C: Healthcare Delivery

Prof. Peter Fong
President, Hong Kong Public Administration Association

Dr Vincent Law
Lecturer, SPEED, The Hong Kong Polytechnic University

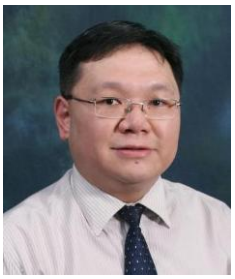
Session D: Education and Training

Prof. Hanqin Qiu
Professor, School of Hotel and Tourism Management, The Hong Kong Polytechnic University

Dr Simon T. Y. Cheung
Lecturer, SPEED, The Hong Kong Polytechnic University

Session E: Community-based Programmes

Prof. Albert Lee
Professor (Clinical) of Jockey Club School of Public Health and Primary Care, and Fellow of Wu Yee Sun College, The Chinese University of Hong Kong



Dr Eric Woo
Senior Lecturer, HKCC, The Hong Kong Polytechnic University

Programme

Time	Event
9:00 – 9:20	**Registration**
9:20 – 10:00	**Opening Ceremony** ***Welcoming Remarks*** **Prof. Peter P. Yuen** PolyU CPCE ***Officiating Guest*** **Prof. Sophia Chan, JP** Under Secretary for Food and Health The HKSAR Government
10:00 – 11:20	**Plenary Session I** Moderators: **Dr S. H. Liu** (HKCHSE) **Dr Ben Y. F. Fong** (PolyU SPEED) ***Health Reform: Critical Challenges for Health Systems Management - Australian Perspective*** **Prof. David Briggs** ***Historical Overview of Health Sector Reform of Japan and its Future Perspective*** **Prof. Toshihiko Hasegawa** ***Health Sector Reform – Japan's Experience*** **Prof. Tomonori Hasegawa** ***Health Reform: Perspectives from the Thai Experience*** **Dr Phudit Tejativaddhana**
11:20 – 11:40	**Morning Tea Break**
11:40 – 12:40	**Plenary Session II** Moderators: **Prof. Maurice Yap** (Faculty of Health and Social Science, PolyU) **Prof. Warren Chiu** (PolyU CPCE) ***Beyond a 20-Year Journey of Universal Health Coverage in Taiwan: Challenges Ahead*** **Prof. Jui-fen Rachel Lu** ***Health Care System in China and Recent Reform Initiatives*** **Dr Zhang Hui (Vivienne)** ***The Lack of Progress in Health Systems Reform in Hong Kong: Reasons, Implications, and The Way Forward*** **Prof. Peter P. Yuen**
12:40 – 12:50	**Awards for Outstanding Student Papers**
12:50 – 14:15	**Lunch Break**
14:15 – 17:30	**Parallel Sessions**

Parallel Sessions and Presenters

A. Health Care Reform

Chairs: Prof. Lee Ngok (HKMA) & Dr Artie W. Ng (PolyU SPEED)

(1) *New Theory and Method of Big Data Management for 21c Super-super Aged Society in Asia* ***(Prof. Toshihiko Hasegawa, Future Health Research Institute, Japan)***

The Comprehensive Cost of Illness in Super-aged Society ***(Dr Kunichika Matsumoto, Dr Yinhui Wu, Prof. Tomonori Hasegawa, Toho University, Japan & Shanghai Jiao Tong University, China)***

(2) *Interrogating the Conditions for the Political Collaboration between the State and the Medical Profession: The Case of Hong Kong* ***(Dr Alex Wo-shun Chan, PolyU SPEED)***

(3) *Public Private Partnership: Comments on Projects' Success and Failure* ***(Dr Sammy Sou, HCF Limited)***

(4) *Challenges in Implementing Public Private Partnership in Health Sector in Indonesia* ***(Mr Erwin Sondang Siagian, National Public Procurement Agency, Indonesia)***

(5) *Shared Economy and Health Services: Implications for Hong Kong and United Kingdom* ***(Dr Fowie Ng, HKCHSE; Prof. Graeme Smith, SHSC, Edinburgh Napier University, Scotland)***

(6) *Developing the Right Public Private Partnership in China's Elderly Healthcare Industry* ***(Dr Sam Yu, Soochow University China-Canada Joint Program)***

(7) *Introducing Universal Healthcare Voucher in Hong Kong: Is It Feasible?* ***(Mr Eddy K. H. Tang, Mr Bing H. F. Wong, Miss Iris H. Y. Siu, Miss Erica W. Y. So, PolyU SPEED)***

B. Financing and Management

Chairs: Dr Fowie Ng (HKCHSE) & Dr Tiffany C. H. Leung (PolyU SPEED)

(1) *Health and Sustainability: A Missing Link in Corporate Sustainability Reports?* ***(Dr Artie W. Ng & Dr Tiffany C. H. Leung, PolyU SPEED)***

(2) *Procurement Management in the Private Elderly Home* ***(Mr Yui-yip Lau, University of Manitoba, Canada; Dr Wang-kin Chiu, Dr Gabriel Hoi-huen Chan, PolyU HKCC)***

(3) *Health Care Financing for the Elderly in China: Evolution, Problems, and Responses* ***(Dr Sabrina Ching-yuen Luk)***

(4) *Electronic Health Records in Chinese Medicine and Integrative Medicine: Experience in China, Hong Kong, United States of America, Canada, Australia* ***(Dr Wilfred Lin, PuraPharm International (H.K.) Limited)***

(5) *Managing a Cybersecurity Risk in the Medical Devices* Industry ***(Dr Maria Lai-ling Lam, AJ-Great Limited, HK; Dr Kei-wing Wong, Calvin College, Michigan, USA)***

(6) *Relationships between Healthcare Analytic Capability, Hospital Quality Management and Service Quality Performance* ***(Dr Kelvin M. F. Lo, Dr Mei-lan Peggy Ng , Dr Tiffany C. H. Leung, PolyU SPEED)***

(7) *Investigation of Hong Kong Government Measures for the Elderly on Medical Benefits* ***(Miss Angela Hei-kai Chan, PolyU SPEED)***

C. Healthcare Delivery

Chairs: Prof. Peter Fong (HKPAA) & Dr Vincent Law (PolyU SPEED)

(1) *Hospital Survey on Patient Safety Culture in Yunnan Province from Western China* ***(Y. Wu, S. Fujita, B. Li, K. Matsumoto, K. Seto, Prof. T. Hasegawa, Toho University, Japan, Shanghai Jiao Tong University, Shanghai & Kunming Medical University, Yunnan, China)***

(2) *Making Learning and Development a Strategic Endeavour* ***(Dr Florence H. C. Ho, PolyU SPEED; Ms Dolly W. Y. Leung, Mr Philip K. S. Lo, Professional Training Institute, Haven of Hope Christian Service, HK)***

(3) *Medico-legal Risks in Practicing Telemedicine: Opportunities and Limitations* ***(Dr Kar-wai Tong, CityU SCOPE)***

(4) *A Comparison of Structural and Tensile Performance of Kinesiology Tapes* ***(Miss Ho-yi Fung, Dr Kit-lun Yick, PolyU Institute of Textiles and Clothing; Dr Sun-pui Ng, PolyU HKCC)***

(5) *First-aid Bicycle Service in Cycling Tracks: A Cost-effective Way in Providing Emergency Medical Services* ***(Dr. K. K. Chan, Auxiliary Medical Service, HK)***

(6) *Special Schools and Residential Care Services for Special Learning Disabilities* ***(Miss Kayla Yuen-shun Chow, PolyU SPEED)***

D. Education and Training

Chairs: Prof. Hanqin Qiu (School of Hotel & Tourism Management, PolyU & Dr Simon T. Y. Cheung (PolyU SPEED)

(1) *Auxiliary Medical Service Formula E Circuit Medical Service: Recruitment, Training and Deployment of Professional Volunteers* ***(Dr Kin-kwan Lam, Ms Winifred Wing-yan Ng, Mr Ting-leung Lau, Auxiliary Medical Service, HK)***

(2) *Healthcare Training by Virtual Reality Technology – Experience in Hong Kong Formula E 2016* ***(Mr Gary Tsz-hang Tsang, Medsim Healthcare Education Co., HK)***

(3) *Breaking the Digital Divide for the Elderly through Service Learning and Data Analytics: A Proposal* ***(Dr Adam K. L. Wong, Dr Jack H. C. Wu, Dr Kelvin M. F. Lo, PolyU SPEED)***

(4) *Experience of a New Undergraduate Top-Up Degree in Healthcare* ***(Dr Ben Y. F. Fong, PolyU SPEED)***

(5) *Telemedicine in Hong Kong* ***(Dr Daniel Tong & Dr Wilson Chi-pun Fung, Hong Kong Telemedicine Association)***

(6) *Designing a Competency-based Undergraduate Health Services Management Programme in Hong Kong in a Rapidly Aging Context* ***(Dr Simon T. Y. Cheung, PolyU SPEED)***

E. Community-based Programmes

Chairs: Prof. Albert Lee (Jockey Club School of Public Health and Primary Care, CUHK) & Dr Eric Woo (PolyU HKCC)

(1) *Current Evidence & Knowledge in ACL Injury Prevention Programme for Community Action* ***(Mr Joseph Chun-cheong Ma, Department of Orthopedics & Dermatology, Faculty of Medicine, CUHK)***

(2) *"First Aid Post" as a Healthcare Delivery Model: the Gatekeeper of the Rural Area in Hong Kong* ***(Dr L. H. Leung, Department of Family Medicine and Primary Health Care, Kowloon West Cluster, Hospital Authority, HK)***

(3) *Visiting Pharmacist and Multi-Dose Medication Management Service Model in Residential Care Homes for the Elderly: A Case Study in Hong Kong* ***(Ms Sau-chu Chiang, Hong Kong Pharmaceutical Care Foundation Ltd.; Dr Daisy Lee, PolyU SPEED; Mr Gary Chong, United Christian Hospital)***

(4) *Ving Tsun Martial Art Training for Middle-aged Adults: An Exploratory Study* ***(Dr Shirley S. M. Fong, School of Public Health, HKU)***

(5) *Effectiveness of EatSmart@restaurant.hk Campaign in Hong Kong* ***(Miss Alison Wing-lam Wan, PolyU SPEED)***

(6) *Promotion of Weight Control in Hong Kong* ***(Mr Paco Pak-yin Shum, PolyU SPEED)***

Plenary Session I

Health Reform: Critical Challenges for Health Systems Management - Australian Perspectives

David Briggs
College of Health Systems Management, Naresuan University, Thailand, and, Schools of Health and Rural Medicine, University of New England, Australia

Correspondence: Prof. David Briggs (dsbriggs007@gmail.com)

Abstract
This presentation describes the Australian Health care system which is positioned as one of the best performing health systems across the range of OECD countries. The Australian health system is complicated as there is shared funding and service delivery between the States and the Commonwealth (National government). While we have a national health insurance system we do not have a simply structured national health system. The system has experienced continuous health reform focused on structure and restructure. Demand and utilization of services are high while health expenditure has risen faster than either population growth or ageing. The challenges for the Australian health system are identified as managing downward fiscal pressure and increasing capacity and demand for services; ensuring we deliver the right mix of care for the chronically ill, frail aged by allocating resources optimally and a continued concern for improved quality and safety of care. The responses to these challenges are likely to be a focus on improving the effectiveness of care; greater investment to address social determinants of health and sustainable development goals (SDGs) and perhaps harmonizing health insurance systems. The article is developed from the contemporary literature about the Australian health system and the future directions are identified from invited expert papers in the current issue of APJHM 3(11). The article describes possible responses to the challenges described and suggests emerging themes and approaches to health reform that are likely to move the emphasis of reform from structure to an emphasis on health outcomes through the use of knowledge, research and social movement to improve collaborative and networked practice. The presentation concludes by suggesting possible future directions from an analysis of the language of health reform.

Historical Overview of Health Sector Reform of Japan and its Future Perspective

Toshihiko Hasegawa

President, Future Health Research Institute

Correspondence: Prof. Toshihiko Hasegawa (pxn14573@nifty.com)

Abstract

There is no clear definition of "Health Sector Reform". But it is an "Integrated change policy of Health Sector to Response to Health Transition, i.e. the health system change due the demographic, epidemiological and social transition". The reform is often initiated by economical trigger such as oil shock like European health sector. Japan also started the structural reform of government sector in late 1980 but slow in motion. In late 1990, Prime Minister Hashimoto declared the radical reform in 6 sectors including health sector and have, ministry of health and Liberal Democratic Party make reform plan in detail in 1997. It was not implemented because of the LDP's land slide defeat in general election The drastic reform started in early 2000 by prime minister Koizumi for 4 domains including delivery system, fee payment, drug policy and social insurance. New health insurance for elderly over age 75 started in 2006. DPC payment in 2003. National hospital was privatized in 2004. Long term care insurance was established in 2000 parallel to health sector reform. Coordination was not enough then. So integrated community care is now promoted. Health sector reform is not active nor integrated at present because of the political confusion due to the regime change from LDP to Democratic Party. Japan is now in the midst of the drastic "Demographic Drift" from stable 19 century demographic structure that age under 50 occupies around 85 % which lasted up to 1970', to stable 21 century society that age over 50 occupies about 60 % starting around 2060. So not only heath sector but also society itself requires profound reform. Asian countries such as Taiwan, Korea, Hong Kong, Singapore and Thailand will follow demographic drift only 10-20 years after Japan. We have only half century left for building entirely new society and health system. We cannot experiment society in laboratory. We only can learn from each other as an action research.

