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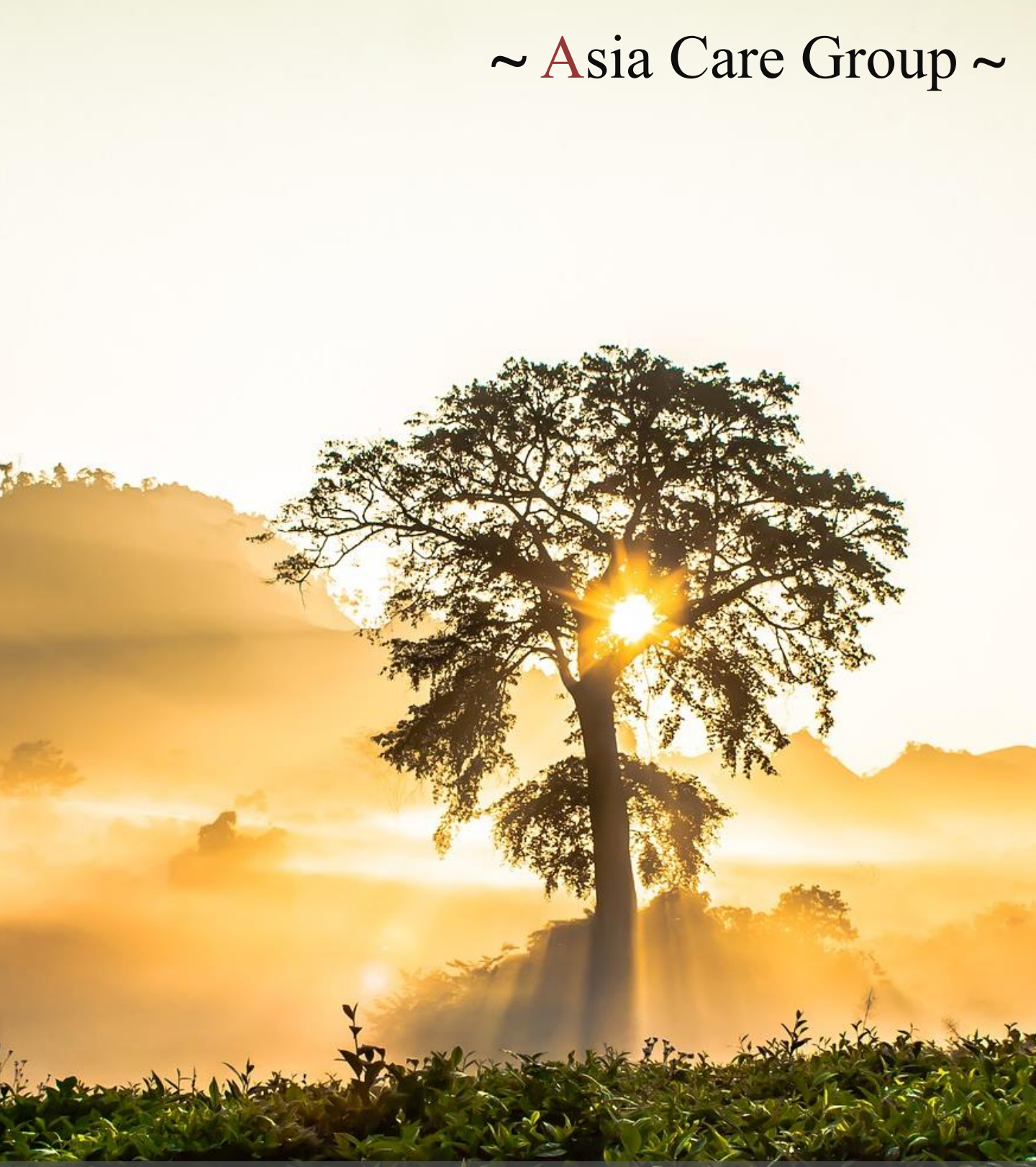

Unsettling Times

Moving Towards Quality Aged Care in Hong Kong

~ Asia Care Group ~

Unsettling Times
Moving Towards Quality Aged Care in Hong Kong

Authored by Thalia Georgiou, Candace Albert, Tifenn Durieux and Titus Lam

July 2018

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An uncertain age: Meeting the needs of Hong Kong's ageing society

Ageing is a collective human experience; one we all experience and one which, for many reasons, we often approach with a great sense of unease. When discussing the issue of ageing with members of our community, the sense of increased vulnerability is pervasive and real. Many fear the loss of autonomy, the limitations that may come from decreased mobility, the economic woes of no longer being able to earn, and, perhaps of greatest concern – the potential move to an institution and away from all that is familiar and normal. And in Hong Kong, which has the highest rate of institutionalisation amongst the elderly population anywhere in the developed world, these concerns are valid. But ageing is predictable.

We have more clarity on how the structure of our population will change - and with it economic, social and health needs – than we do almost any other area of policy. However, despite this, planning for the "silver tsunami" remains stubbornly slow. Major gaps in financial protection continue to place the elderly at risk of poverty or catastrophic expenditure to cover a period of illness or care. This lack of financial protection and liquidity has, in turn, meant there has been no stimulus for a provider market to develop that properly caters to the needs of a growing section of our society. Models of care are outdated; harking back to an era when the lonely walls of institutions were the boundaries that enclosed a person's golden years. And perhaps of greatest concern is the likelihood that this situation is resulting in avoidable risks to vulnerable adults. Hong Kong's regulatory regime for the operation of residential care facilities is one of the weakest globally. Of the few standards that must be met, inspections that have taken place in recent years reveal that almost half has resulted in advisory or warning letters due to a lack of compliance – indicating deep-seated quality issues.

The picture – and outlook – is of great concern and requires truly collective action. In this publication, *Unsettling Times: Moving Towards Quality Aged Care in Hong Kong*, we advocate a rallying and urgent call to action. As we challenged ourselves, we seek to challenge our readers – to think about what can be done to improve this situation. In our work across the healthcare landscape and through our interactions with its many diverse stakeholders, we now have identified ten key barriers to quality aged care in Hong Kong. We feel that sharing these barriers is important and do so in the hope that this knowledge will enable our partners to design better, more sustainable solutions.

Thalia Georgiou
Head of Healthcare Advisory, Asia Pacific
Asia Care Group

A demanding issue: the aged-care capacity challenge

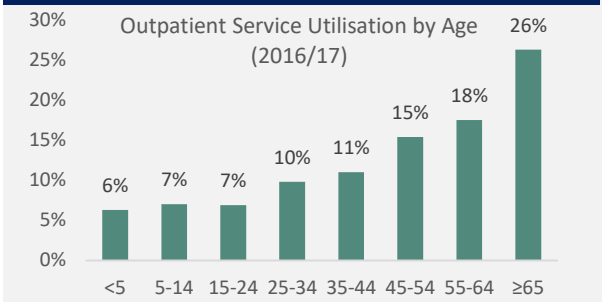
The impact of ageing on Hong Kong's healthcare system is pronounced. In 2016/17, patients aged 65 or above utilised one-fourth of all outpatient services, and one-third of all inpatient services.[2] The impact of this demand on health financing has been crippling. Hospital Authority statistics reveal elderly patients spend, on average, 2.9 bed days longer in hospital than other age groups. This translates to an extra cost of $14,007 per patient annually.[3] In 2017, it was estimated that 5.9 billion HKD was spent on inpatient care for patients aged 65 or above, accounting for 37% of the total inpatient care.[3]

In capacity terms, this demand translates to severely overburdened public healthcare facilities, with 120-130% capacity an increasingly common occurrence during peak flu-seasons. In less than ten years' time, Hong Kong will need a minimum increase of 27% in bed capacity just to deliver services to the same access and quality standards seen today.

These staggering statistics highlight the very real possibility of populations facing worsening access to care, unless new models of care are developed or vast increases in infrastructure are realised.

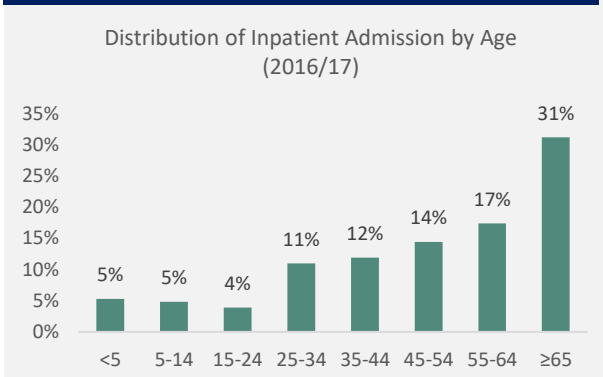
However, the opportunity for such a transformation is significant. Currently over 90% of Hong Kong's population die in hospital; the highest institutionalisation rate in world. Asia Care Group estimate that improved out-of-hospital palliative care support, which would bring Hong Kong's end-of-life model in-line with other developed health economies, could result in 92,710 bed days saved annually by 2027.

One in four patients who use outpatient services are aged 65 or above



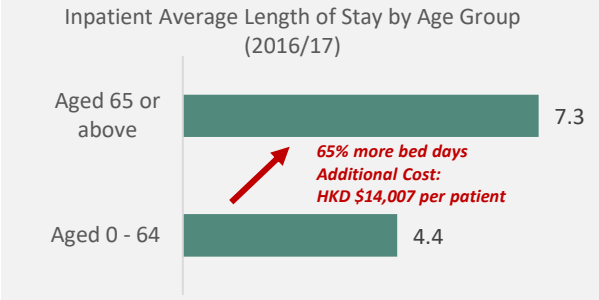
Source: Census and Statistics Department (2017)

One-third of the patients who use inpatient services are aged 65 or above



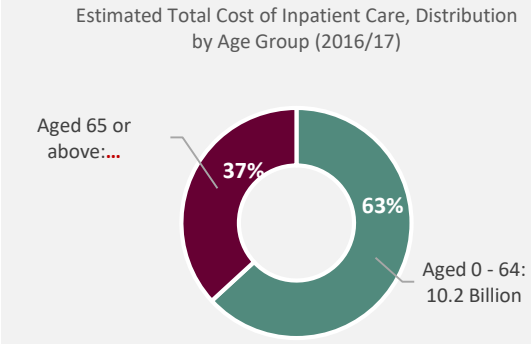
Source: Census and Statistics Department (2017)

On average, elderly patients use three times more inpatient days than younger individuals



Source: Legislative Council (2017)

37% of the total cost of inpatient care has been spent on the elderly



Source: Census and Statistics Department (2017), Legislative Council (2017), Asia Care Group Analysis

10 Key barriers to quality aged care in Hong Kong

Asia Care Group have identified ten key barriers to quality aged care in Hong Kong.