Health Sector Reform – Japan's Experience

Tomonori Hasegawa

Department of Social Medicine, Toho University School of Medicine of Japan, Japan

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Abstract

Rapidly aging and how to deal with problems relating aging are major challenges common in East and South-east Asian countries. Reform of the total society is needed to deal with aging related problems and make the society and social systems sustainable. Although Japan is highly industrialized and Japanese makers are highly competitive in global markets, there are several areas which are protected by barriers such as authorization by governments and governmental financial aid. Education, agriculture and healthcare are highly protected areas, and regarded as main battle fields. In Japan, health sector reform led by P.M. Koizumi (2001-2006) was characterized by neoliberalism; tried to strengthen the power of the cabinet office (secretariat of the P.M.) compared to each assigned ministry, implement internal market through deregulation. The reform was succeeded by P.M. Abe whose government lasted less than 1 year (2006-2007) because of his health problem. Reform by Koizumi and Abe specified several important areas for reform with recommendations, and suggested that 1) change of decision making process among governments would be effective, 2) political stability was essential since the reform takes relatively long time (at least several years). After experiencing serious retreat by the government of Democratic Party of Japan (2009-2012), Abe came back to the government again in 2012, and has been leading the reform. Japan witnessed 1) increase of the elderly and worsened fiscal situation, 2) the role of healthcare as a safety net in case of disaster such as earthquake and tsunami in 2011 and 3) introduction of expensive new medical technologies. They accelerate the reform with some modification. Areas for deregulation are clearly distinguished from areas under public control, where the power of authority was strengthened. Regional health plan and integrated healthcare system are characterized by strict control of number of hospital beds by function based upon the expected number of patients in future. OPDIVO (Nivolumab) is highly effective in about 20% of patients with lung cancer or malignant melanoma. The average annual cost per patient is about 35,000,000 JPN, and is clearly unacceptable. It changed the revising process of national tariff for medications from every two years to every year paying attention to real sales compared to expected sales, and encouraged precision medicine. As an infrastructure, genome bank of cancer patients will be built to facilitate genome-base diagnosis as for responsiveness to expensive anti-cancer medications resulting in cost-effective personalized medicine. My presentation will address Japan's experience from 2011 and try to extract lessons learned.

Health Reform: Perspectives from the Thai Experience

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Abstract

Thailand has performed admirably in its health reform over the last few decades and achieved universal health insurance. The challenges now faced by Thailand are similar to most developed countries; an ageing and increasingly urban population reflecting adult mortality and risk factors of an upper-middle income population and the need to modify institutional structures to reflect these changing circumstances. The approach to these challenges has focused on the move to District Health Systems as the access point to healthcare and the service delivery structure demands competent qualified leadership and management. The main concept of this approach is relevant to the concept and principle of the WHO's DHS development based on primary health care as specified in the Harare Declaration signed in 1987. The aims of this concept are to improve quality of life of people and to encourage people to have better self-care and to look after each other in their own communities. This approach provides recognition of the need to build the capacity and capability of health professionals in the management and leadership of health systems. The purpose of this paper is to discuss the current initiatives in reforming the Thai health system at the district level by improving quality of primary care services and strengthening governance and management capacity of district health boards in order to meet the concept of DHS development. Also, this paper will discuss the role of the recently established College of Health Systems Management of Naresuan University, Thailand in those initiatives within the context of attaining Sustainable Development Goals (SDGs) implementation.

Plenary Session II

Beyond a 20-Year Journey of Universal Health Coverage in Taiwan: Challenges Ahead

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Abstract

Universal Health Coverage (UHC) is being embraced globally as an important goal to improve population health. In 2015, Taiwan National Health Insurance (NHI) celebrated its 20th anniversary since its historical inauguration in 1995. The single-payer NHI program, operated by National Health Insurance Administration (NHIA), was established through integrating three existing social insurance schemes and extended the coverage to the then uninsured 43% of the population. Taiwan NHI offers comprehensive benefit coverage that includes ambulatory care (Western and Chinese medicines, and dental services) as well as inpatient services. On the service side, Taiwan has a market-oriented health care delivery system, reflecting its free-enterprise economy, as evidenced by the pluralistic organization of health services. Hospital ownership is mixed where public hospitals only account for 35% of all beds. There is no gate keeping mechanism and the insured essentially enjoy complete freedom of choice which is likely a source of overuse. As a single payer, NHIA has effectively exploited its market power to experiment with various payment reforms in its 20-year history. NHIA gradually set up separate global budgets for dental services, Chinese medicines, primary care services, and hospital services since 1998. The annual growth rate of the total NHI budget is negotiated among stakeholders. NHI revenue mainly relies on payroll-based premiums, supplemented by a levy on non-payroll income and government subsidies. In 2014, NHI spent roughly NTD 538 (USD 16.9) billion on medical claims, accounting for approximately 52% of national health expenditures, and in total, Taiwan devoted 6.2% of GDP to health. The NHI program, which provides universal health coverage (UHC) to Taiwan's population of 23 million, has had a profound impact on Taiwan's health system. This presentation will showcase Taiwan's NHI scheme, the recent financing reform and challenges ahead, in terms of impact of physician supply and long-term care.

Health Care System in China and Recent Reform Initiatives

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Abstract

Since launching the health care reform in 2009, China has made significant progress in establishment of a basic health insurance system covering both urban and rural residents. China's social health insurance schemes – including the Urban Employee Basic Medical Insurance scheme (UEBMI; launched in 1998), Urban Resident Basic Medical Insurance scheme (URBMI; launched in 2007), and the New Rural Cooperative Medical Scheme (NRCMS; launched in 2003) – have rapidly expanded during the past decade and now cover almost the whole Chinese population. The UEBMI scheme is mandatory for the employees and retirees in urban areas, with premiums paid by both employers and employees, covering outpatient expenditures, inpatient services and designated pharmacies. Those not covered by the UEBMI scheme could join the voluntary URBMI scheme jointly financed by enrollees and the government. Rural residents enroll voluntarily in the NRCMS scheme in the units of families, financed by the enrollees and the government. Payroll taxes are the main funding source for the UEBMI scheme, and government subsidies are the major funding sources for the URBMI scheme and NRCMS. In recent years, government health funding increased obviously and China's total health expenditure as a percentage of GDP has attained 6% in 2015. Proportion of out-of-pocket payments in total health expenditures has been rapidly reduced after introduction of the social health insurance schemes. Due to the complexity and systematic nature, health care system reform in China is faced with many challenges that require persistence and development. The reform needs to go further in promoting comprehensive reform of health insurance, medical services delivery, and integrating basic health insurance schemes.

The Lack of Progress in Health Systems Reform in Hong Kong: Reasons, Implications, and The Way Forward

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Abstract

The author reviews major health care reform initiative attempts by the Hong Kong government since the 1990's. The author applies public choice and other public policy theories to explain the lack of success in these initiatives. The current financing and delivery system is evaluated in terms of its efficiency and its ability to cope with the rapidly ageing population. Government subvention amounts and the number of doctors employed in public hospitals are measured against output. The results of the analyses suggest that, contrary to popular opinion that not enough resources are given to public hospitals, government has, in fact, been providing more resources to the public health care system year after year (measured by subvention amount, doctor to population ratio, doctor to bed ratio, doctor to patient days, etc.). Long standing problems, such as waiting time, appear to be worsening despite increases in funding. The results suggest that the structure of the health care system is too acute-centric, and the current funding mechanism creates perverse incentives. The author concludes that Hong Kong is poorly prepared to cope with the rapidly ageing population, and that the quality of care and accessibility to care are likely to further deteriorate. Given the existing constitutional arrangement in Hong Kong, the author recommends reforming the existing tax based financing system instead of launching new initiatives to replace it. The restructuring of some existing funding and administrative responsibilities of relevant public bodies to address the compartmentalization and perverse incentive problems and the establishment of an earmarked government future fund to assure the future viability of the tax-based system are suggested as the way forward.

Parallel Sessions

A. Healthcare Reform

New Theory and Method of Big Data Management for 21c Super-super aged Society in Japan

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Abstract

Because of the epidemiological transition, method of analysis and evaluation for health care should be changed drastically. Disease event of young population is episodic. So the care can be assessed at the end of each episode by measuring health outcome and satisfaction for example. But for elderly population disease is continuous, multiple and often difficult to cure. Death is eventually impossible to prevent. So it cannot be measured by cure rate or survival rate of one episode. Quality of life and quality of death through whole course of long term care should be measured and summed. To do so new format of information and new method of analysis is needed. New data format include the continuous follow up of each individual life course. Both data of medical and welfare care should be linked till death. The method of analysis should cover the life course approach using life table analysis or micro simulation. In traditional epidemiology 2 by 2 tale has been used assuming one intervention and one outcome. Method was developed during the period when majority of the population is still under 50 years old because each patient can be very homogeneous and return normal after episode. 2 by 2 tale has been a simple and powerful method. But for 21 century super-super aged society new analytical tool is needed. Japan happen to have both Long term care insurance started in 2000 and elderly medical insurance started in 2008. The information of service delivery and health checkup can be connected. And also detailed & high quality data of ADL, IADL and geriatric assessment for qualification of long term care exist. All information can be connected by individual ID. Currently real data of the certain municipality is all connected and started to be analyzed. By doing so we found that traditional significance of disease and the meaning of death being changing. These findings illuminate the need of new theory of medicine and public health in 21 century.

The Comprehensive Cost of Illness in Super-aged Society

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Abstract

In a super-aged society, diseases that need long term care (LTC) are becoming increasingly important. However, it is difficult to measure the social burden of such chronical diseases. The purpose of this study is to measure the burden of diseases that need LTC using cost of illness (COI) method. As for a disease that needs LTC we measured the social burden of cerebrovascular disease (CVD). Modifying the COI method developed by Rice D, we newly defined and estimated comprehensive cost of illness (C-COI) of CVD (I60-I69), and we compared it with C-COI of cancer (ICD10 code: C00-D09) and heart disease (I01-I02.0, I05-I09, I20-I25, I27, I30-I52). C-COI consists of five parts; direct cost (medical), morbidity cost, mortality cost, direct cost (LTC) and family's burden. Direct cost (medical) is health care cost of each disease. Morbidity cost is opportunity cost for inpatient care and outpatient care. Mortality cost is measured as the loss of human capital (human capital method). These three costs are known as components of original cost of illness by Rice D. Direct cost (LTC) is long term care insurance benefits. And family's burden is "unpaid care cost" by family, relatives and friends in-home and in-community (opportunity cost). We calculated such costs at 2013-2014 using Japanese official statistics. C-COI of CVD, cancer and heart disease amount to 6.5 trillion JPY, 9.8 trillion JPY, and 4.5 trillion JPY, respectively. As for composition of C-COI, the mortality cost occupied the largest part for cancer (63.5%) and heart disease (50.6%), but the direct cost (LTC) occupied the largest part for CVD (26.7%). Cost of LTC for CVD was 11.1 times of that of cancer and 6.2 times of that of heart disease. With governmental statistics, the study demonstrated that the family's burden could be estimated and it could be a major cost component in CVD, where long term disability is a salient feature of the disease. When policies to decrease direct cost, that is the expenditure from medical and LTC insurance, are taken, they may mean just cost-transfer from direct cost to family's burden. Family's burden is unpaid burden, but by including family's burden when estimating the COI (C-COI), we can estimate the COI correctly, and measure the impact of health policy.

Interrogating the Conditions for the Political Collaboration between the State and the Medical Profession: the Case of Hong Kong

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Abstract

In July 2016, the Hong Kong Medical Association (HKMA) mobilized several hundred doctors and medical students to join a sit-in protest outside the Legislative Council, which is the legislative branch of the Hong Kong government. Eventually, an amendment bill failed to pass through the Legislative Council. This paper argues that the open confrontation between the state and the medical profession in Hong Kong is a result of public-private imbalance, and the suffering of the medical profession through the process. Today, there are more medical doctors in the private sector than the public sector. However, the public sector shares almost ninety percent of all hospital beds, and the demand for services in terms of bed-days. Although the problem about the undersupply of medical doctors in Hong Kong is real, with only 1.9 doctors serving 1,000 patients which is below the standard in many developed countries, the medical profession does not benefit. Because of the underfunding by the government, an increasing number of doctors are leaving the public sector to join the private sector. On the other hand, the public-private imbalance in terms of the market share of services and the number of hospital beds remains, with 90 percent of patients seeking services from the public sector. As a result, the doctor-patient ratio in the public sector deteriorates from 1.9 to 0.9, which means an even heavier workload on the doctors within the public sector. On the other hand, the doctor-patient ratio in the private sector is as high as 9.0, which means an oversupply of medical doctors to an alarming degree. A further study of the Annual Report of the HKMA, especially the President's message, through the last ten years also provides evidence for the growing frustration and even hostility of the medical profession to the government. Anecdotal evidence will also be presented about the suffering of public doctors due to inordinately heavy workload on the one hand, and the suffering of private doctors due to oversupply on the other hand. The aggravation of the problem of public-private imbalance which explains the open confrontation between the medical profession and the state must be traced to the myopic vision of the state, especially during the colonial era, which focuses on the development of the public sector only, without taking a holistic view of the two-track healthcare system in Hong Kong. Even though there is sign that the state is beginning to adopt a more holistic view of the two-track healthcare system in the last several years, whether the state can take any action to reverse the deterioration of the relationship between the state and the medical profession requires political skills as much as political will.

Public Private Partnership: Comments on Projects' Success and Failure

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Abstract

In Hong Kong, about 90% of hospital users rely on the public hospital system (Hospital Authority) while 70% of primary care utilization take place in the private sector. The Government of the HKSAR and the Hospital Authority have committed to involve the private sector to provide better healthcare services as a whole. An obvious initiative is the ten-year 700 million dollar eHealth initiative which aims at inter-operability and partnership between the public and private healthcare sectors. There are several unique favourable factors in the eHealth ecology of Hong Kong, making the eHealth initiative prone to success when compared with similar projects in cities/areas like Singapore, Taiwan, and the United States. The 11 private hospitals are keen on the partnership. However, limitation exists which will anchor the ceiling of the success level of the bold eHealth initiative for decades. Work habits and fear of private medical experts and leaders in private clinics is a main issue to be tackled, or tolerated. The once very keen plan of tendering of four pieces of land for private hospital use had encountered lower than expected level of real interest. The planning was most likely based on public sector mentality and successful track records. There exist views from private hospital owners/investors/operators, which may not be well understood by the public sector in planning land uses. The Public Private Partnership on diagnostic imaging service provision, the Elderly Health Care Voucher Pilot Scheme and vaccination programmes, the new and significantly subsidized colorectal cancer screening, cataract surgery queue shortening, regular monitoring of chronic diseases such as diabetes and hypertension, etc., all aim at better and more efficient healthcare service delivery to the people of Hong Kong. The goals of Public Private Partnership: better service delivery and investment opportunities, improvement in quality of care, efficient utilization of resources and doctors' expertise, cost-effectiveness, and promoting healthy collaboration-competition, are admirable. Their success or failure depends on innovations and dedications, and a taskforce with good understanding of both public and private sectors, or at least a good interflow of ideas /minds among experts of both sectors. Public Private Partnership is facing more challenges nowadays. Political uprising could quickly turn a sensitive issue into emotional resistance of the people against good initiatives. The author will present interesting and pragmatic views on the topic through his over two decades of management career in private hospital and listed medical group, active public sector networking, and current business experience on healthcare investment and management advisory consultancy for Hong Kong and the People's Republic of China.

Challenges in Implementing Public Private Partnership in Health Sector in Indonesia

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Abstract

Public Private Partnership (PPP) in Indonesia was introduced through Presidential Decree (Keppres) Number 7 Year 1998. Then, Keppres has been replaced through Presidential Regulation (Perpres) Number 67 Year 2005 and its revision. In 2015, the Government stipulated a Perpres Number 38 of 2015 regarding Cooperation between the Government and Business Entities in Infrastructure Provision to replace Perpres 67 of 2005 and its revisions. In Indonesia, PPP in Health Sector is newly regulated, based on Article 5 chapter 2 Perpres Number 38 of 2015 regarding Cooperation between the Government and Private Business Entities. Based on Article 30 Law Number 44 of 2009 regarding Hospital, it has been mandated about co-operation and partnership for hospital. But until now, the technical regulation for implementing PPP in health sector has not yet regulated by the Ministry of Health. So, if the government is going to regulate technical regulation for PPP in Health Sector I recommend several things that should be regulated under this technical regulation, as follows: (i) Project planning - This phase must clear give information about the step by step that is needed by governments. (ii) Project preparation - This phase gives clear information who prepares the PPP project and how they do the preparation, both of for solicited project and unsolicited project. Furthermore, including regulate about establish a Special Purpose Company is a must or a choice. (iii) Project transaction - This phase has to clear give information how to do the bidding process. (iv) Contract management - This phase will give information how to manage PPP project that can give equal treatment for government side and private sector side. To produce this regulation, at least 5 (five) government institutions must work together, such as Ministry of Finance, Ministry of Health (including hospitals), Ministry of Home Affairs, National Planning Agency, and National Public Procurement Agency and as additional local governments that owned the local hospitals. If the government can produce clear technical regulation, I believe PPP in health sector can be implemented successfully in Indonesia.

Shared Economy and Health Services: Implications for Hong Kong and United Kingdom

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Abstract

The recent arise of the so called 'Shared Economy' or 'Gig Economy' has shaped the business world with new business models in a lot of industries such as 'airbnb' in the hospitality industry as well as 'uber' in the transport industry. This kind of economy is changing the way how consumers buy goods and services. Startups and Entrepreneurs are being attracted to invest their time and efforts in turning their ideas into reality. It also attracts investment ranging from incubation support to venture capitalist to these budding markets. Major players in the field and their game-changing companies are challenging traditional industry models and structures so as to redefine the market as well as to create vast opportunity locally, regionally as well as internationally. Cities around the globe are joining the 'Sharing Cities Network' to share their experiences in local movements and to build up better cities for their people. The Sharing Economy eco-system is increasing to affect many facet of the society including health care with both positive and negative effects to the economy. Currently, many of the initiatives are concentrated on areas such as transport, finance, real estates and labor market. In health services, there are also new initiatives around the world to adopt this approach in an attempt to improve access and quality as well as to maximize the use of unused or under-utilized resources. Health services providers and their executives have to prepare themselves for these challenges that they are currently facing as well as they do not know what they will be facing in the future. Knowledge about the current landscape is essential for the future developments in this area. Hence, this paper will review the current situations of 'Shared Economy' in Hong Kong and United Kingdom (UK) with regard to health services. It also addresses the overseas experiences of implementing this new model of health care to shred light into what local health services can be innovative in their offering of health services to improve the health status of their citizens. Both potential benefits and risks will be highlighted to justify this worldwide phenomenon into health services in Hong Kong and UK.

Developing the Right Public Private Partnership in China's Elderly Healthcare Industry

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Abstract

According to the National Statistics Bureau, China's over 60 population – the age at which it classifies an elderly person – reached 222 million in 2015, accounting for 16.1 percent of the overall population. This rate is now predicted to grow by three percent year on year, resulting in the proportion of elderly citizens exceeding that of those aged 14 and under by 2030, and one in three people in China being aged over 65 by 2050. This increasing elderly population has and will necessitate more senior healthcare in China. While the provision of elderly healthcare by using public private partnership (PPP) is increasingly discussed in China, both central and sub-national governments are significantly looking to this approach as to whether it would actually help address growing financial burdens. However, the existence of imperfect information, constraints on governments and human's self-interested nature mean the social optimal outcome is hard to achieve when coordination failed. Questions remain unanswered such as: is it a joint ownership of an elderly healthcare program / proposal by two or more stakeholders that really aim to achieve a common goal? Will such partnership generate a higher level of collaboration that delivers a better and more balanced elderly care services to the community in China in a sustainable manner? This paper is attempting to elaborate the potential problems and existing challenges of using PPP to provide elderly care under the current institutional settings in China. In addition, this paper discusses the significance of the roles (and preferences) of sub-national governments, as agents on behalf of the central government, in shaping regional elderly healthcare market. How the preferences of sub-national governments will then impact the private investment / involvement in the regional elderly healthcare setting, how these private sector reactions would influence the decision of selecting 'right' PPP mode made by the sub-national government and how these interlinked relationships will ultimately direct the development of the elderly healthcare industry in the future. This paper will try to explore what would be the key factors that influence the application of PPP in elderly healthcare services in China from institutional perspective. This paper will also analyze the related policy changes, examine their underlying rationale and consider the ramifications on China's elderly care finance.

Introducing Universal Healthcare Voucher in Hong Kong: Is It Feasible?

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Abstract

The imbalance use of the public and private healthcare sectors is one of the most fundamental problems faced by the Hong Kong government in the area of the public health management. Meanwhile, the general public requires a larger amount of medical subsidy from the government in order to improve the personal health, especially for the elderly group. Hence, the government introduced Elderly Healthcare Voucher scheme in 2009, aiming to relieve the pressure of public hospital, and regarding it as a gift to the elderly. With the 'success' of the Elderly Healthcare Voucher scheme, some residents have suggested that the coverage of healthcare voucher should be extended to the universal level, in order to extend the intentions of adopting healthcare voucher scheme. The thesis of this study is to allege the intentions of adopting Universal Healthcare Vouchers scheme in Hong Kong is positive. However, due to the implementation gap of healthcare voucher scheme, the scheme might not be applicable in reality. This study examines the implementation of the Elderly Healthcare Voucher scheme, and foresees the problems of the Universal Healthcare Voucher to prove the above thesis. The intentions of adopting elderly healthcare voucher are encouraging the elderly to strengthen the sense of illness prevention and to narrow down the imbalance usage of public and private healthcare sectors. Moreover, the ideas of equity and equality, and social resource redistribution could be further achieved if the healthcare vouchers scheme is expanded to the universal level. Undoubtedly, the above intention is good and worth to be expanding, yet, the above intentions might not able to fully achieve while adopting because of the low sense of illness prevention and the technological limitations of some service providers. On the other hand, the adoption of Universal Healthcare Voucher would potentially face the suspicion from the government, and some of the civil organisations. In addition, Universal Healthcare Voucher might not able to bypass the specialist outpatients effectively due to the implementation gap mentioned. Therefore, the possibility of passing the bills is relatively low in the current political situations. Finally, the paper will conclude with the suggestions of introducing universal body-check vouchers and expanding the age group of elderly healthcare voucher, which will be more rational in order to achieve the intention proposed.

B. Financing and Management

Health and Sustainability: A Missing Link in Corporate Sustainability Reports?

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Abstract

There have been increasing efforts among the financial regulators to encourage Corporate Social Responsibility (CSR) and sustainability reporting. The current reporting rate of Corporate Social Responsibility Disclosure of the Global 250 companies is over 90 percent in 2015 and over 75 percent of national 100 companies in both developed and developing countries report on the non-financial information (social and environmental information) in their annual reports and standalone sustainability reports. However, the enthusiasm has been linked largely for the interests of the financial stakeholders, namely the investors, stockholders and financiers in general for the relationship to reputation enhancement, corporate financial performance, and risk management. The multinational companies tend to pay less attention to social stakeholders, such as local communities, or even the primary nonsocial stakeholders, namely natural environment, nonhuman generations and nonhuman species. From a social scientist's point of view, such a focus is rather myopic in light of the social and environmental implications. Currently, the environmentally sensitive industries, such as mining, automotive, oil and gas, disclose more social and environmental information in their annual reports or standalone reports, with a global reporting rate more than 78 percent in 2015. However, non-environmentally sensitive industries, such as healthcare, retail and leisure, still lag behind all other industries, with a global reporting rate of below 65 percent in 2015. The Global 250 companies adopt the most popular voluntary the Global Reporting Initiative (GRI) guideline with three main disclosure categories, namely economic, environmental, and social (including labour practices and decent work, human rights, society and product responsibility). The application rate of GRI among the multinational companies is above 72 percent in 2015. In particular, the ultimate concerns in association with human health have been largely ignored in annual reports or standalone reports. Through literature review and a pilot study on corporate disclosures, we argue that there could be a disconnect between health and sustainability as currently practiced in annual reports or sustainability reporting. We take a social scientist approach that accounting and accountability if serving the public interests at large may explore such a missing link to the underlying social costs relating to health resulting from social and environmental un-sustainability.

Procurement Management in the Private Elderly Home

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Abstract

In Hong Kong, the current population has almost reached at 7.4 million. The population growth rate will be 0.6% in the forthcoming years. By 2043, population in Hong Kong will be speculated to reach a peak of 8.22 million. The demand for elderly service is high on the social agenda, notably an elderly home. An elderly home is the place to provide accommodation, meals, personal care and basic medical and nursing care to senior citizens. In general, elderly homes are now operated by three key parties including public, private and non-profit making organizations. In the context of private elderly home, the drug procurement process is in the spotlight and plays a significant role in the twenty-first century. Basically, the drug procurement process of the private elderly homes are governed by the Stores and Procurement Regulations (hereafter called "Regulations") issued by the Financial Secretary under the Public Finance Ordinance (Cap. 2). The Regulations set out the comprehensive criteria of fair treatment of suppliers and producers. We would also discuss the key issues including the need to establish a Drug Quality Assurance Office and the enrichment of the database of registered pharmaceutical products. In this study, important issues in the supplier evaluation in private elderly homes will be discussed based on eight key inter-related steps including (1) identify a problem; (2) identify decision criteria; (3) allocate weights to the criteria; (4) develop alternatives; (5) analyze alternatives; (6) select an alternative; (7) implement the alternative; and (8) evaluate decision effectiveness. Considering the importance of procurement management in the healthcare industry, a framework of supplier selection is also presented to highlight the methods and strategies needed to enhance the performance of supplier. Additionally, the private elderly homes have demonstrated a series of problems pertaining to (1) gain advantages over loose government regulations and control; (2) a lack of professionals (3) poor quality assurance systems; (4) insufficient campus facilities management; and (5) extremely lack community support. To this end, a series of problems had been continuously arising from the private elderly homes. We illustrate the balanced scorecard framework including different perspectives of customer, internal operations, financial and continual learning and growth to examine the performance of private elderly home.