We feel that sharing these barriers is important, and that this knowledge will enable our partners to design better, more sustainable solutions.

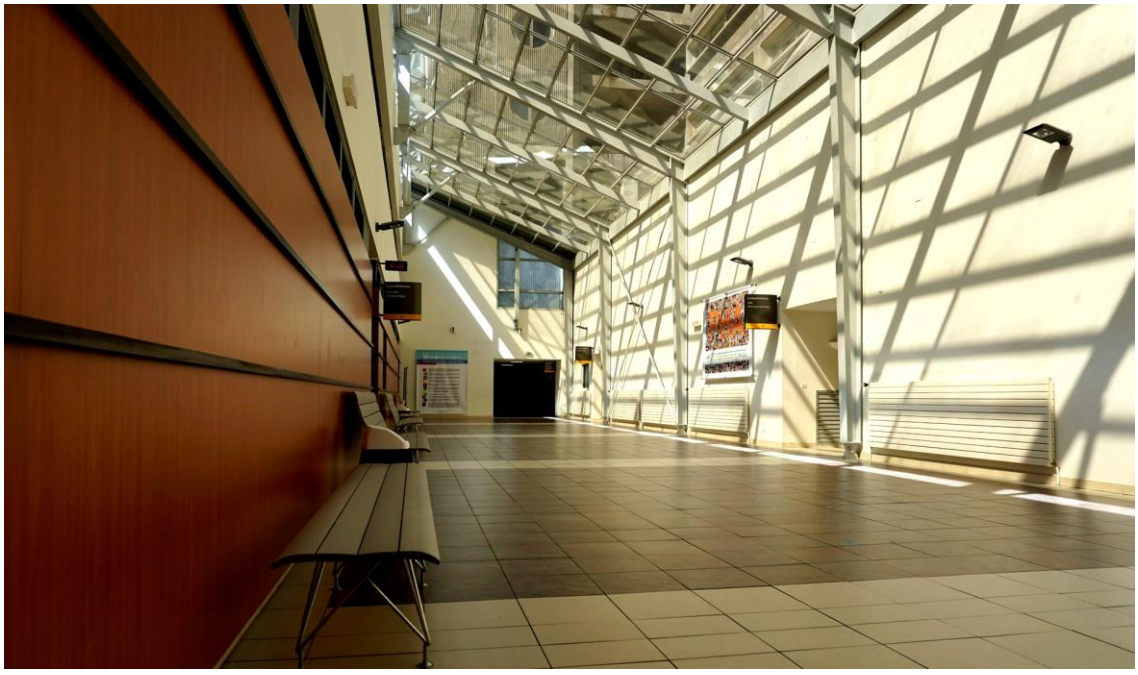
10 Key Barriers		Our Proposed Solutions				
		Prevention & Healthy Aging	Integrated Care Pathway	Case Management	Home-based Hospice Care	Aged Care Protection Products
Regulatory						
1	There is no guiding policy for elderly services	✓	✓	✓	✓	✓
Health System						
2	Services are highly fragmented and skewed towards costly acute care	✓	✓	✓	✓	✓
3	New solutions are needed to refocus the model of care away from institutionalisation	✓	✓	✓	✓	✓
4	There is a shortage of affordable skilled healthcare workers	✓	✓	✓	✓	✓
Financial						
5	Government resource allocation is not sustainable in the mid-term	✓	✓	✓	✓	✓
6	Retirees are unable to support their own health and care needs after retirement	✓		✓		✓
7	In spite of a willingness to pay, Hong Kong's elderly do not have appealing options	✓			✓	✓
Sociocultural						
8	There is a lack of support for informal carers	✓		✓		✓
9	Social stigma impacts placement of family members in care facilities				✓	✓
10	Filial duty to care for elderly family members is at odds with economic reality	✓			✓	✓

Financing the silver tsunami

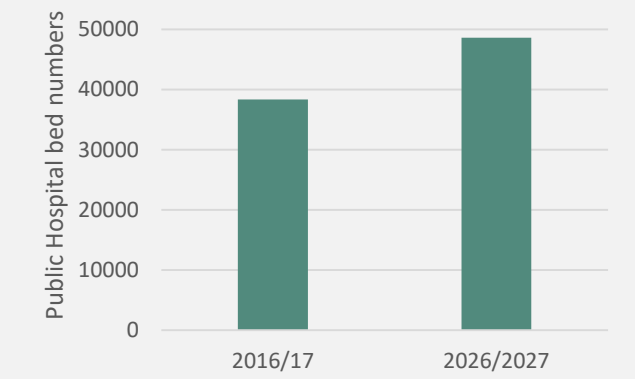
The challenge of financing an ageing society is perhaps the single biggest policy challenge facing Hong Kong's Government. Healthcare spending continues to outpace growth in GDP at an unsustainable rate. Over a ten-year period (2005-2015), other developed markets - like the UK and the US - saw less than 15% difference in growth of GDP versus growth in healthcare expenditure. In Hong Kong during the same period, there was some 29.2% higher growth in health spending versus GDP. At a top-line level, these figures are worrying. The rapid and disproportional growth of health spend versus general economic growth points toward a marked sustainability challenge.

Hong Kong's total health care expenditure is expected to grow from about 6.3% of GDP in 2015 to 8.7% of GDP by the year 2030.[4] Long-term care expenditure is projected to increase from the current level of 1.5% to 3% by 2034[5], which would be the highest among developed countries. Concurrently, the burden of financing future healthcare will fall on a shrinking workforce – the labour force participation rate is estimated to decline from current 59% to 52% by 2035.[6] The government will soon face a structural deficit problem, and a reduced tax base from which to achieve a sustainable financial positioning.

In the near-term, these issues manifest in longer waiting times for healthcare services. In certain specialities, waiting times have increased by over 300%, whilst access to care homes remains stubbornly low. There is therefore an urgent need to rethink the underpinning financial models to ensure better protection and broaden the availability of financing for the future.

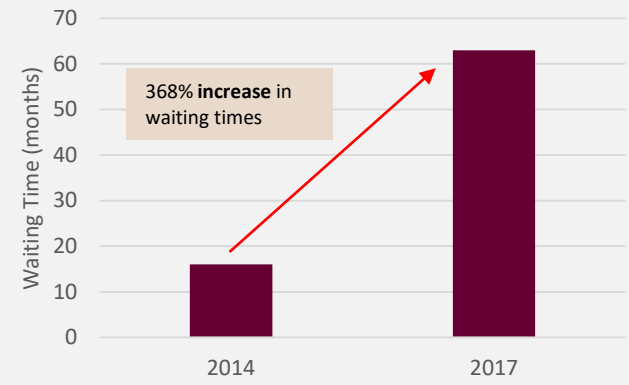


In the next ten years, Hong Kong will need 27% more hospital beds to maintain current levels of service



Source: Asia Care Group Analysis

Average waiting time for total joint replacement in Hong Kong's public hospitals tripled in three years



Source: Asia Care Group Analysis of Hospital Authority Data

Our analysis highlights a projected shortage of hospital beds across Asia in the coming 10 years

	Extra Beds Required to Maintain Current Level of Service	% Increase Compared with Current Bed Number	Current Bed Ratio (Beds per 1000 Population)	Extra Beds Required to Meet OECD Average	% Increase to meet OECD average
China	334,383	43.81%	5.11	310,755	40.7%
Singapore	7,902	39.43%	3.58	18,985	94.7%
Hong Kong	10,270	26.77%	5.20	8,399	21.9%
Australia	17,926	19.65%	3.90	48,716	53.4%
United States	123,016	13.45%	2.80	938,248	102.6%
United Kingdom	17,590	9.70%	2.80	173,903	95.9%

Action areas at a national level

Government has made efforts to support ageing in place, but to date, little has materialised. This is captured in the work of the Elderly Commission, which has championed an Elderly Care agenda for more than twenty years yet operates with no financial resources to carry out key activities. The Commission's power is limited to liaising with Government bodies that supply or direct elderly services, yet objectives often lose out to competing priorities and agendas (*see Appendix*). The two most pressing issues facing aged care planning at a system level are the lack of a cohesive regulatory framework and the increasing cost of care associated with Hong Kong's ageing population. In light of this, two essential action areas for Government in coming years will be the following:

1. • Creation of a comprehensive guiding policy framework (with a focus on prevention, standardised quality, risk stratification, and ageing in place).
2. • Explore new financing mechanisms to ensure better financial protection, broaden the availability of financing for the future, and expand service scope and reach.

Action areas for Individual Stakeholders

For actors across the healthcare landscape, there are individual-level action areas that can be pursued in the absence of formal reforms. Several payors and providers are already experimenting with many of the mechanisms that underpin aged care models in other markets. These mechanisms include creating infrastructure for richer data collection and data sharing (payors), intersectoral collaboration between health and care entities (providers), and experiments with innovative financing mechanisms (both).

Through our understanding of the local market, we find it most pertinent to highlight five key action areas that individual stakeholders can readily pursue: focus implementation and planning at the local level; coordinate actors across domains; actively engage first-line carers; develop new methods of support for information caregivers; incentivise and support the creation of new aged care protection products. These action areas build upon the early gains of individual stakeholders, and offer a path to overcome critical barriers to quality aged care. In Chapter 3 of this work, Asia Care Group present a number of international case studies that illustrate the above action areas in motion. The highlighted models focus on a range of next steps for individual stakeholders, including solutions for prevention and healthy living, standardization of care pathways, risk stratification and case management for fragile individuals, support for individuals and families during the end-of-life process, and new financing models and product design for aged care across the continuum.

2. The main barriers facing Hong Kong today

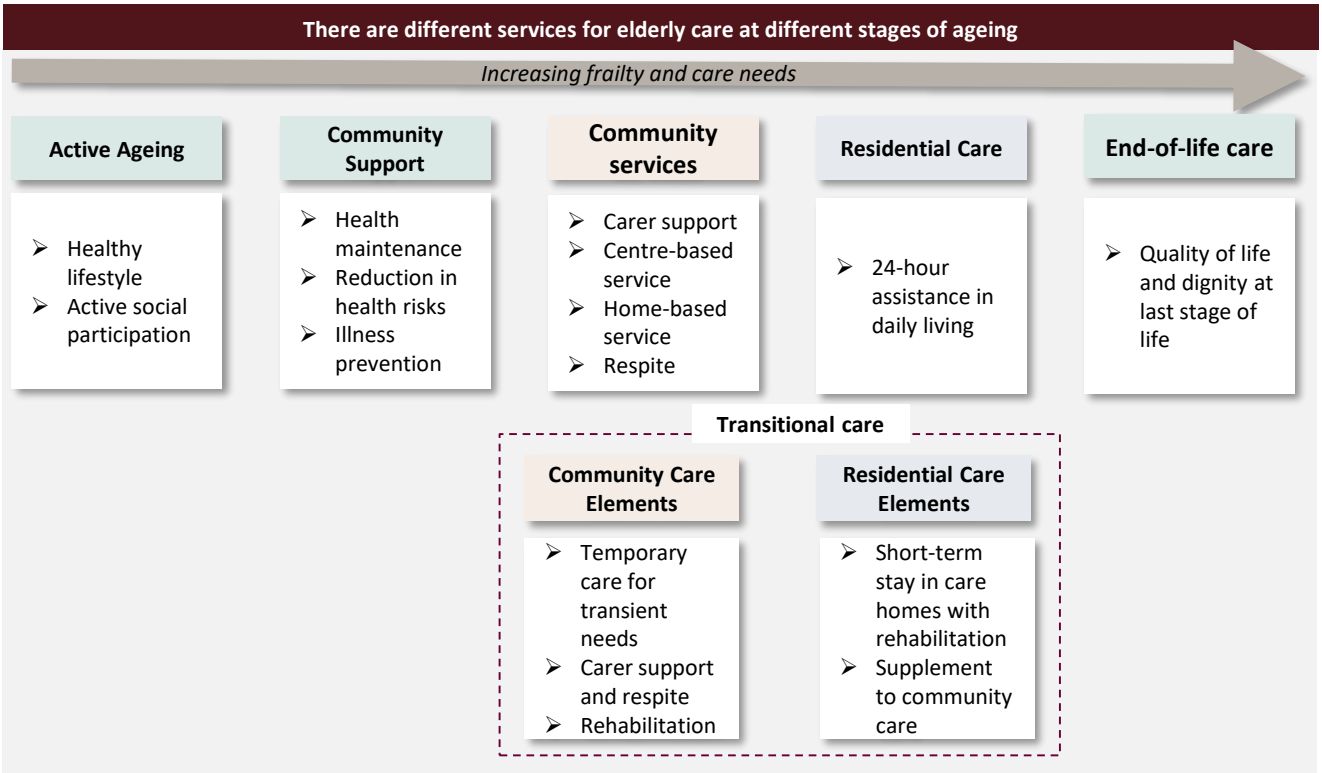
Regulatory barriers
Health system barriers
Financial barriers
Sociocultural barriers

1. There is no guiding policy for elderly care services in Hong Kong

There are different types of elderly care services in Hong Kong in terms of funding, providers, and service scope – yet these services have no overarching policy framework. Five classes of elderly care services are under the coordination, planning and regulation of the Social Welfare Department (SWD), however, there are no coordinated regulations governing these programmes[12]. The result is a patchwork system with a lack of coordination between programme levels, and fragmentation of services. For elderly patients, this greatly impacts their patient journey, and increases the likelihood of poorly managed health conditions and exacerbation of chronic diseases along the care continuum.

Community Support and Community Care Services (CCS) are delivered through NGOs, targeting individuals in the early stage of ageing[16]. Most elderly individuals wish to stay in the community and remain close to their families, where foreign domestic helpers (FDH) play a significant role in delivery of informal care in Hong Kong. CCS is in place to enable family carers and FDH to meet the different levels of care needs of the elderly[17]. CCS offers a range of services including training programmes, financial assistance, emotional support and respite services – however, these services remain highly underfunded and underutilised.

With advanced ageing, health conditions deteriorate -- and the care needs of the elderly exceed the level of support offered by CCS. For these individuals, increased medical oversight becomes a growing need. Residential care services (RCS) are one option for individuals with advancing medical needs. RCS is delivered through both public and private providers, covering a wide range of services and support to the elderly living in institutions. Service provision is determined by a range of factors including medical need, availability, patient preference, and ability to pay [16].



Source: Social Welfare Department & Asia Care Group Analysis(2018)

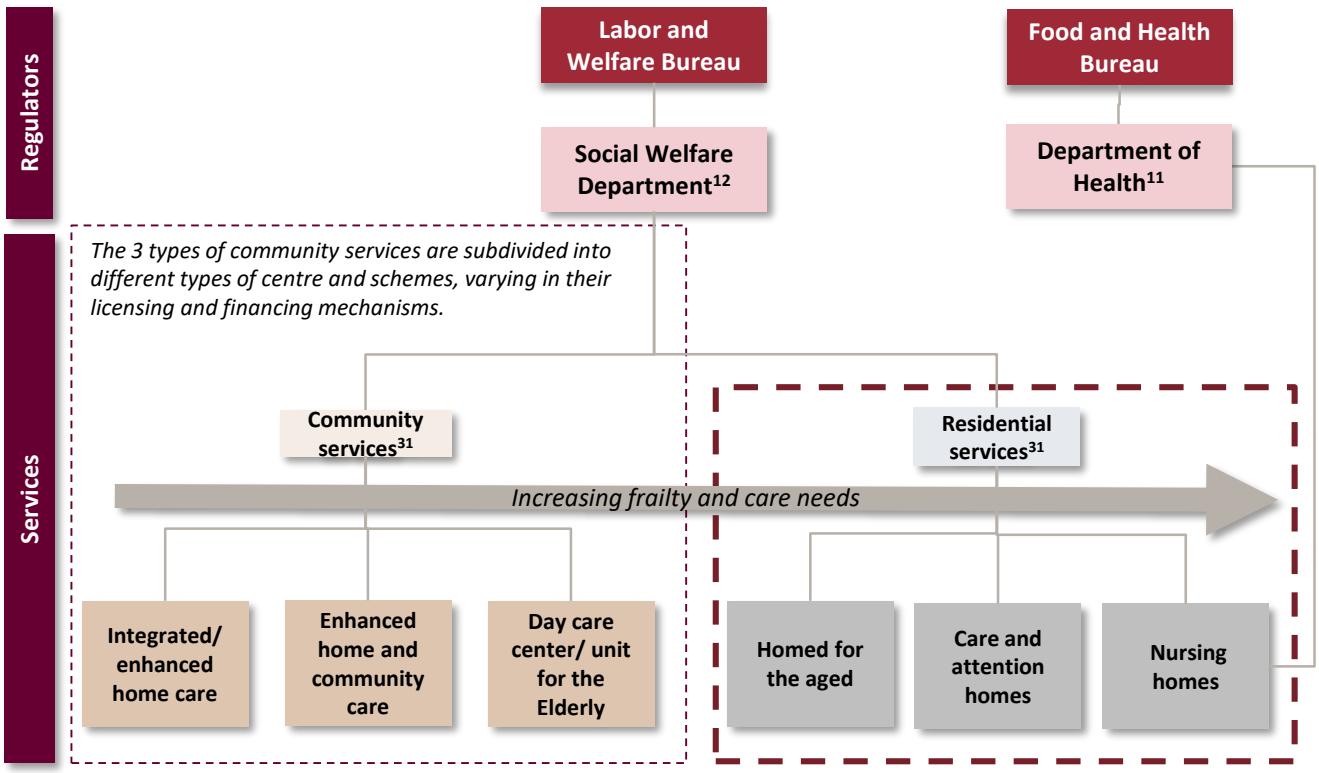
Transitional care (including rehabilitation services, care support through community or short-term RCS, support and training to family carers), is in place for individuals who see an improvement in health and transition back to community settings with the support of CCS. These services require further expansion and investment to meet population needs[16].

At the final stage of life, palliative care is required. Drawing from a multidisciplinary approach to the specialised needs of terminally-ill patients, these services focus on providing pain relief, emotional and coping skills, addressing caregiver needs, and ensuring patients die with dignity. Currently, there are several problem areas with the model for end-of-life care in Hong Kong. It remains an ongoing challenge from a regulatory perspective because the existing regulations have not been updated to reflect the reality of an ageing society; uptake of Advance Directives (AD) and Advance Care Planning (ACP) remains low and when they are in place they are not legally recognised[18]. Patient preference for Do Not Resuscitate (DNR) is in conflict with the outlined medical procedures for emergency care services – reflecting back on the absence of an overarching policy framework to guide elderly care services[18].