Health Care Financing for the Elderly in China: Evolution, Problems and Responses

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Abstract

Since 1999, China has become an ageing society when more than 7 per cent of its total population is over the age of 65. Due to ageing at an unprecedented speed and scale, China in 2013 had the world's largest number of oldest-old group aged 80- years or over, which amounted to 23 million persons. China's demographic shift towards an ageing society unavoidably puts great strain on the health care financing system because old people usually have poorer health status, frequently suffer from multiple chronic conditions, and have greater medical needs. Meanwhile, the problem of 'getting old before getting rich', which refers to population ageing outpacing economic development, increases the vulnerability of old people to fall into poverty when they have illness. It also imposes financial burden to family members or grown children of old people because they are the primary source of social support for old people. The Confucian norm of filial piety has been eroded due to profound demographic and socio-economic changes. Falling fertility rate, higher old-age dependency ratio, and urbanization have made the fulfillment of filial piety by grown child become increasingly difficult. As a result, the Chinese government is under great pressure to finance health care for the elderly in a more feasible and sustainable way. Using the revised version of the theory of historical institutionalism, this paper examines how the dynamic interplay among political institutions, actors, ideology and environmental triggers has shaped the trajectory of health care financing for the elderly in China since the late 1990s. At present, China relies on a multi-layered health care financing system to pay for medical expenses for the elderly. The multi-layered health care financing system consists of the Urban Employee Basic Medical Insurance (UEBMI), the New Rural Cooperative Medical System (NRCMS), the Urban Resident Basic Medical Insurance System (URBMI), the Critical Illness Insurance Scheme (CIIS), and Medical Financial Assistance (MFA) System. This paper examines problems caused by the fragmentation of health care financing system, such as inequality and disparity in treatment, high out-of-pocket payment and poor risk-pooling capacity. And it examines how the government responds to these problems by implementing an experiment of integrating medical and nursing care for the elderly (*yi yang jie he*) in some pilot cities.

Electronic Health Records in Chinese Medicine and Integrative Medicine: Experience in China, Hong Kong, United States of America, Canada, Australia

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Abstract

Healthcare informatics such as clinical management system has long been developed for health-related purposes in Western medicine. A clinical management is a computer program that assists healthcare providers in performing clinical tasks. An important feature of a clinical management system is the ability to store patient information as electronic health records (EHRs). An EHR contains patient demographic and medical information that is managed and transferred electronically. Clinical Management System that are designed and developed for Chinese Medicine are now available for clinical use. Traditional Chinese Medicine Advisor (TCMA) is a clinical management system developed by PuraPharm/Nong's and HerbMiners Informatics Limited. It is currently deployed over 100 clinics in Hong Kong and over 300 hospitals in China. The mobile clinic are deployed in many NGOs (such as Yan Oi Tong). It is technically possible to integrate clinical data with patient records from Chinese Medicine clinics using Chinese Medicine Systems and to conduct Chinese Medicine and Integrative Medicine research. To evaluate the feasibility of adopting a centralized Chinese Medicine database, two factors need to be studied: (1) The barriers to and facilitators for uptake of the Chinese Medicine database; (2) The feasibility of conducting epidemiological analyses using data from the Chinese Medicine database. A survey study was conducted to investigate Factor 1 and a descriptive pilot study to investigate Factor 2. PuraPharm international integrative (Chinese-Western) Medicine research collaboration with University of Toronto, King's College London, University of Sydney, University of Hong Kong. Increasingly western allopathic medical practitioners are utilizing TCM Herbs or techniques in conjunction with the allopathic drugs. While this is a welcome development, it requires careful elaboration in its use. It is known that if more than one allopathic drug is used, drug interactions can produce one of the following situations: (i) The drugs have a positive and complementary effect on each other increasing their therapeutic capability; (ii) They have a negative effect which reduces the potential effect of one or more of the drugs; (iii) They can have an adverse reaction introducing further undesirable side effects; and (iv) They can have no effect on each other. When using TCM Herbs with Orthodox allopathic drugs, one has to be aware that the above four interactions can also take place. When we introduce the use of TCM Herbs with the orthodox allopathic, the situation can become more complex due to the fact that the TCM Medical model is somewhat different than the Allopathic model and hence it is necessary to get a more precise understanding of the pharmacology properties of TCM Herbs.

Managing a Cybersecurity Risk in the Medical Devices Industry

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Abstract

Digital networked medical technology can improve the quality of health care at a much lower cost but also can create a cybersecurity risk. Many American medical devices manufacturers are key global innovators and are criticized lagging behind other industries in terms of cybersecurity management. During 2016, the American government has set up more guidelines for the medical devices industry to manage its cybersecurity risks. This paper is to investigate how these key American medical devices companies respond to the FDA cybersecurity guidelines and thus provide better health care to patients. Here are these two necessary research questions: (1) What factors led these manufactures not to invest in cybersecurity management? (2) Under what conditions will these manufacturers develop their cybersecurity capabilities and increase their digital global competitive advantages? The authors reviewed the literature related to the U.S. medical devices industry, FDA cybersecurity guidelines, the voices of medical devices manufacturers, industry associations and relevant consultant companies. The authors also interviewed many manufacturers and representatives in the medical trade shows and tours in China, Germany, Israel and U.S. during 2013 to 2016. They also interviewed the business executives in the medical devices industry in Hong Kong. Here are the findings: medical devices manufacturers emphasize solely the functions of medical devices, and utilize a quick innovation at a lower cost within the U.S. legal framework at a highly price competitive global market. Health care providers are responsible for the cybersecurity risk of many medical devices. There is a need for the integration of IT and bioengineering systems to change the culture of medical devices companies. There are key characteristics of medical devices companies that develop cybersecurity competence as their competitive advantages; they developed their privacy and security guidelines before the U.S. government's regulations; they have collaborated with the government to develop regulations, and their employees have engaged in many dialogues among different stakeholders about cybersecurity issues. The companies have close relationships with medical schools and hospitals; the companies create a platform for their stakeholders to reduce their cybersecurity risks and provide products that fit the needs of a hospital in particular social-technical contexts. They also practice how to open their data and permit the public to test their codes in the software. These companies are usually the leaders and have changed their strategies from making products to providing health care services by using integrated system perspectives.

Relationships between Healthcare Analytic Capability, Hospital Quality Management and Service Quality Performance

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Abstract

Big data analytics applications have increasingly become important in management studies over the past few years. Several studies proved that the use of business analytics enhanced both the quality and acceptability of decisions made by management and ultimately increased the firm performance. In particular, a huge volume of data is being collected or generated from the electronic health records systems, laboratories, medical instruments, pharmacy, administrative systems, and inter-organizational entities in healthcare industry. With proper use of these big data, healthcare organizations can benefit from different areas, such as clinical operations, research and development, public health, and patient analysis, and in turn enhancing the service quality being offered. As there is limited study investigating the linkage between healthcare analytics and the quality management in healthcare sector, this study aims to develop a research framework to address such gap. This study first reviews the characteristics of big data (5Vs) in healthcare sector, followed by the benefits of healthcare analytics. Moreover, different stages of healthcare analytics (descriptive analytics, predictive analytics, prescriptive analytics, and discovery analytics) are discussed. Drawing from prior literature, business analytics is further divided into three sub-components: data management capability, analytical capability, and performance management capability. Data management capability refers to ability of an organization to extract, acquire, transform and integrated healthcare data. Secondly, analytical capability is considered as the knowledge and skills that the healthcare organizations possess to perform predictive analytics, prescriptive analytics, and even discovery analytics. Balanced scorecard is widely adopted for performance management in healthcare sector. However, the potential of healthcare analytics cannot be leveraged without proper hospital quality management. In a classical healthcare study, researcher found out that the five components in hospital quality management factor (top management leadership, organizational cooperation, technology leadership, workforce development, and information analysis) are the significant predictors to service quality. By integrating the healthcare analytic capability into the hospital quality management, a conceptual framework is proposed to address their relationships with healthcare service quality. The propositions in the conceptual framework are then discussed. Moreover, this study also addresses the potential challenges (data quality, data privacy and governance) concerned with healthcare analytics and followed by future research.

Investigation of Hong Kong Government Measures for the Elderly on Medical Benefits

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Abstract

Being richer or poorer among the elderly reflects the imbalanced allocation of social resources in Hong Kong. The elders have an important social role as they have given their whole life to contribute to the society when they were young. Most of them are living in poverty and with social problems such as inadequate medical services in the public hospital. What problems do the elderlies face with? What are their needs? What has the government done to ease the burden on the medical needs of the elders? This paper aims to understand what medical benefits are being provided for the elderly from the Hong Kong government and how can these medical supports benefit the elders, for instance providing an Elderly Health Care Voucher Scheme, Medical Subsidies for elderly, Residential Care Services for the Elderly, etc. It investigates how the policy helps to subsidize the elders to ease their expenditure on health. There is a comprehensive report that investigates and analyses the information about the health policies, which are suggested by the Hong Kong government and focus on the elderly. It also aims to recommends ways to cope with these social problems in Hong Kong. The results of the research show that those health policies have not solved the problems of elderly poverty fully in Hong Kong as people rely on the Hong Kong Government's medical subsidies and welfare. On the other side, people will not rely on the medical subsidies if there is a balance in allocating the social resources in the society. It also shows that different people of social ranks in society have different points of view and concepts about what the Hong Kong Government have done in the medical policy such as curtailing the medical expenditure in public hospitals. Some recommendations for improving the poverty and the quality life of elderly will also be presented. A conclusion can be drawn that the Hong Kong Government is responsible to plan a long-term solution to deal with the problem of poverty and their medical needs of the elders in Hong Kong.

C. Healthcare Delivery

Hospital Survey on Patient Safety Culture in Yunnan Province from Western China

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Abstract

A positive patient safety culture (PSC) has been considered as one of the most critical components which could improve the quality and safety in healthcare. Hospital Survey on Patient Safety Culture (HSOPS) developed by the US Agency for Healthcare Research and Quality (AHRQ) has been used to assess the patient safety culture in 45 countries including China. However, HSOPS was distributed only in big cities of the central and eastern China, such as Beijing, Shanghai, and Guangzhou and no study focus on the PSC in the western China. The aim of this study is to reveal the situation of PSC in tertiary hospitals in Yunnan which is a big province in western China. A cross-section survey was conducted in 7 tertiary hospitals in Yunnan province by using Hospital Survey on Patient Safety culture (HSOPS) and 3550 nurses were recruited from each unit of all hospitals. The HSOPS questionnaire measures 12 sub-dimensions of PSC by a five-point Likert scale with higher scores indicating a more positive PSC. Percent positive score more than 75% was considered as superior sub-dimension and less than 50% considered as inferior. The ranking of 12 sub-dimensions by percent positive score was compared with those of other existing literature in the central and eastern China. Tukey's test was used to verify whether there were differences in each sub-dimension among three different working-hour groups. T test measured the effect of education and academic title on 12 sub-dimensions. Among 2629 valid responses, 191 nurses (7.17%) rated patient safety conditions of their work area as 'Poor' or 'Failing', 1090 nurses (40.96%) reported no event and 827 nurses (31.08%) reported 1 to 2 event reports during the past one year. The proportion of positive responses of "Teamwork within Hospital Units", "Organizational Learning-Continuous Improvement" and "Feedback and Communication about Error" were more than 75% and those 3 sub-dimensions were defined as superior sub-dimensions. However, those of "Teamwork across hospital units", "Staffing" and "Nonpunitive response to error" were less than 50% and those 3 sub-dimensions were defined as inferior sub-dimensions. Nurses with bachelor degree or above rated lower scores than lower educated nurses in "Hospital management support for patient safety", "Overall perceptions of patient safety", "Teamwork across hospital units" and "Staffing" ($P<0.05$). Nurses with senior title rated higher scores than Juniors in "Supervisor/manager expectations and actions promoting safety", "Hospital

management support for patient safety", "Overall perceptions of patient safety", "Hospital handoffs and transitions" and "staffing" ($P<0.05$). Two superior sub-dimensions, "Teamwork within Hospital Units" and "Organizational Learning-Continuous Improvement", and two inferior sub-dimensions, "Staffing" and "Nonpunitive response to error", in Yunnan hospitals were same as hospitals' in other areas of China, while "Feedback and Communication about Error" was superior and "Teamwork across hospital units" was inferior sub-dimensions in Yunnan hospitals. To improve PSC in Yunnan hospitals, managers may need more effort to build a more positive culture of nonpunitive response to error, promote hospital units coordinate well with each other and adjust staffing. Nurses with bachelor degree or above or senior title gave a lower evaluation that may be linked to their higher expectations promoting PSC.

Making Learning and Development a Strategic Endeavour

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Abstract

Responding to the growing demand for healthcare services, coupled with the impending drive for greater efficiency, healthcare services providers are striving to deliver their services more efficiently, securely and cost-effectively --- and in the process improve the overall quality of healthcare services. The key to make that transition is attracting, training, and retaining their core workforce. Job-related training designed and delivered in-house tends to focus on specific aspects of job processes or responsibilities. While the intention is to develop the operational competency of individual employees, the purpose far exceeds than merely ensuring that employees will, thus, be able to improve their skills and enhance their performance. Continuous learning steered in a purposeful and structured mode helps developing employees' as well as the organisation's capabilities. Healthcare service providers utilise training to acclimate new employees, teach current employees new skills for the same job, advance employees into jobs requiring different skill sets, and support employees as they transit through senior management positions. Ongoing training and development do not only provide employees with fresh perspectives and enhance their skills; the provision of continuous learning and development has also been used as an incentive to retain key employees within the organisation. This win-win arrangement creates more competent employees for the organisation and gives them a broader portfolio of skills and recognised qualifications. In addition to being an excellent means to support their employees' learning and development needs, Haven of Hope has also leveraged on this strategic endeavour to offer a number of such courses to external applicants in the healthcare field, who are either working with other service providers, or who want to acquire the requisite trade qualifications. Through its Professional Training Institute, Haven of Hope has, therefore, also been instrumental in promoting continuous learning and development for practitioners in the healthcare industry. In this paper, we will look at the model currently adopted by Haven of Hope, with the objective to demonstrate the significance of organisational learning and development, and explore how they operationalise strategic endeavours and at the same time play a pioneering role in initiating an inclusive approach to open up the much-needed continuous professional development opportunities to care workers in the industry.