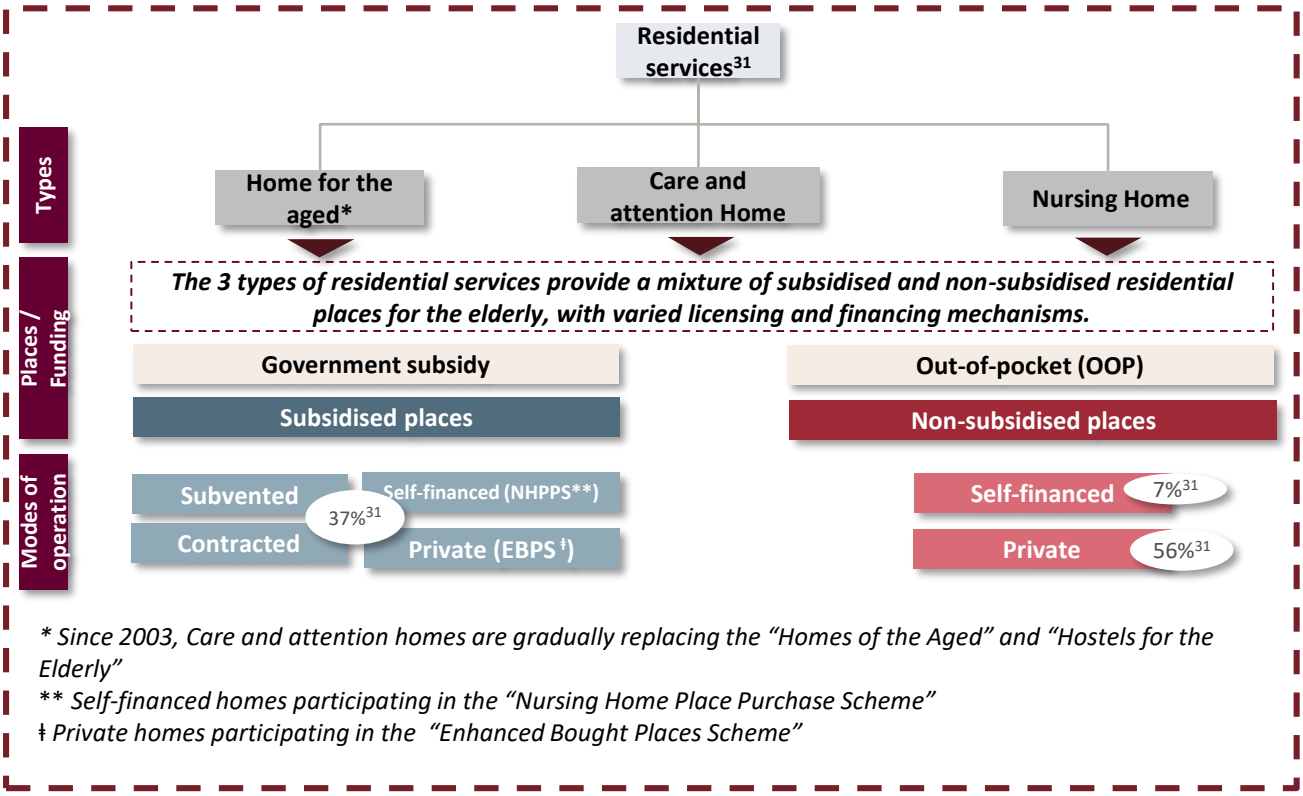
Selected indicators that are commonly used in aged-care regulatory frameworks[12,19-30]					
Indicator	**UK**	**Australia**	**Hong Kong**	**Taiwan**	**Singapore**
Legal status					
Advance Directive	✓	✓	×	✓	✓
Advance Care Plan	✓	✓	×	✓	✓
National Standard/accreditation on quality					
Community Care	✓	✓	×	✓	✓
Residential Care	✓	✓	×	✓	✓
Home Care	✓	✓	×	✓	✓
Palliative Care	✓	✓	×	✓	✓
Public education/promotion on care services available					
Elderly Care	✓	✓	✓	✓	✓
Palliative Care	✓	✓	×	✓	✓
Healthcare providers with licensing provisions					
Elderly Care	✓	✓	✓	✓	✓
Palliative Care	✓	✓	×	×	×
Recognition as medical specialty/sub-specialty					
Elderly Care	✓	✓	✓	✓	✓
Palliative Care	✓	✓	✓	✓	✓
National strategy for implementation					
Elderly Care	✓	✓	✓	✓	✓
Palliative Care	✓	✓	×	✓	✓
Government subsidies for care facilities					
Elderly Care	✓	✓	✓	✓	✓
Palliative Care	✓	✓	×	✓	✓

Compared to Australia and United Kingdom, Hong Kong, Taiwan and Singapore are less developed in terms of the licensing provisions for palliative service providers. Hong Kong lags behind in formal recognition of the legal status of Advance Directive and Advance Care Plans. Resultantly, care plans for end-of-life services may not be recognised. Without acknowledging the patient voice, services often fall short of expectation and preference for both quality and models of care. Additionally, the absence of a national standard or accreditation scheme for elderly/ palliative care facilities has resulted in high variation in quality between provider settings in Hong Kong. Public awareness programmes, subsidy scheme, and a guided strategy for palliative care are all absent in the Hong Kong context. These subjects have historically been taboo topics for Hong Kong civil society.

Overview of Elderly Care Services in Hong Kong



Source: Social Welfare Department & Department and Health (2018)



** Since 2003, Care and attention homes are gradually replacing the "Homes of the Aged" and "Hostels for the Elderly"*

*** Self-financed homes participating in the "Nursing Home Place Purchase Scheme"*

ǂ Private homes participating in the "Enhanced Bought Places Scheme"

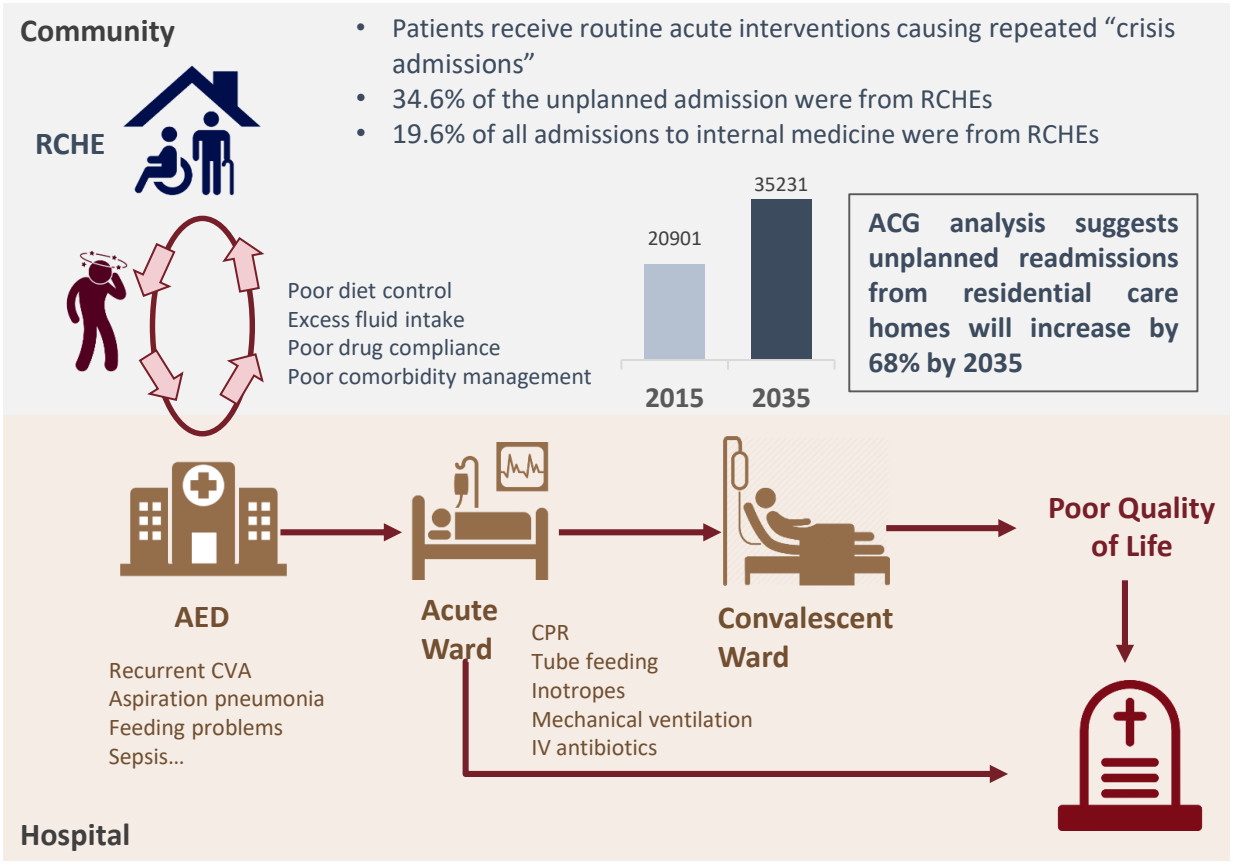
Source: Social Welfare Department (2018)

2. Services are highly fragmented and skewed towards costly acute care

Most elderly individuals suffer comorbidities, which are associated with various adverse outcomes. These include higher risk of premature mortality, longer hospital stays, greater health service utilisation and increased costs. The health system in its current form is ill-equipped to meet the demands of high-intensity patients.

Residential Care Homes for the Elderly (RCHEs) face several problem areas. They do not receive adequate monitoring and medical oversight, as many RCHEs do not have a designated primary care physician. Allied health teams to provide on-going healthcare support for residents are often understaffed. These staffing issues have contributed to the estimated 34.5% of unplanned admissions occurring in HA from RCHEs[32]. Additionally, 33.5% of HA deaths annually are RCHEs residents, and 34.7% of RCHEs residents visit the hospital twice during the last six months of life[33].

The problem of repeated unplanned "crisis readmission" from elderly homes has been referred to as the "revolving door syndrome" in overseas studies[34]. Considering population growth, trends in ageing, and an increasing number of RCHEs residents, Asia Care Group analysis suggests unplanned readmissions from RCHEs will increase by 68% by year 2035[35].