Medico-Legal Risks in Practicing Telehealth: Opportunities and Limitations

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Abstract

Telehealth, with alternative terminologies such as telemedicine, ehealth and mhealth, becomes one of the healthcare strategies in contemporary societies. Realizing that health is a basic human right, governments welcome the use of telehealth as one of the painkillers for the headache about how to provide equitable access to healthcare for people. Telehealth is now widely applied in different specialties of healthcare, as exemplified by services like telesurgery and robotics, teleradiology, telepathology, teledermatology, transmission of patient data, tele-community care, telehealth education, etc. The increased uptake of telehealth is not coincidental and can be attributed to factors such as wide availability and lowered cost of information technologies and computers, higher acceptance of information technologies by both patients and healthcare practitioners, reduction of healthcare costs, ageing populations, enhanced options of diagnosis and treatment, etc. Despite the state-of-the-art technologies, practices of telehealth are not escapable from possible medico-legal risks. Legal issues in relation to telehealth may include but are not limited to clinical negligence, contract, intellectual property rights, information technologies, and criminal laws, covering daily practices such as licensure and credentialing, health records, data privacy and protection, sales of drugs and medical device, electronic signatures, taxation and reimbursement, jurisdiction of alleged negligent events in cross-border telehealth practices, enforcement of judgment in cross-border lawsuits, etc. Some jurisdictions have taken a more proactive approach in dealing with legal issues arising from telehealth. For instance, Germany being a civil-law country passed the first Teleservices Data Protection Act in Europe in 1997 and other relevant law in subsequent years. In common-law communities, Malaysia enacted law to regulate the practices of telehealth in 1997. In the United States, the federal government developed nation-wide telehealth strategies and introduced more than 20 legislations in the period of 1997-1999. In particular, in Oregon, for example, it made enactment in the late 1990s to provide new licences for out-of-state doctors treating patients through telehealth practices in that state. In California, the Telemedicine Development Act of 1996 was updated and replaced with a new Telehealth Advancement Act in 2011. However, other societies may not have paid enough legal attention to this sophisticated development. Hong Kong is no exception. To allow a sustainable development in practicing telehealth, the author argues that it is indispensable for practitioners in Hong Kong to have basic understanding on the inherent potential medico-legal risks. The author will briefly discuss such risks and share his views on the current opportunities and limitations.

A Comparison of Structural and Tensile Performance of Kinesiology Tapes

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Abstract

Kinesiology tape (KT tape) is a material that provides therapeutic benefits by imposing tensile force onto joints and muscles for clinical treatment and sports injuries. Different brands and forms of KT tape provide different elastic properties. As physical therapists may apply KT tape for treatment purposes, they should have good understanding of the material properties so as to prescribe the most suitable tension for effectiveness. However, only a handful of studies have been carried out on the properties of KT tape. The aim of this study is to compare the structural properties and mechanical tensile behaviour of different types of KT tapes. The brands include Kinesio Tex Classic, ATEX and 3M FUTURO. The structural properties, including thickness, weight, density and yarn count of the fabric layer, are examined, while the mechanical tensile behaviour of the KT tapes is measured by imposing tensile force with the Instron 4411 tensile tester. Three samples from each brand are tested. The stress and Young's modulus are measured at strains of 10%, 30%, 50%, 70% and 100% or maximum load prior to elongation, as well as their corresponding changes in tensile behaviour after 1, 4, 8 and 24 hours of elongation at 30% of their resting length. These are carried out to observe whether time affects the tension (MPa) along with the tensile strain of the KT tapes. It is found that the tensile behavior of Kinesio Tex Classic, as opposed to ATEX and 3M FUTURO, is comparatively more stable as determined from the duration of elongation. The tensile performance and Young's modulus at a strain greater than 70% tends to vary inter- and intra-brands. To ensure that the KT tapes are applied with the correct tension in correspondence with the end-use, clinicians need to understand the tensile behaviour of the different brands of KT tapes. Therefore, further study on the tensile behaviour of KT tape is recommended, for example, more different brands and number of test specimens per trial should be considered to provide a more complete picture of the properties of the different types of KT tapes in the market today.

First-aid Bicycle Service in Cycling Tracks: a Cost-effective Way in Providing Emergency Medical Services

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Abstract

According to the report from the Hong Kong Police, bicycle accidents comprise about 15-20% of the total road traffic accidents in the New Territories. A significant number of these accidents occurred in cycling tracks. Most of the injuries were due to fall from bicycle, resulting in simple abrasions and contusion only. These minor injuries can be treated on site without the need to summon ambulance service and hospital admission. In order to provide more comprehensive community services to the members of the general public, Auxiliary Medical Service (AMS) formed the First-aid Bicycle Volunteer Team in 2002. First-aid posts were set up and first-aid bicycle patrolling services were provided in the cycling track between Tai Wai, Tai Po and Ma On Shan during weekends and public holidays. Between 2011 and 2013, AMS treated 5684 patients on the cycling tracks. 95% of the injuries were of minor in nature and could be treated on spot without the need of subsequent Fire Services Department (FSD) ambulance service. With nearly 15 years of AMS first-aid bicycle services, this proved to be an effective way in providing on-site first-aid services in cycling tracks. First-aid bicycle team members can treat the injured on the spot within minutes, which greatly reduces the waiting time before initial medical treatment, and alleviates the stress of the injured due to prolonged waiting. As most of the cases are only minor injuries which only requires first-aid treatment, this service also greatly reduces the need for ambulance service and unnecessary hospital admission or treatment. This is also a reduction in the demand for the police to be involved in handling such type of minor traffic accident. Because of these, AMS extended her first-aid bicycle service in 2016. Currently, there is a regular service network in Sha Tin, Ma On Shan and Tai Po areas to enhance the emergency medical services provided to cycling track users during weekends and public holidays. In the long run, this service can be extended to cycling tracks in other parts of the New Territories.

Special Schools and Residential Care Services for Special Learning Disabilities

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Abstract

The Hong Kong Government have noticed that the problem of Special Learning Disabilities is increasing seriousness. Special learning disabilities are also called Special education needs (SEN), including intellectual disabilities. SEN is trying to offer some help to let the disabilities throwing themselves to get involved in the campus and society. The government is committed to offer residential care service and special schools, promoting integrated education in normal schools for the disabilities to fulfil their basic needs to live. Moreover, the enjoyment of the rights of these children and teens should be protected. They need to try their best to be a part of the society to carry their functions to the society. However, the reality is not too satisfactory. SENs are medicalized in today's society, in which the disorder can be cured and controlled by using medicine. There are still many challenges in lowering society's discriminations, from which the group of vulnerable and their family are stigmatised. As the disabilities are growing up, their family will be more stressful from taking care of them and facing the accusation from the public. Furthermore, the quality of the services is not meeting the target. The media has reported professional misconduct of the personnel in teaching SEN students because of spraying alcohol to the face of intellectual disability students. The Licensing Scheme for Residential Care Home for Persons with disabilities is carried out by government to manage the quality of different type of residential care homes for person with disabilities (RCHDs). Unfortunately, the number of homes that government offer is not enough to satisfy the demand. Furthermore, the Social Welfare Department has decided to revoke the Certificate of Exemption from a private RCHD because of a series of neglect of care incidents. The government should review the teachers' personal and teaching quality to assure they are professionals, meeting the requirements of professionalism. Besides, it must put more effort in improving the enjoyment of rights of the disabilities such as making testimony in the court, increasing the social class of the disabilities, educating the public to respect them, etc., in order to create a harmonious society, in which everyone can function to maintain the stability of the society.

D. Education and Training

Auxiliary Medical Service Formula E Circuit Medical Service: Recruitment, Training and Deployment of Professional Volunteers

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Abstract

The 2016 FIA Formula E Hong Kong ePrix was organized by Formula Electric Racing (HK) Limited and Hong Kong Automobile Association (HKAA) and supported by government departments. Auxiliary Medical Service (AMS) provided on track medical, first aid and ambulance services for the participants during this international motorsports racing event. The AMS Medical Team Coordinator was appointed by HKAA as Chief Medical Officer (CMO). The CMO was responsible for the overall control of the organisation and administration of the circuit medical service. He affirmed to FIA that he had contacted the designated hospitals and got their support. He confirmed the FIA Medical Delegate the list of medical personnel present on the Medical Centre and track would be present in the numbers and specialisations stated, as would the list of medical intervention equipment met the minimum requirement of FIA in the required quantity and quality. As for training, firstly, marshal-type training on scene safety, racing regulations and flag symbolisation was delivered by HKAA to AMS doctors, nurses and paramedics. The removal of HANS device, a head restraint attached to helmet was drilled. Secondly, Ambulance Aid Training Course tailored for Formula E duty was practised in AMS headquarter. Thirdly, Motorsport Medicine Incident Management Course, which aligns with the Formula 1 training program, was organised by Hong Kong Academy of Medicine. Fourthly, FIA Medical Incident Commander held on-site ad hoc drills on the emergency response to calling for help, and demonstrated near the pit lane the extrication of the drivers from an open chassis car. As for the recruitment, open recruit for AMS doctors, nurses and paramedics was announced well before the event. They needed to participate in the above training courses. As for the deployment, the deployment of doctors matched the requirement on the numbers and specialisations stated, and that for nurses and paramedics aligned with the numbers and profession. A briefing was held before the event to facilitate duty members to familiarise the venue layout plan and the operation order on command, communication, reporting time and location, collection of ambulances and dress code. Over the two event days, the patients treated by AMS suffered a spectrum of illness including dizziness, headache, cuts, fracture, contusion, heat exhaustion and sunburn. Most were treated and discharged on site. A few attended A&E for further assessment and management. The challenges faced were the threat of injury by the flying fragment of broken racing cars, the heat-related injury in outdoor posts and the difficulty in logistic support due to restriction of traffic across the track. A few weeks after the event, a debriefing was held to review and evaluate the whole operation. First of all, it

was concluded that wearing of personal protective equipment for outdoor duty did help in mitigating the severity of injury. Secondly, recruit, training and deployment of volunteers who are professional doctors, nurses and paramedics requires a good planning and the expert input from Medical Professional Committee on Major Events (MPCOME) of AMS. Thirdly, the model, that the AMS Medical Team Coordinator and the CMO of FIA Formula E Hong Kong ePrix is the same person, enhances the efficiency in the collaboration between AMS and HKAA and hence contributes to the success in the overall control of the organisation and administration of the circuit medical service.

Healthcare Training by Virtual Reality Technology: Experience in Hong Kong Formula E 2016

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Abstract

The working environment for the healthcare providers working for medical care in motorsports could be different from other places. A constant desire to enhance their knowledge, skill and coordination, is very important to enhance safety during motorsport events. In October 2016, Formula E race was held in Hong Kong for the first time. To make sure all the healthcare providers in the venue having enough skill and knowledge to provide medical care for the race drivers and all participants, a series of trainings were provided. The training course aligned with the Formula 1 training program in worldwide by different FIA ASN according to FIA guideline, together with the latest research finding such as ILCOR resuscitation guideline on traumatic cardiac arrest, Tactical and Combat causality guideline for trackside care. The main objective of the training is to develop knowledge and skills for healthcare professionals in providing emergency care in motorsport environment and enhance the command and coordination with different parties such as fire service, police and racing control involved in FIA Formula E. The training was held in two days. Each day had 40 trainees who are all the healthcare professionals from AMS. The training was divided to 4 sessions: trackside care simulation, ambulance care and hemorrhage control simulation, medical room care simulation, command and coordination. To enhance the command and coordination with different parties such as fire service, police and racing control involved in FIA Formula E, Virtual Reality (VR) technology was utilized instead of the traditional tabletop exercise. Students were divided to different groups and assigned to different roles and then they started to enter the virtual environment to receive training. After the training, both instructors and learners had very positive feedback to having training in a virtual environment. Not only they could be more effective to learn how to collect information and make decision in the scene, but it was also a very good method to train communication and command skills as compared with the traditional tabletop exercise. In conclusion, there will be lots of area for further development and improvement about VR implementation in healthcare training area, particularly when the course developers have more training experience by using VR and the related technology becomes more and more mature. Students could have received training in a more realistic and absolutely safe environment in order to learn different medical knowledge and skills in various situations, for example triage in a traffic accident in the highway, mass casualty incident in a large event or many different types of accidents.

Breaking the Digital Divide for the Elderly through Service Learning and Data Analytics: A Proposal

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Abstract

According to the statistics provided by the HKSAR Government, in 2014, there were 1.07 million people aged 65 or above in Hong Kong which accounted for 15% of the population. It is estimated that by 2034, the elderly population will be doubled to 2.28 million. Recent research shows that digital divide among elderly is larger in Hong Kong than in other developed countries. The problem of digital divide refers to the issue of the difference in the amount of information received through digital channels between those who have effective access to the Internet and those who do not. In a recent study, the Internet use rates were 18% for citizens aged 65 or above while it was 74% for the overall population. Therefore, the problem of digital divide among the elderly clearly exists in Hong Kong. The lack of effective Internet access is a cause for social disconnectedness, perceived isolation and mental-health problems among the elderly. This paper proposes to bridge the digital divide for the elderly through service learning and data analytics. The objective is to enhance mental health of the elderly through information technologies, by providing training on digital literacies for the elderly. According to the World Health Organization (WHO), mental health has an impact on physical health and vice versa. For example, untreated depression in an older person with heart disease can negatively affect the outcome of the physical disease. It is believed that digital literacies are crucial for the mental health of the elderly in this modern information society. They can also enable the elderly to use the Internet effectively without being victims of digital crimes. Service-learning projects will be conducted by students to train the elderly on essential information technology skills such as assessing the Internet, participating in online social networks, searching and evaluating information from the Internet. Throughout the process, data (e.g. mental health data) are collected from the elderly through observations and surveys. Elderly with special needs (i.e. outliers) can be identified using data clustering technique. Analysis of the data will be performed by measuring the *compactness* and *isolation* of the data. Specifically, compactness measures the cohesion or uniqueness of the objects in each of the individual clusters with respect to other objects outside the cluster, while isolation measures the distinctiveness or separation between different clusters. To summarise, this paper proposes the approach of using service learning to reduce digital divide among the elderlies, and use data analytics to understand the digital literacy of the elderly in Hong Kong.

Experience of a New Undergraduate Top-Up Degree in Healthcare

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Abstract

A new top-up Bachelor of Science in Applied Sciences programme, with a concentration in general health subjects, was first introduced by the School of Professional Education and Executive Development (SPEED) of The Hong Kong Polytechnic University in September 2014. The programme aims to equip students with the abilities to communicate effectively and efficiently, to identify key legal, compliance and ethical issues in the health-related industries, to apply the essential practical and analytical skills in the areas of health education, health promotion and primary care, to translate research into practice through skills in programme planning and evaluation, management, information dissemination and continuous learning for personal and professional development, as well as to contribute to the improvement of healthcare delivery systems. Candidates of the first cohort of intake came from all local higher educational institutions. Compulsory subjects include Infection Control, Health Informatics, Epidemiology, Health Behaviours, Operations Management, Health Promotion, Health Care Systems, Legal and Ethical Considerations, Nutrition and Diseases. Guest lecturers were invited to present talks to students in most subjects. In addition to the course work, students were provided with opportunities in the work-integrated education during their two years of studies. They were involved in health campaigns in and out of the campus, conferences within and outside the university, summer internship at medical groups and clinics, as well as research projects at an insurance consultancy and The University of Hong Kong. Ten students joined the Auxiliary Medical Service as members. Moreover, fifteen students participated in scholarly activities and had presented working papers and conference papers. Two of them were chapter co-authors of a new book being prepared. Forty-three students graduated in the summer of 2016. Among the graduates, nine pursued further study in health-related Master's programmes at The Chinese University of Hong Kong and The Hong Kong Polytechnic University. Most the rest are employed by the Hospital Authority, private hospitals, non-government organisations, health education agency, pharmaceutical companies, etc. One joined the ambulance service of the Fire Services Department. The graduates are committed to the healthcare industry and have accomplished the objectives and expectations of the new programme, which are not designated for training the conventional healthcare professionals. This new programme has demonstrated great potential in shaping the work force in the health sector by filling the "unattended" gap of middle-level non-professional grade staff with undergraduates educated in health studies subjects. Areas of development include community health programmes, health policy, project planning and management, health insurance, chronic disease management, long-term care services, etc.

Telemedicine in Hong Kong

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Hong Kong Telemedicine Association

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Abstract

Hong Kong is one of pioneers in the development of telemedicine in the world. With local publications, it has been demonstrated that telemedicine is applicable in different areas of medicine including educational activities by teleconferences and medical care in various specialties such as elderly care. Hong Kong health care system is facing substantial challenges. Telemedicine technology has great potential to combat these challenges. Currently, the life expectancy for men is 80.5 years and for women is 86.7 years in Hong Kong. The proportion of population older than 65 years was 2.8% in 1961 and increased to 13.3% in 2011. By 2030, it is expected that 28%, more than one fourth, of our population will be older than 65 years. Government annual medical expenditure in 2016/17 is 57 billion which equivalents to a 16.7% of total regular expenditure. Currently, government is subsiding 90% of medical expenditure in the public sector. Moreover, only 60% of medical professionals contribute 90% of the medical service of the whole Society. These, aging population, substantial medical financial burden, inadequacy of human resource and imbalance between public and private sector post unique challenges to the health care system. Advancement of electronic technology in past few decades has potential to combat these challenges. The rate of smart phone ownership population coverage is high in Hong Kong. Smart phone programs allow direct, both sound and visual, instant communication. When apply in health care, doctor can provide remote consultation service whereby reduce the patient transportation and potentially reduce casualty attendance. Some smart phone programs also allow daily regular health parameters monitoring. Linkage to paramedical and allied health support is possible in making patient care more comprehensive. Examples include program links to pharmacy shop so that after remote doctor patient consultation, patient can purchase medication directly from pharmacy. This recruits more medical service from the private sector instead of adding more burden to the public sector. To summarize, application of information technology in medical field can potentially ameliorates the burden on health care human resource demand by resolving the imbalance between public and private sector, financial burden and thus combating the aging population challenges.

Designing a Competency-based Undergraduate Health Services Management Programme in Hong Kong in a Rapidly Aging Context

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Abstract

The Hong Kong health system has often been applauded for its ability to provide some of the best vital statistics when compared to other developed countries. In 2015, the average life expectancy at birth in Hong Kong was 87.3 for women and 81.2 for men, being one of the highest in the world; while the infant mortality rate in Hong Kong was 2 per 1,000 live births, being one of the lowest in the world. Nonetheless, the Hong Kong health system is also facing challenges with an increasing demand for health services driven by factors such as over-dependence on secondary and tertiary healthcare, changing patient culture and most important of all, an ageing population. With a reduction in public funding due to a rising dependency ratio compounded by a narrow tax base, the sustainability of the Hong Kong health system is called into question. Whilst a comprehensive reform on health system may improve its efficiency and sustainability in the long run, the need to supply well-trained health professionals in the near term is of vital importance. ***Methods***: Local supply and demand of undergraduate training programs in health services management (HSM) was assessed. A HSM competency framework for undergraduate programme is developed based on analysis of relevant HSM job vacancies in Hong Kong. Core competencies and interviews with key employers are determined. Appropriate learning outcomes and employability skills for the undergraduate HSM program are then constructed based on the analysis. Currently, there seems to be an important gap in providing undergraduate training for HSM in Hong Kong. A lack of structured training promotes poor decision making, and may lead to inadequate health services and adversely affect patients. This study suggested that there was a strong demand for local universities to develop new HSM undergraduate programmes. Work experience, communication skills, and language skills are amongst the top generic employability skills perceived by employers in general in Hong Kong. Holistic health, community-based care, long term care, knowledge of the healthcare system, as well as basic medical knowledge are identified as important components by healthcare providers. Recommendations drawn from the study informed an integrated approach to HSM undergraduate education, which combined formal teaching with service learning. This approach aims at training up future health services executives, not only as effective leaders but also professionals with relevant employability skills who can ultimately improve patient care.

E. Community-based Programmes

Current Evidence & Knowledge in ACL Injury Prevention Programme for Community Action

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Abstract

Anterior Cruciate Ligament (ACL) injury is exceedingly common in the worldwide sports population. The epidemiology of ACL injury occurrence rate in females is four to six fold greater that of males who play the same landing and cutting sports. The ACL injury not only creates physiological burden to sportspeople, but also financial and psychological ones. After injury, sportspeople may incur immense medical cost in imaging, reconstruction surgery, postoperative bracing and rehabilitation, as well as loss of income. Typically, sportspeople will miss about six to nine months of sport engagement as a result of ACL injury. Results of systematic review show that the current evidenced-based ACL injury prevention programmes can largely reduce the occurrence and re-occurrence of ACL injury by Neuromuscular Training, Prevention and Enhancement Performance (PEP) Programme, as well as ACL injury screening test at very low cost. In long run, ACL injury prevention programme should be included in community action in order to reduce public health burden and promote optimal health, excess demand for public orthopedics, and traumatology health service.

“First Aid Post” as a Healthcare Delivery Model: the Gatekeeper of the Rural Area in Hong Kong

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Abstract

On the outlying islands of Hong Kong, the healthcare service for the local population is mostly provided by the local Hospital Authority General Out-patient Clinic (GOPC) in the region, as there is no Accident & Emergency Department (AED) nearby with a limited access to private medical service. The rural GOPCs operate at the regular hours on weekdays similar to the service provided by the urban GOPCs. In addition to the regular GOPC service, the rural GOPCs are also responsible for managing emergency patients 24 hours a day throughout the year known as “First Aid Post” (FAP) service which is similar to the “Walk-in Centre” in overseas countries. Most population within the area with health needs would attend the FAP instead of the regional AED when regular GOPC service is not available. Patients could either walk-in the FAP or be transferred-in by ambulance at any time which do not require booking or pre-registration, in contrary to the GOPC service which requires prior telephone booking. The patient would be attended by the onsite Medical Officer for assessment. Basic diagnostic equipment and surgery tests are available. Patients could receive basic treatment within the FAP formulary (the pre-packed short-term items dispensed by nurses instead of the usual GOPC formulary operated by pharmacist). After assessment and treatment, patients would be either discharged home or referred to AED if further complex management or admission is required. The discharged patient may return to clinic for the follow-up at the next regular GOPC session depending on clinical need. One year of FAP data at a single centre on the Lantau Island were reviewed. Non-office hour attendances (N=794) were included for analysis. 232 attendances (29.2%) were transfer-in cases by ambulance and 562 (70.8%) were walk-in patients. Out of the 794 consultations, a majority of 535 (67.4%) were discharged directly from the FAP while 259 (32.6%) required referral to the AED. The FAP delivery model, the unique after-hour service model of the public sector, could have avoided unnecessary transferal and queue at the AED as patients were managed at the rural community primary care setting. This probably may reduce the workload of the regional AED.

Visiting Pharmacist and Multi-Dose Medication Management Service Model in Residential Care Homes for the Elderly (RCHE): A Case Study in Hong Kong

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ABSTRACT

Visiting Pharmacist Service (VPS) involves trained pharmacists to perform regular visits to primary healthcare providers. Multi-Dose Medication (MDM) Management refers to the use of automated drug dispensing and packaging machines to prepare multi-dose packs on the oral medications for patients according to their sequential times of administration. Studies indicated that the integration of VPS and MDM reduces medication related problems and eliminates errors associated with manual drug picking procedures. However, despite the affirmative influence on the both the efficiency and safety aspects by the Visiting Pharmacist coupled with the application of MDM service in the medication packing process and the electronic capturing of the drug administration process, the entire concept is still inchoate in Asia. The Hong Kong Pharmaceutical Care Foundation has started the implementation of the VPS since 2010, the pilot run of MDM management service model and the electronic drug administration process since 2015 to safeguard patient safety and drug management accuracy for Residential Care Homes for the Elderly (RCHE) in Hong Kong as an integrated operation model to ensure the appropriate medication use and medication safety at transitions of healthcare service. During the visits, the Visiting Pharmacist will assume the professional responsibility to review the medication profiles for all Residents in the RCHEs, perform medication reconciliation, update and check Residents' medication records, supervise all medication related matters, identify possible causes leading to drug incidents to ensure that the Residents' medication profile is complete and appropriate so as to eliminate drug duplication or any unintended or inappropriate dosages leading to drug interactions and incidents; and to prepare the full list of medications with clear drug images, names, dosage and frequency for drug administration. In the process, VPs will make the necessary contacts and communicate with the relevant parties to make clarifications to optimize the drug treatment for the Residents. Together with the MDM which is further supported by mobile device for electronic drug administration capturing and recording, the efficiency and accuracies of drug administration rounds will be further improved in the drug administration process by the health care workers in the RCHEs. The initiative aims to provide a long term medication management solution for the ageing population in Hong Kong along the continuum of care.

Ving Tsun Martial Art Training for Middle-aged Adults: An Exploratory Study

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Abstract

It is well known that the human aging process, from maturity to senescence, is associated with a reduction in bone mineral content (BMC) and bone mineral density (BMD) as well as loss of skeletal muscle mass and muscle strength. Exercise training can effectively attenuate the decline in BMC and BMD and increase the size and strength of the trained muscles. Ving Tsun (VT) is a hard-style Chinese martial art characterized by fast and powerful movements. This cross-sectional study aimed to compare the axial and appendicular BMD, muscle mass and muscle strength of middle-aged practitioners of VT with those of non-practitioners. *Findings may shed light on the use of VT training programme for physical conditioning and improving musculoskeletal health of middle-aged individuals in the community.* Eighteen VT practitioners (mean age ± standard deviation = 51.8 ± 17.7 years; 12 males and 6 females) and 36 matched controls (mean age ± standard deviation = 58.7 ± 11.0 years; 18 males and 18 females) participated in the study. All of them underwent a one-day battery of musculoskeletal examinations in a University laboratory. BMD of total radius, total hip, femoral neck, and lumbar spine were assessed using dual-energy X-ray absorptiometry (DXA). Lean (muscle) masses of the arm, leg and trunk were also quantified by a whole-body DXA scan. Muscular performances (including maximum muscle strength and speed of muscle force production) of the dominant upper limb and lower limb were assessed using a Jamar dynamometer and an isokinetic dynamometer at 60°/s, respectively. Results revealed that VT practitioners demonstrated 11.5% higher total radius BMD ($p = 0.023$); 17.8% higher leg lean mass ($p = 0.014$); 56.4% higher isokinetic body weight-adjusted peak torque of the knee extensor muscles ($p < 0.001$); 60.8% higher isokinetic body weight-adjusted peak torque of the knee flexor muscles ($p < 0.001$); and 31.4% shorter time to reach peak torque in the knee flexor muscles ($p = 0.001$) than the controls. No significant between-group differences were found in all other musculoskeletal outcomes ($p > 0.05$). Middle-aged VT practitioners displayed higher total radius BMD and leg lean mass and better knee extensor and flexor muscular performances than their healthy active counterparts. Therefore, health care professionals may consider using this novel, non-expensive and enjoyable training method to improve the musculoskeletal health of middle-aged adults. Certainly, further randomized controlled trial is needed to confirm the aforementioned beneficial effects of VT training in the adult population.