Additionally, there is a lack of transportation services for elderly individuals, inhibiting access to social support, medical appointments, and reducing individuals' capacity to remain active members of the community. This, in turn, results in avoidable (re)admissions to hospital. Strengthened community support would increase capacity for healthy ageing and a smoother transition back to community life following an inpatient stay.

Older adults have different healthcare and social support needs than younger age groups, which needs to be incorporated into service planning. The optimal care of an elderly patient with long-term conditions requires a holistic approach that recognises and treats all aspects of the disease and comorbidities, with ongoing feedback and reinforcement from healthcare professionals.

The current reality in Hong Kong is that resource allocation continues to skew towards high-cost inpatient acute care, with only 3% of the resources being spent on community care services by the Hospital Authority[36]. Elderly patients often engage in an episodic relationship with the healthcare system, as a combined result of the fragmentation of departments and organizations, and the lack of care continuum and coordination within the care pathway. These systematic issues have driven trends like unnecessary AED attendances and high readmissions rates for preventable illnesses among the elderly population.

Ambulatory Care Sensitive Conditions (ACSCs)		
Conditions for which hospitalisation could be prevented by better interventions in primary care.	Hospitalisation rates for ACSCs are often used as a proxy to analyse quality of and access to primary care services	Poor access or low quality of primary care often results in higher hospitalisation rates for these conditions.

A 2014 CUHK study identified potentially avoidable Ambulatory Care Sensitive Conditions (ACSCs) among older adults in Hong Kong[37]. The research revealed 44% of all AED admissions stem from preventable hospitalisations, whilst 21.4% were unplanned readmissions. In the UK, the percentage of avoidable hospitalisations is around 20%. Asia Care Group analysis suggests the estimated total cost of ACSCs for A&E admissions is approximately $4.47 billion each year, whilst avoidable readmissions total over $744.7 million annually.

Local evidence suggests that over 40% of unplanned readmissions could be prevented through effective community care and case management[37]. If health conditions amongst seniors were better managed through effective community care and case management, more than $2.24 billion could be saved annually in preventable hospitalisations, and over 144,000 bed days could be saved in avoidable readmissions, assuming international best practices are adopted.

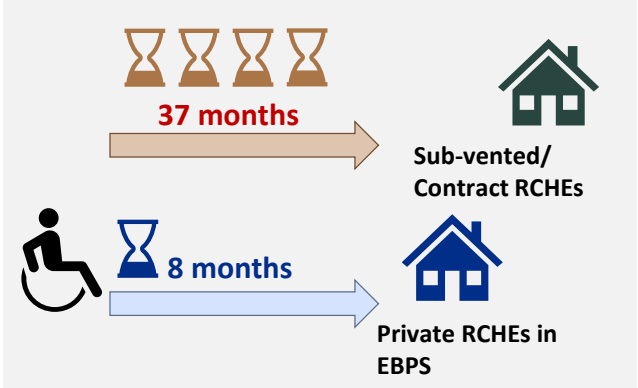
3. New solutions are needed to refocus the model of care away from institutionalisation

Over the past five years, the total number of places available in residential care homes has fallen by 3%, contrasted against the 24% rise in the elderly population[39]. Elderly applicants who seek a residential care placement face extended waiting times. In 2014-2015, the average waiting time reached 37 months for admission to sub-vented/contract Residential Care Homes for the Elderly (RCHEs), which are usually considered a better living environment and cheaper in cost. The average waiting time for sub-vented placement in a private RCHEs under the Enhanced Bought Places Scheme (EBPS) -- is shorter, at eight months[40]. There are no available figures for the waiting time of private RCHEs not under the EBPS.

The long waiting times for subsidised placements have contributed to an increasing role of private RCHEs to meet rising demands. Many elderly applicants stay in private RCHEs whilst waiting for a subsidised place, or as an emergency placement. The cost associated with private RCHEs is tremendous, and Consumer Council found that charges for private RCHEs ranged from $8,000 to $21,000 per month in 2015[41]. The combination of issues around affordability and wait time has dramatically limited the access to residential services for Hong Kong's elderly. Approximately 6,000 applicants passed away in 2015 (versus 5,000 applicants in 2011) before their placement in a subsidised facility. This 20% increase in death among the waitlisted over a 4 year period highlights both the urgent need for expansion of residential services and the need for new solutions[40].

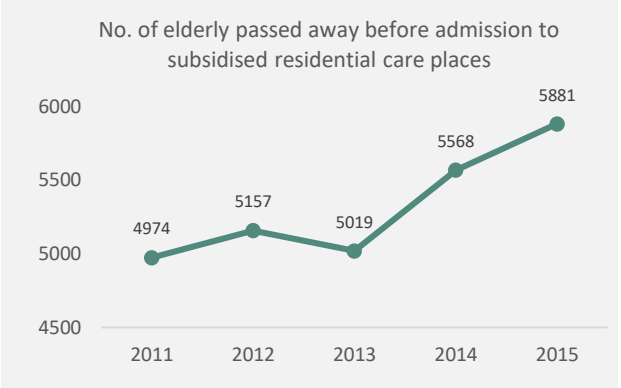
Whilst Hong Kong has both highest bed ratio and institutionalisation rates for residential elderly care facilities in Asia, it is nonetheless difficult for ageing patients to be admitted to RCHEs. This illustrates two points: as a model, institutionalisation is unsustainable; and the aged care system desperately needs to be refocused away from institutionalisation.

Average Waiting time for admission to subsidised RCHEs



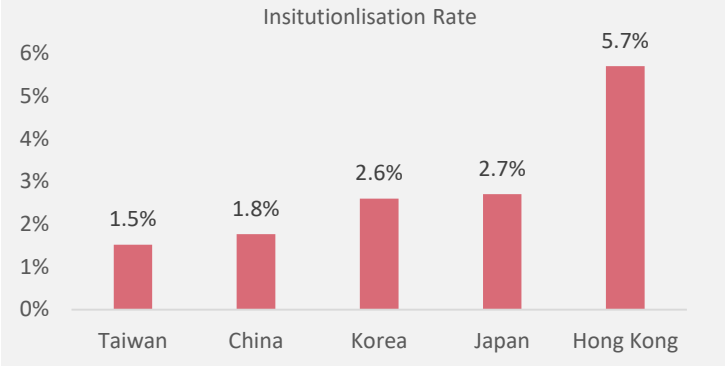
Source: Social Welfare Department

~6000 applicants passed away before admission to care places



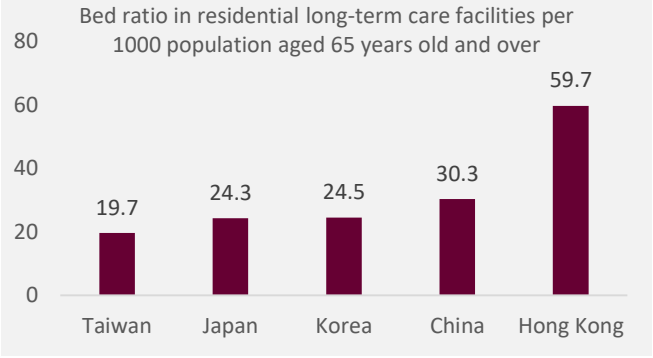
Source: Social Welfare Department

Hong Kong has the highest institutionalisation rate in Asia



Source: Asia Care Group Analysis (2018)

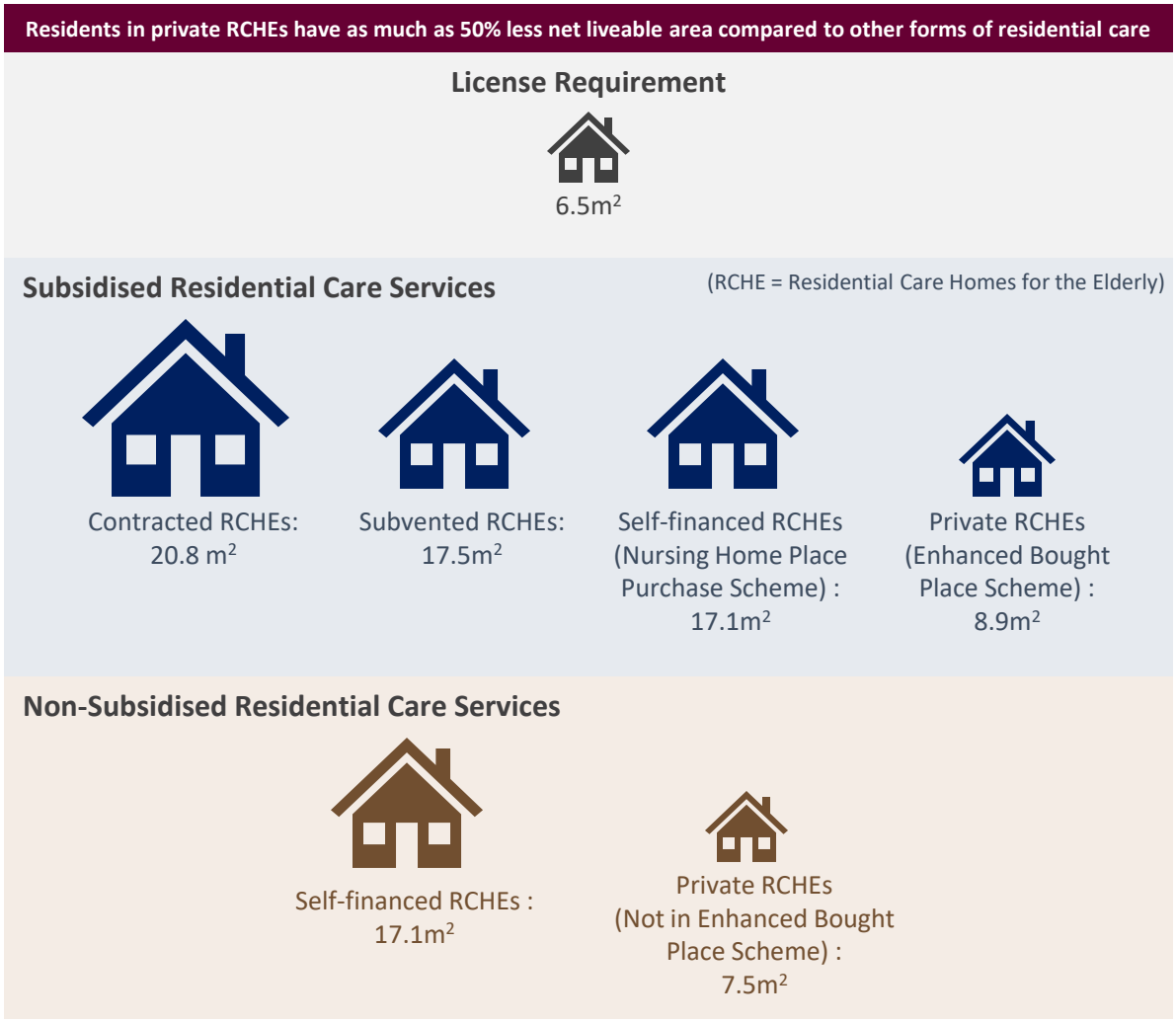
Hong Kong has the highest residential bed to population ratio in Asia