Effectiveness of EatSmart@restaurant.hk Campaign in Hong Kong

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Abstract

Hong Kong is a cosmopolitan city. However, undoubtedly, Hong Kong people overlook the importance of healthy eating. The majority of them have an eating out habit. It is well known that the restaurant dishes are commonly high in fat, sugar and salt, which are harmful to health. In addition, restaurants provide large portion sizes of food. Therefore, it may increase the risk of suffering nutrition-related chronic diseases, such as cardiovascular diseases, hypertension, diabetes and obesity. The government launched the "EatSmart@restaurant.hk" Campaign in 2008 in order to provide customers with healthier meals and to promote a healthy and balanced diet. Participating restaurants would receive EatSmart Restaurants door decal, which denotes that they are joining this campaign and are providing customers the healthier food choices. However, this campaign seems to be ineffective as obesity in Hong Kong has still been increasing. Moreover, the participation rate of restaurants in this campaign is also much lower than expected. As such, it has not encouraged people to opt for healthier dishes when eating out in restaurants, and has not helped to raise public awareness of healthy eating. Indeed, there are some deficiencies in the promotion of the campaign, namely unsustainability of the campaign promotion and problems of promotion materials. These factors are important in the outcome of the campaign, which should be a good method to promote health. Unfortunately, the campaign has appeared to be ineffective. Therefore, Hong Kong government should reconsider and improve its promotional methods, such as simplifying the application procedures in order to increase the participation rate. More attractive and easy-to-understand promotional materials should be designed to target the restaurant patrons. Community awareness should be enhanced to promote the benefits of healthy eating in EatSmart Restaurants. The catering industry can assist in encouraging more restaurants to participate in the campaign and nurture a healthy menu culture among the operators and chefs, with the objective to make the healthy choice of meals an easy choice. Nonetheless, the government sector plays crucial role in promotion. Sustained efforts in promotion must be continued to make the campaign a success for the benefits of the community.

Promotion of Weight Control in Hong Kong

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Abstract

Obesity has long been an epidemic in the world. The World Health Organization (WHO) has stated that the "Globesity", which means the increased prevalence of overweight and obesity have taken over the world. Weight control is an important strategy of health promotion in the community. Obesity is a condition which involves personal and social dimensions. There are several studies investigating different risk factors of obesity, including the history and behaviours of family members, unhealthy diet and inadequate exercise. People have higher risks of overweight and obesity if they possess obesity genes. Besides, in a fast food culture, people tend to eat various types of food containing higher proportion of fat, sugar and salt. In addition to accumulation of excessive fat, inadequate physical activities also increase the risk of overweight and obesity. Currently, the Hong Kong government takes initiative to promote weight control. It has implemented the nutrition labelling scheme in order to help customers make informed food choices based on their health conditions. Moreover, the Department of Health has co-operated with schools to promote adequate exercise and healthy eating and a comprehensive weight control education. However, in health promotion, community awareness is also an important component that can affect the long-term maintenance of weight control in Hong Kong. Factors influencing community awareness include lower health literacy, inadequate personal interest, as well as insufficient allocation of technical and financial resources. People who are less motivated would possess lack of understandings towards technology and obesity. This finally disturbs accessibility to health information and affects the qualities of communication between patients and health professionals. Furthermore, health knowledge of professionals would influence the validity of the weight control information to the public. The adequacy of financial resources is also one of the determinants in the effectiveness of the weight control promotion. Governmental regulation in health policy can affect resources allocation in obesity prevention. In order to increase the effectiveness of weight control promotion, education of weight control should be strengthened to enhance health literacy of the society. Health professionals should be encouraged to enrich and acquire more professional knowledge in obesity and weight management. To alleviate the prevalence of obesity continuously, the government, the schools and the public should take initiatives in the promotion of weight control in Hong Kong.

P. Poster Presentations

Will EatSmart@restaurant.hk Campaign and Nutrition Labeling Scheme Lower the Prevalence of Obesity in Hong Kong?

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Abstract
The obese population in Hong Kong includes nearly 15% in female and a third in male from 2007 to 2014. It has been proved that low socioeconomic status, eating out habit and unhealthy food advertisements have contributed to the poor eating habit which is highly associated with increasing prevalence of the obesity. To lower the obesity rate in Hong Kong, many health promotion campaigns have been implemented. EatSmart@restaurant.hk Campaign and Nutrition labeling Scheme are two of the well-known progammes to deal with the risk factors of obesity in Hong Kong, but they are not as successful as they are expected. The trend of obesity will go forward. EatSmart@restaurant.hk Campaign targets at the eating out culture and promotes the health eating environment with more healthy food choices to keep the customers from unhealthy dishes. For instance, registered restaurants of the campaign are required to constantly provide EatSmart Dishes, either with adequate vegetables and fruit, or less in sodium, sugar and fat. On the other hand, in order to encourage the citizens to make better food purchasing choices and protecting them from dishonest food advertisements, mandatory Nutrition labeling Scheme was released in 2007. The amount of energy and seven nutrients have to be listed on most of the prepackaged foods as the World Health Organisation has recommended. Improvement is essential to attain a higher level of success of the two health promotion initiatives. Regular advertising and spot checking of restaurants are recommended for the EatSmart@restaurant.hk Campaign, since there are deficiencies of poor advocacy and failing in keeping the campaign reputation from rumours. On the other hand, increasing the knowledge of nutritional label and encouraging the additional use of Nutritional label are suggested for the Nutrition labeling Scheme to narrow the knowledge gap in nutritional label usage among the local people. Likewise enhancing the health literacy of residents are essential to improve the labelling programme. It is believed that both of the programmes can be effective health promotion policies, with supportive strategies and the cooperation between every sectors in the community, with the hope to further lower the morbidity of obesity in Hong Kong.

A Two Years' Review on Geriatric Screening at the Emergency Department Front Door Project

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Abstract

The increasing number of elderly patients attending the Emergency Department (ED) especially during winter surge posed a significant burden to the Hospital Authority (HA) hospitals, with many of them had to wait for long time for admission to wards. The Geriatric Screening at the ED Front Door Project was initiated in the Prince of Wales Hospital with an aim to reduce hospital admission by providing an alternate clinical journey with a more appropriate care for elderly. It was implemented through the collaboration of Geriatrician, the Community Outreach Services Team (COST), the ED and staff of a convalescent hospital. The program had run for 3 months during winter of 2015 (January –March) and 2016 (mid December 2016 – mid March 2017). A clear workflow was developed for recruiting elderly patients at the ED based on agreed criteria. A Geriatric Front Door Team (GFDT) consisting of one geriatric specialist and a Community Advanced Practice Nurse attended the ED to provide patient assessment from Monday to Friday in the morning for three months. Senior doctors in the ED identified those potential elderly patients who were pending medical admission for geriatric assessment. Recruited patients might avoid admission to the acute hospital by either i) discharge back home/aged home with COST early support; ii) admission to a convalescent hospital for further care; iii) admission to the Emergency Medical Ward (EMW) for short stay management. Fast track clinic follow up was arranged as indicated. Process indicators and patient outcome including successful discharge, length of stay (LOS), hospital readmission rate and adverse events were evaluated. A total of 148 and 183 patients were screened by GFDT during winter of 2015 and 2016 respectively. The mean patient age were 83.7 (2015) and 83.9 (2016). Results showed that 55.4% (82/148, 2015) and 67.2% (123/183, 2016) were not admitted in acute hospital. Among them, 30 (36.6%, 2015) and 40 (21.8 %, 2016) were discharged back home/aged home with COST support or fast track clinic follow up; 27 (31.7%, 2015) and 47 (24.1%, 2016) were transferred to convalescent hospital for further management; 25 (30.5%, 2015) and 36 (19.7%, 2016) were admitted to EMW for short stay and then discharged with COST support. The hospital readmission rates within 28 days were 10.9% (2015) and 11.8 % (2016) which were lower than the pre-project period (14.6%, same season of 2014). The data suggested that this new admission reduction project was feasible to provide appropriate care for the elderly patients without jeopardizing their clinical outcomes.

Health Promotion on Smoking Cessation in Hong Kong

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Abstract
Smoking is a common behavior in the modern society. In recent decades, much medical research has indicated that smoking could lead to many unhealthy conditions and life-threating diseases. The human body would inhale different kinds of chemicals in the cigarette during smoking, and these chemicals are harmful to human health. Smoking is highly related to different serious and potentially fatal diseases, such as cardiovascular disease, respiratory disease and lung cancer. There are four main factors contributed to smoking. The socioeconomic factors would influence the decision on one's behavior. People with low socioeconomic status would have a habit to smoke. Cultural factors, including peer influence and value orientations, would affect people's tendency to smoking. In the financial aspect, low-income people would be more likely to seek for cheap or low-price material resource for pleasure like cigarettes. For psychological factor, nicotine in the cigarettes may improve the concentration and mood, and help to release stress and anger. Smoking acts as a 'self-medication' for people with stress and depression. To combat smoking, health education on the harmful effects of smoking and the importance of cessation is the main priority targeted to smokers and the general public. The health authority and organisations can conduct health education through different ways. Peer education involves information and experience sharing with past or regular smokers in a small group setting. Theatres would be a more interesting way to attract public to join. Furthermore, media advocacy can disseminate and promote health information in the community. The government has a role in smoking-related legislation and administrative measures, such as setting up smoking-restriction areas in public areas and raising the tax of cigarettes. These policies can affect the behaviour and orientation of smokers. Advertisement of tobacco to the public should be banned or limited. Since 1 January, 2007, the government had banned smoking in indoor areas such as restaurants, schools, workplaces, shopping malls and bus interchanges, with a penalty of $1500 for smoking illegally in those areas. Taxation of tobacco had been raised by 50% in 2009 and by 41.5% in 2011. The Tobacco Control Office has been organizing talks on smoking cessation for the public. The Tung Wah Group of Hospitals and the Hospital Authority provide hotline services for counseling. Several smoking cessation clinics are managed by the Department of Health and Tung Wah Group of Hospitals.

Poster Presentations

Will EatSmart@restaurant.hk Campaign and Nutrition Labeling Scheme Lower the Prevalence of Obesity in Hong Kong?

Elsa Chan K. Y. Chan

Health Promotion on Smoking Cessation in Hong Kong

David W. H. Wong

Health Promotion on Smoking Cessation in Hong Kong

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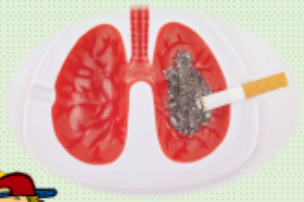
Smoking is a common behavior in the modern society. Smoking can lead to many unhealthy conditions and life-threating diseases, such as cardiovascular disease, respiratory disease and lung cancer.



Factors contributing to smoking

1. Socioeconomic status - education level
2. Cultural factors - peer influence, value orientations
3. Financial aspect - personal income
4. Psychological factor - "self-medication"

Health promotion on smoking cessation

1.Health education on the harmful effects of smoking and the importance of cessation is the main priority targeted to smokers and the general public. The health authority and organizations can conduct health education through different ways, such as peer education, theatres and media advocacy.

2.The Government has a role in smoking-related legislation and administrative measures, such as setting up smoking-restriction areas in public areas, raising the tax of cigarettes. These policies can affect the behavior and orientation of smokers. The advertisement of tobacco to the public should be banned or limited.