Source: Asia Care Group Analysis (2018)

Both the ordinance and regulation governing RCHEs have not been updated or reviewed since establishment back in the 1990s. What has ensued are a host of sub-par practices that reinforce the need for greater quality measurement. Staffing ratios, provision of qualified professional nurses, and the average net area per resident all vary widely between facilities. Average area per resident in private RCHEs is more 50% smaller than room conditions in sub-vented settings. Quality indicators are not currently considered in the requirements for license application or renewal, speaking to the severity of the situation – and an imminent need for review.

The current inspection system is outdated and ineffective, with only 30 RCHEs prosecuted in the over 25,000 cases of inspection between 2011 and 2016. An average of approximately 3,000 advisory letters and 350 warning letters have been to RCHEs warning letters to RCHEs[39,43]. The infractions spanned a wide array of quality violations, further highlighting a pressing need to strengthen the monitoring and evaluation process, improve service quality across RCHEs, and protect the vulnerable elderly population.[44,45]



Source: Legislative Council - Challenges of Population Aging

An inadequate regulatory regime has resulted in variable quality in residential care facilities					
Residential Care Homes	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**
Number of inspections	5373	5313	5254	5445	5260
Number of advisory letters issued	3097	3042	3204	3028	2674
Number of warning letters issued	377	348	364	320	361
Number of prosecutions	5	10	11	2	2

Source: Legislative Council, Social Welfare Department

There is wide variation in staffing levels and types of staff employed depending on the type of RCHEs					
	Average number of staff per 100 residents				
	RCHEs offering subsidised places			RCHEs not offering subsidised places	
	Subvented RCHEs	Contract RCHEs	Private RCHEs in EBPS	Private RCHEs not in EBPS	Self-financing RCHEs
Nurse	5.1	7.7	2.6	0.2	3.2
Health worker	2.8	4.6	5.8	3.4	4.6
Care worker	16.3	18.7	14.7	8.4	15.2
Ancillary worker	12.8	8.7	7	3	9.8
Other staff*	3.2	2.6	1.9	1.3	2.2
Total	40.2	42.3	32	16.3	35

Source: Legislative Council

*Other types of staff: home manager, social workers, occupational therapists and physiotherapists

(RCHEs = Residential Care Homes for the Elderly)
(EBPS = Enhanced brought place scheme)

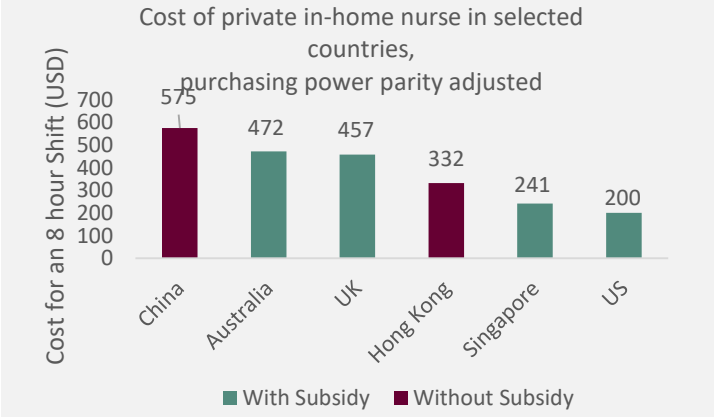
4. Hong Kong faces a shortage of affordable skilled healthcare workers

Hong Kong currently has a shortfall of care workers and professionally trained personnel. Estimates by the Business and Professionals Federation suggest over 20,000 additional healthcare workers will be necessary over the next decade to handle the growth in demand for increased care needs and ageing.[46]

In particular, the impacts of manpower shortages in the aged care sector are crippling, as elderly care service providers have to compete with other service sectors (such as hospitals and clinics) for staff with similar qualifications. An overall shortage of manpower in the elderly care services sector has been continually reported as the result of an inadequate supply of health care professionals in general, and lack of career prospects in the elderly service field.[47] Stakeholders have considered the workforce shortage to be the greatest barrier in providing quality care and expanding service capacity.

Manpower shortages have been observed in various professional positions across aged care in Hong Kong, including nurses, occupational therapists, physiotherapists, as well as frontline caregivers such as personal care workers and home helpers.[16] The high demand for elderly care workers has been reflected in escalating private nursing fees, which can cost up to $750 per hour.[48] In other developed countries, various government subsidies are available for home-care services. In Hong Kong, individuals have to pay in out-of-pocket and in full for private nursing.

Individuals in Hong Kong have to pay out-of-pocket if they need a private nurse



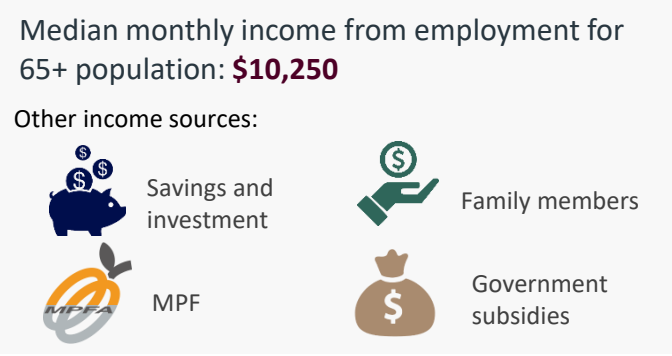
Source: Asia Care Group Analysis of in-home private nursing providers across countries

The cost for hiring private nurses is not affordable for most of the elderly population in Hong Kong

	Registered Nurse	Enrolled Nurse
1 Hr	$750	$600
3 Hrs	$1,030	$850
6 Hrs	$1,490	$1,300
9 Hrs	$2,130	$1,830
12 Hrs	$2,720	$2,400

Source: Quality Health Medical Services (2017)

High costs for private nursing is unaffordable for most of the elderly population in Hong Kong. The average monthly income for the working population aged 65+ is slightly above the $10,000 threshold,[49] but even less for retirees. Elderly individuals are thus forced to rely on previous savings or the financial support of family members. Even for individuals with private health insurance, a standard ward-level health policy only covers the cost of a private home nurse at a rate of $450 per day – and only then as a time-limited post-hospitalization service. Long-term conditions that require nursing care (e.g. feeding tubes, urinary catheterization, sputum suction) almost always fall outside of the insurance spectrum.



Source: Census and Statistics Department (2017), Legislative Council (2016)

Comparison of the level of subsidy for in-home private nursing services	
Country	Subsidy for In-home Private Nurse
Australia	Government subsidised Home Care Package available, in which the government subsidises 60% to 90% of the cost, depending on the seriousness of the patient
Singapore	Government provides subsidies for intermediate and long term care services (including home nursing) for individuals meeting the eligibility criteria
United Kingdom	Local council provides subsidy for at-home care services for individuals with savings and properties less than £23,250
United State	Many states allow their residents to use Medicaid to pay for assisted living communities or other alternatives to nursing homes such as in-home care

5. Government resource allocation is not sustainable in the mid-term

In the year 2016/17, the government spent $7.1 billion on providing subsidised community care and support services and residential care services for elderly individuals.[51] Approximately 80-90% of total elderly service cost was borne by Government.[16] The Working Group on Long-Term Fiscal Planning suggested that the Government will begin to face a structural deficit problem by 2030.[36] There is, therefore, an urgent need for stakeholders to consider the long-term financial implications of the current funding models and propose new solutions.