Current health promotion in Hong Kong

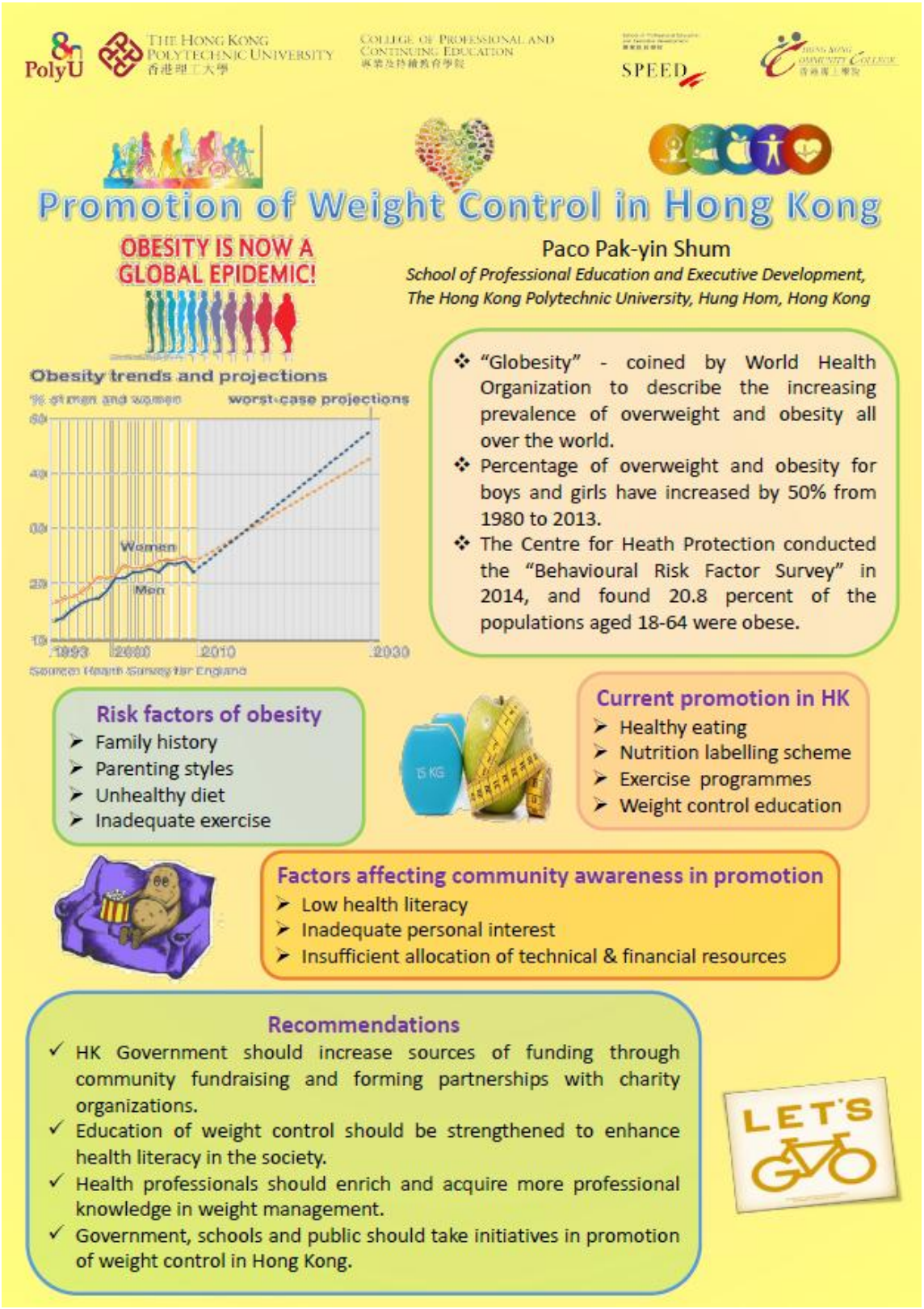
Since 1 January, 2007, the Government has banned smoking in indoor areas such as restaurants, schools, workplaces, shopping malls and bus interchanges, with a penalty of $1500 for smoking illegally in those areas. Taxation of tobacco had risen by 50% in 2009 and by 41.5%in 2011. The Tobacco Control Office has been organizing talks on smoking cessation to the public. The Tung Wah Group of Hospitals, Department of Health and Hospital Authority provide hotline services for counseling and manage several smoking cessation clinics to general public.

Effectiveness of EatSmart@restaurant.hk Campaign in Hong Kong

Alison Wing-lam Wan

Promotion of Weight Control in Hong Kong

Paco Pak-yin Shum



Introducing Universal Healthcare Voucher in Hong Kong: Is It Feasible?

Eddy K. H. Tang, Bing H. F. Wong, Iris H. Y. Siu, and Erica W. Y. So

A Two Years' Review on Geriatric Screening at the Emergency Department Front Door Project

C. K. Chim, Wency W.S. Ho

A Two Years' Review on Geriatric Screening at the Emergency Department Front Door Project

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Introduction

The increasing number of elderly patients attending the Emergency Department (ED) especially during winter surge posed a significant burden to the Hospital Authority (HA) hospitals, with many of them had to wait for long time for admission to wards. The Geriatric Screening at the ED Front Door Project was initiated to address the problem in the Prince of Wales Hospital in 2015 and 2016 during winter with the collaboration of Geriatrician, the Community Outreach Services Team (COST), the ED and a convalescent hospital.

Objectives

1) To reduce hospital admission
2) To provide an alternate clinical journey with a more appropriate care for elderly

Methodology

1) To form a Geriatric Front Door Team (GFDT) consisting of one geriatric specialist and a Community Advanced Practice Nurse
2) To design a clear workflow for recruiting elderly patients at the ED based on agreed criteria and provide assessment
2) To design a hospital admission avoidance diversion pathway
3) To design medical support for the discharged elderly patients
4) To evaluate the outcome in terms of hospital admission, patient or carer satisfaction towards the project

Result

A total of 148 and 183 patients were screened by GFDT during winter of 2015 and 2016 respectively. The mean patient age were 83.7 (2015) and 83.9 (2016). Results showed that 55.4% (82/148, 2015) and 67.2% (123/183, 2016) were not admitted in acute hospital. Among them, 30 (36.6%, 2015) and 40 (21.8 %, 2016) patients were discharged back home/aged home with COST support or fast track clinic follow up; 27 (31.7%, 2015) and 47 (24.1%, 2016) were transferred to convalescent hospital for further management; 25 (30.5%, 2015) and 36 (19.7%, 2016) were admitted to EMW for short stay and then discharged with COST support. The hospital readmission rates within 28 days were 10.9% (2015) and 11.8 % (2016) which were lower than the pre-project period (14.6%, same season of 2014). Satisfaction survey showed that 82.6% recruited patients or their caregiver support by COST satisfied the early discharge community support service; 81.4 % agreed that the direct transfer to convalescent hospital from ED could shorten their waiting for a bed.

Conclusion

The data suggested that this new admission reduction project was feasible to provide appropriate care for the elderly patients without jeopardizing their clinical outcomes. The recruited elderly patients or their caregiver also showed good acceptability to the services.

Special Schools and Residential Care Services for Special Learning Disabilities

Kayla Yuen-shun Chow

Special Schools and Residential Care Service for Special Learning Disabilities

Kayla Y. S. Chow

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Children and teens are potential leaders who are going to lead the society moving forward. Unfortunately, there are chances of children born with learning disabilities. Government and public are having responsibility on giving support, subsidies on building special schools and providing resident care service. There are still many challenges.

Special learning disabilities (SEN) are medicalized

Public thinks that SEN should be treated and controlled by medicine. The disabilities rely on medicine so much and this makes the standard in diagnosis on SEN become more lower. How can we change the mind of public and even the family of the disabilities.?

Special learning disabilities (SEN) are stigmatized

Public discredit people by blemishing of personal characteristic. There are pressure and misunderstanding from society that can hurt the disabilities and caregivers. Government should educate the public to avoid discriminations and to protect the rights of SEN children.

Integrated education in normal schools

Government is promoting integrated education in normal schools and having a target of making the SEN students to have more chance on throwing themselves into campus live with the support from peers and teachers. However, there is not enough resources on promoting this programme in higher grade and their career …

Number of special schools & residential care service not enough

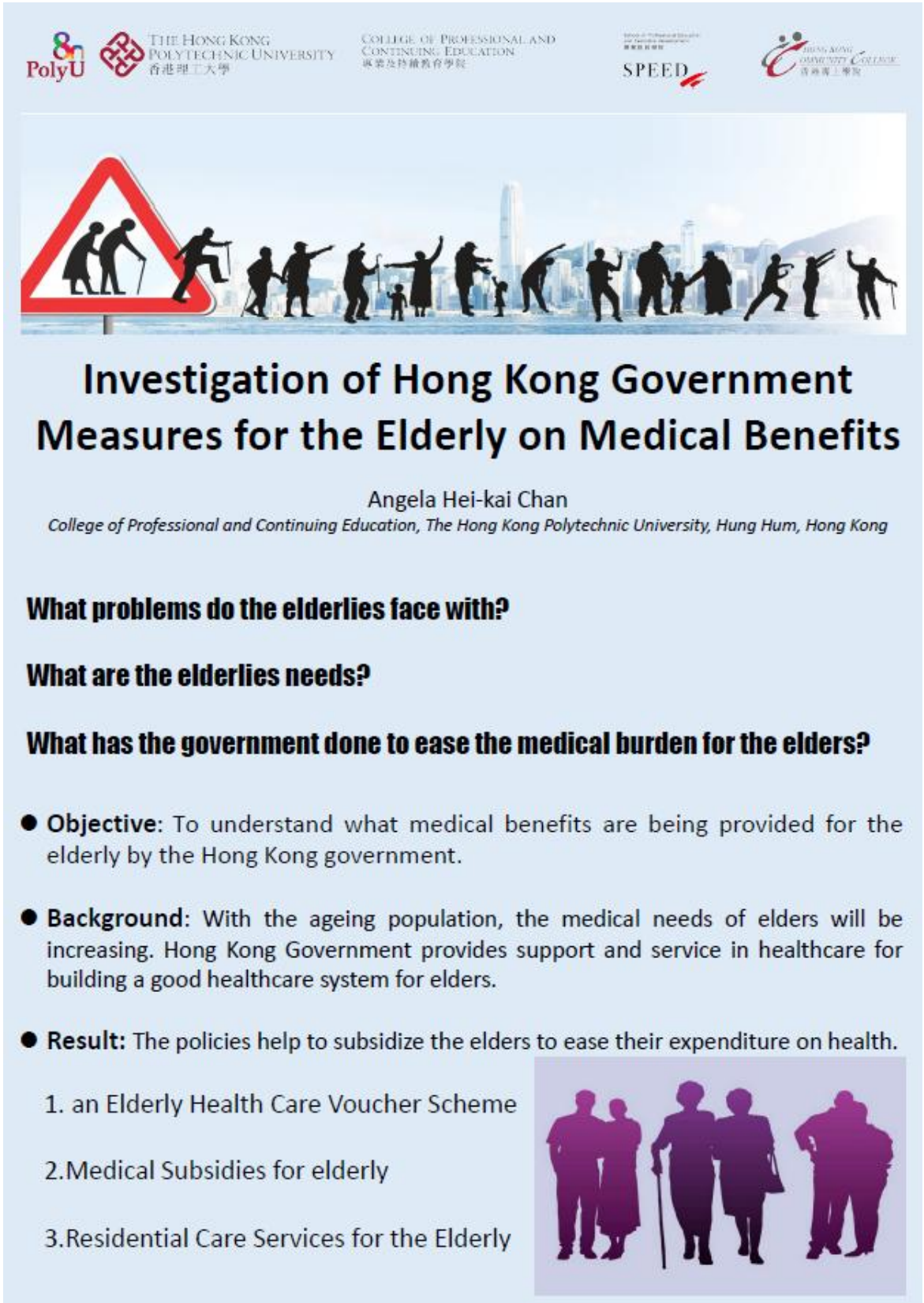
Special schools are offering appropriate educations and care to children in needs, which is custom-made for them. However, the waiting time for a care home can be up to 7 years and there are only few of them are organized by the government …

Licensing Scheme for Residential Care Home for Persons with Disabilities

In 2016, a private care home was informed their Certificate of Exemption would be revoked by the Social Welfare Department because of a series of incident related to unusual death, sexual harassment and other problem. There is also a rise of problem related to the intellectual disabilities' right in the law in making testimony.

Investigation of Hong Kong Government Measures for the Elder on Medical Benefits

Angela Hei-kai Chan



Awards for Outstanding Student Papers in Health Studies

1. *Will EatSmart@restaurant.hk Campaign and Nutrition Labeling Scheme Lower the Prevalence of Obesity in Hong Kong?*
   Elsa Chan

2. *Health Promotion on Smoking Cessation in Hong Kong*
   David Wong

3. *Effectiveness of EatSmart@restaurant.hk Campaign in Hong Kong*
   Alison Wan

4. *Promotion of Weight Control in Hong Kong*
   Paco Shum

5. *Introducing Universal Healthcare Voucher in Hong Kong: Is It Feasible?*
   Eddy Tang, Bing Wong, Iris Siu, and Erica So

6. *Special Schools and Residential Care Services for Special Learning Disabilities*
   Kayla Chow

7. *Investigation of Hong Kong Government Measures for the Elder on Medical Benefits*
   Angela Hei-kai Chan

Acknowledgement

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We are honoured to have the blessings of the Under Secretary for Food and Health, Professor Sophia Chan, and Dean of CPCE, Professor Peter P. Yuen, to officiate the opening. Moreover, the presence of academics from Australia, Canada, Hong Kong, Indonesia, Japan, Chinese Mainland, Taiwan, Thailand, and the United States as speakers at the Conference has granted the programme a great learning opportunity for our students, academic colleagues, as well as professionals in health care and other disciplines.

The enthusiastic submissions by authors and presenters of papers in the Parallel Sessions and Poster Presentations reflect the importance of the themes under discussion at the Conference. We would like to express our sincere thanks for their contributions to the knowledge and ideas on the topics of concern in healthcare delivery and financing reform.

We wish to thank all participants, from both local and overseas, for their time and support dedicated to the Conference and hope to meet them again in future seminars and events. Best wishes and good health!