The Elderly Commission has made recommendations to ensure the long-term sustainability of elderly services, including the following:[16]

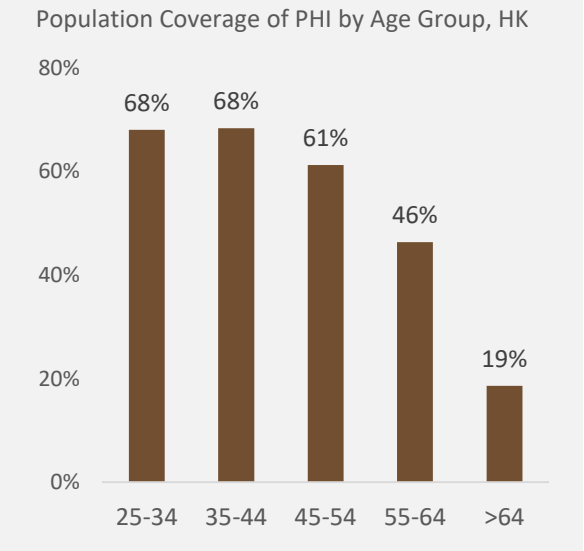
1. A principle akin to "shared responsibility of care" wherein those who have better financial affordability shoulder a greater share of the contributions
2. Explore alternative financing options, e.g. long-term care insurance, contributory savings, and co-payment for services
3. Encourage NGOs to provide self-financing services
4. The community and families should take active part in actualising community care

6. Retirees are unable to support their own health and care needs after retirement

Whilst the government is encouraging more contributions from individuals, the elderly have difficulty in financing their own long-term care needs. According to research funded by the Central Policy Unit, around 60% of surveyed individuals responded that they had no confidence or little confidence in making enough money for retirement.[52] Polled retirees were most concerned with post-retirement health-related problems.[52]

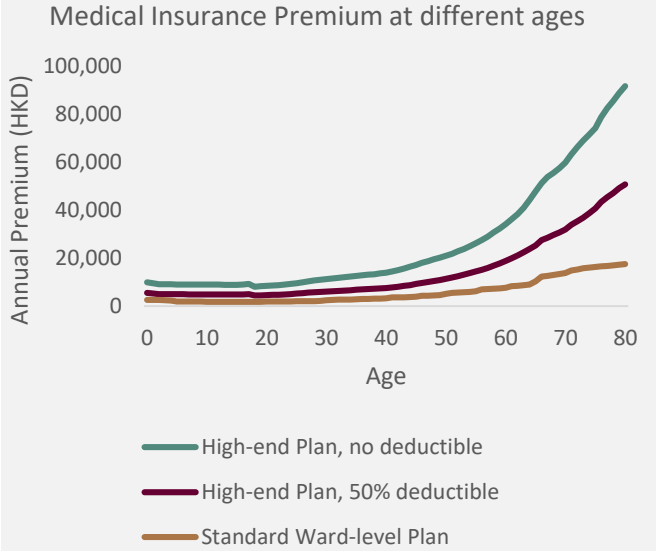
Average annual spending for a retired couple ranges from HK$79,200 to HK$459,600, covering housing expenditure (rent or mortgage), food, and miscellaneous expenditure like medical costs or telecommunications.[50] Health insurance pricing increases as a policy holder ages; a standard ward-level reimbursement plan can cost more than HK$10,000 annually for a 65 year-old male - as much as 13% of the average elderly person's annual expenditure. A decline in private health insurance (PHI) coverage among the 55-64 age group is therefore common in Hong Kong.[2] Whilst the drawdown of MPF assets and family contribution can provide partial support, retirees would need to accumulate substantial savings before being able to live in a self-reliant manner.[50]

Aged adults fall off the health insurance coverage spectrum



Source: Census and Statistics Department 2017

PHI becomes unaffordable as individuals age



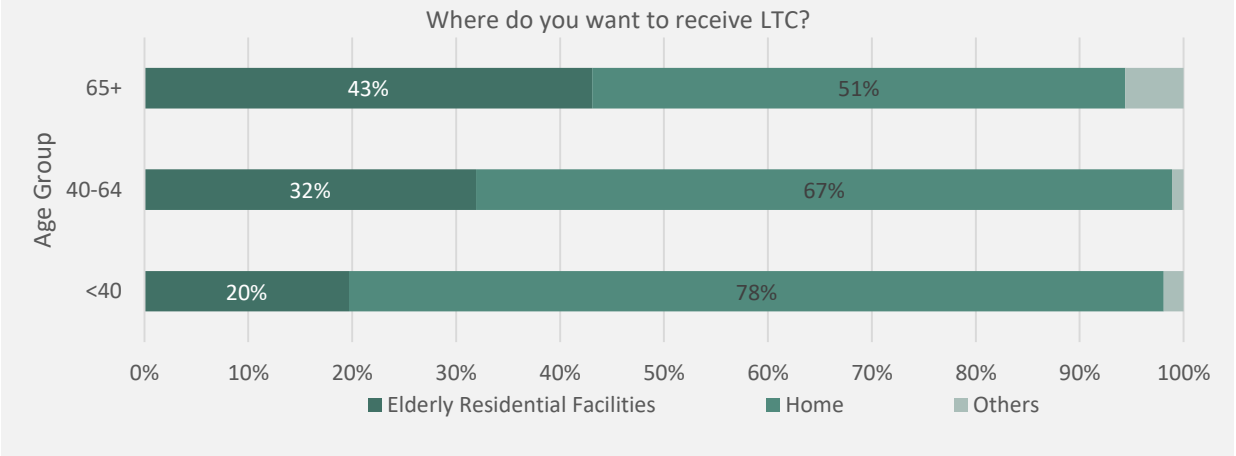
Source: Asia Care Group Analysis of PHI products in Hong Kong

7. In spite of a willingness to pay, Hong Kong's elderly do not have appealing options

In traditional Hong Kong society, an elderly individual's dependants – usually their children – have historically borne responsibility for funding their care needs. In light of the rapidly increasing costs associated with ageing, Hong Kong families no longer have enough resources to pay for the long-term care needs of their loved ones. In 2017, the Hong Kong Council of Social Service published a survey measuring willingness to pay for long-term care costs of elderly individuals. The survey sample included 1,466 participants across three age groups: below 40 years-old, 40 to 64 years-old, and individuals 65+ years-old.[53]

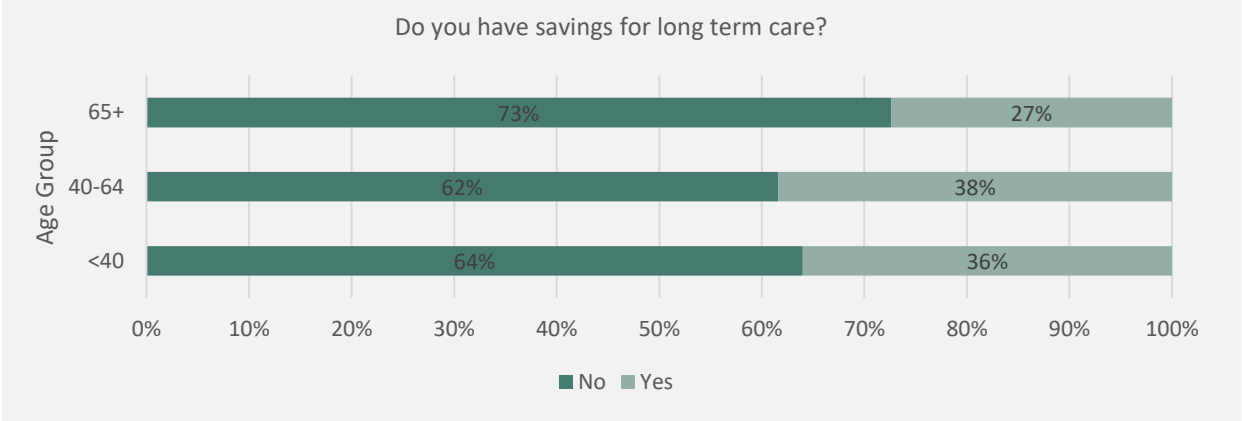
Across the three age groups, the survey found that most respondents want to receive long-term care at home. A corresponding question from the same survey revealed that only 27% of individuals aged 65+ had savings – of any kind – for long-term care costs.

Most correspondents want to receive long term care (LTC) at home



Source: The Hong Kong Council of Social Service (2017)

Most correspondents do not have savings for long term care

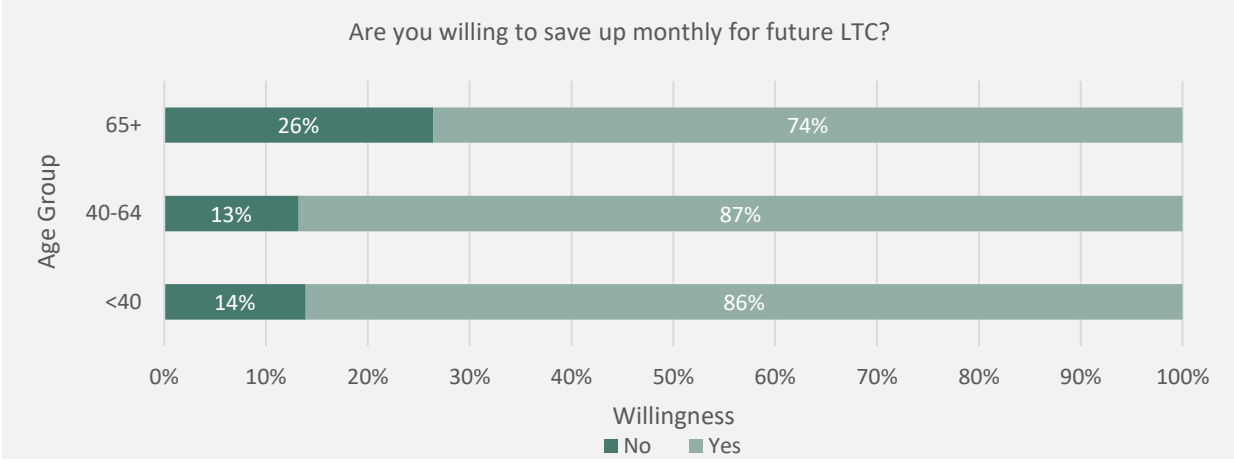


Source: The Hong Kong Council of Social Service (2017)

Over 80% of surveyed responded expressed a willingness to save up for the future long-term care costs.

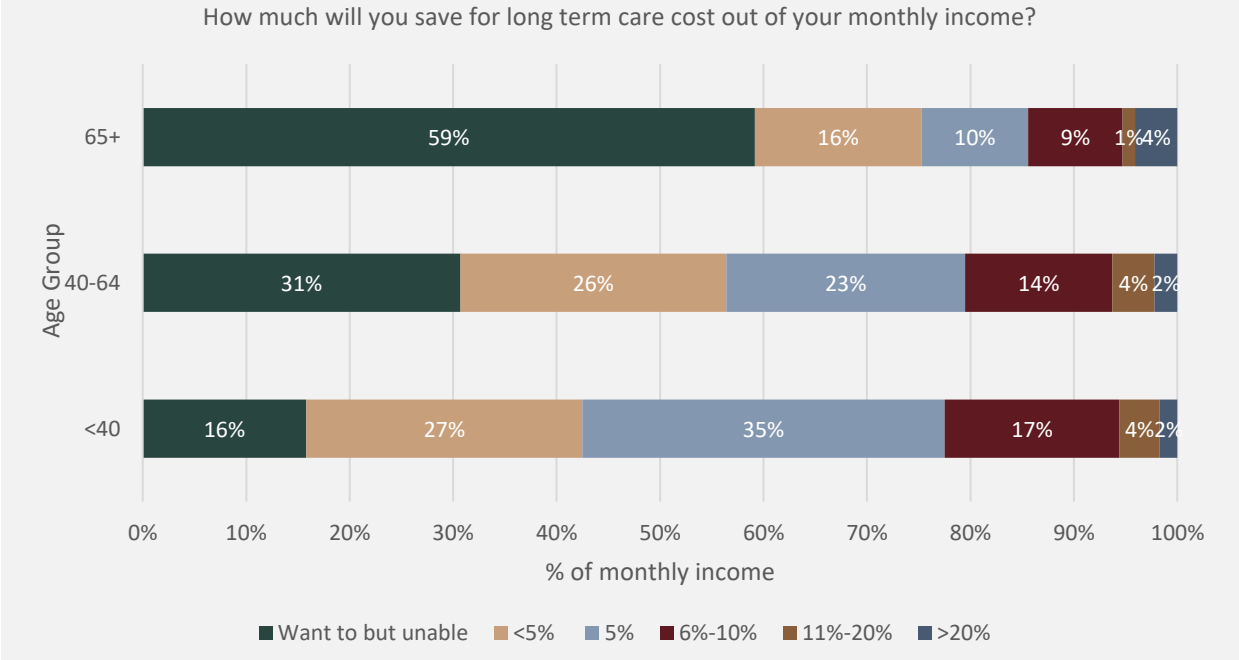
When asked about the proportion of income respondents could save, over one-third of respondents in the 40-64 age group stated that they would like to save but would be unable to (30.7%). Likewise, 59.1% of respondents aged 65+ expressed a willingness to save but financially could not afford to do so. 35% of individuals in the 40 below category expressed a willingness to save approximately 5% of monthly income for future long-term care. These findings are telling, because individuals in Hong Kong recognise a need to finance care needs, yet rising medical costs coupled with unaffordable housing options, low pension rates, and overall gaps in social protection offer few appealing/affordable options for self-financed care or financial planning.[53]

Around 80% of the correspondents are willing to save up for future long term care (LTC)



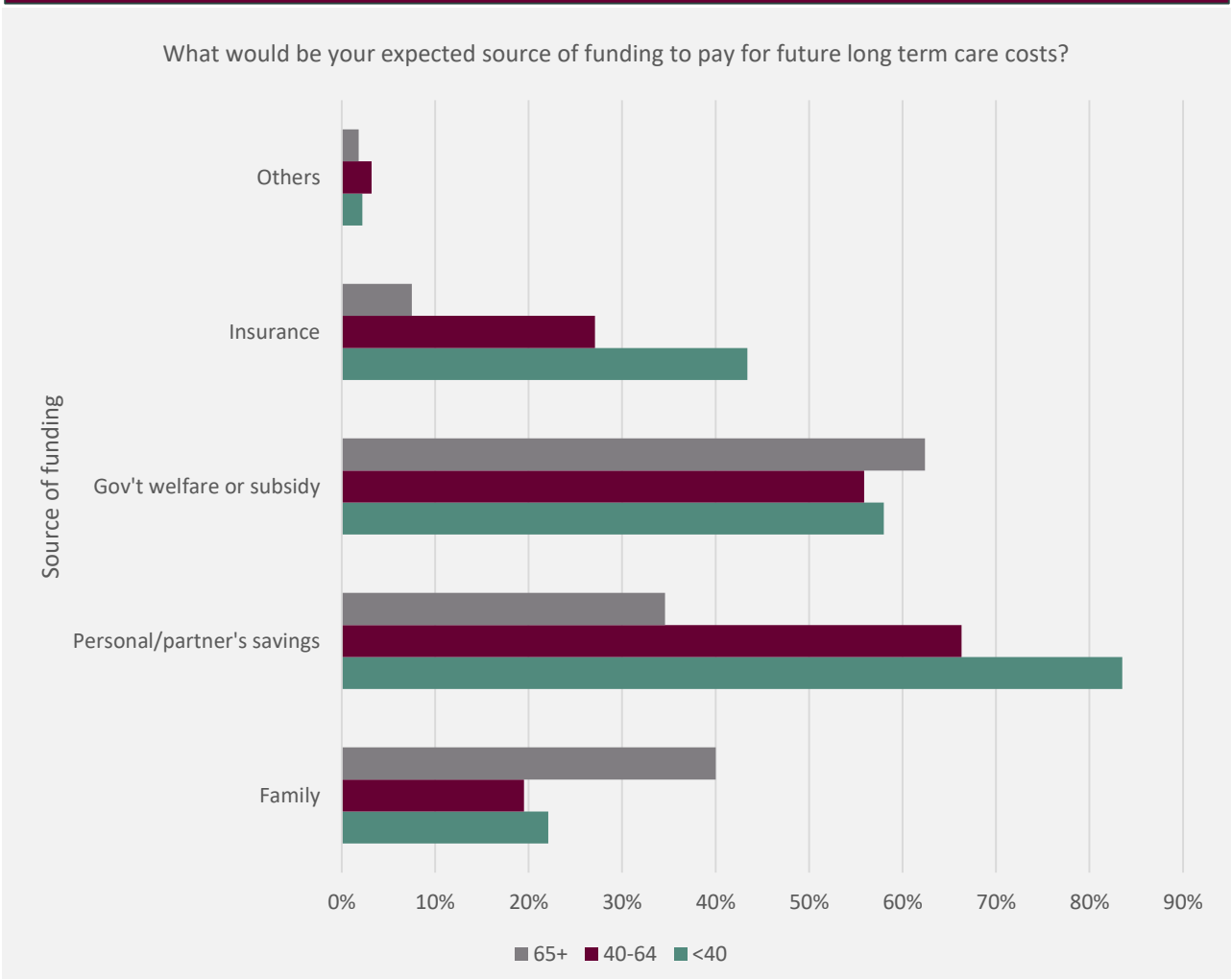
Source: The Hong Kong Council of Social Service (2017)

The amount that can be saved up each month varies a lot depending on the age groups



Most respondents aged 65+ will rely on Government welfare or subsidy, individual savings, or contributions from their family to finance future long-term care. Respondents below 64 advised that they would be financing long-term care needs through individual savings, private insurance, or (in some cases) through Government welfare or subsidy. Funding sources for long-term care, and preparedness for financing, vary with each age group and in many cases is influenced by several socioeconomic factors.[53]

The source of funding to pay for future long term care costs changes with age groups



Source: The Hong Kong Council of Social Service (2017)

8. There is a lack of support for informal carers

The informal care delivered by family carers is not well-supported by Government nor is it recognised by society. According to the "Pilot Scheme on Living Allowance for Carers of Elderly Persons from Low Income Families,"[54] each eligible carer is disbursed a monthly allowance of $2,000 only, which is inadequate to provide quality care. The cost for staffing a private registered nurse can be as high as $750 per hour,[48] and the minimum wage of a domestic helper without professional training is approximately $4,500 per month.[55]

Thus, family members often have little choice but to take turns in delivering unpaid informal care to elderly family members. Apart from the lack of medical oversight, this creates additional stress amongst informal carers -- further necessitating the need for new solutions to offer support to the elderly and their families.

9. Social stigma impacts placement of individuals in care facilities

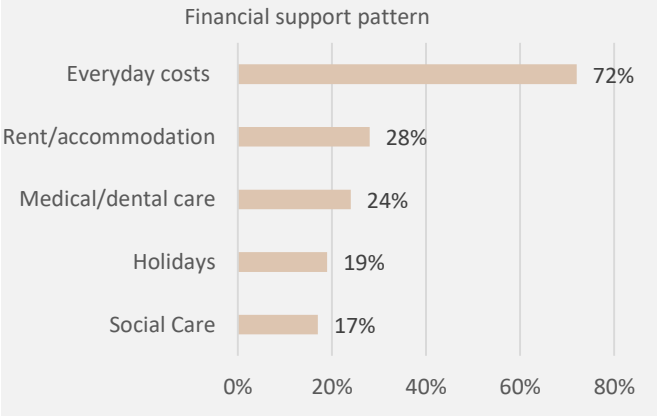
At a societal level, there is a pervasive social stigma associated with placing family members in care facilities. In Hong Kong culture, this gives the appearance that a familial relationship has been substituted by a third party, and tarnishes traditional Chinese virtues. Most elders would prefer to continue to live in their own homes, however, when they gradually lose capacity for self-care and require assistance with everyday tasks, it becomes a dilemma. A family must choose between sending an elderly family member for outside care, or to take up the responsibility themselves.

The economic reality for most families is that neither choice, regardless of cultural preference, is an affordable option. Institutional placements are very costly, subsidised placements come with a long waiting time, and most of a family's financial resources go to everyday costs for elderly relatives in the interim.

The price difference between subsidised and private care facilities is great

Service	Price of sub-vented sector	Price of private sector
Care and Attention Home	$1,605 to $1,803 per month[56]	$15,424 per month (Average)[51]
Nursing Home	$1,994 - $2,000 per month[56]	$22,583 per month (Average) [51]
Day Care	$901 – 988 per month[56]	$8,827 per month (Average) [51]
Community Nurse	$80 per visit5[7]	$730 per visit[58]

Most of the financial support goes towards everyday costs [59]



10. Filial duty to care for elderly family members is at odds with economic reality

In Chinese society, traditional values confer that adult children have a moral obligation to care for their elderly parents, including their long-term care[60]. At a societal level, public policy should be established in ways to facilitate the undertaking of such obligations. Following this ideology, if one's elderly parents prefer to remain in their home rather than move to an institution, the adult child should respect this wish and provide the necessary assistance for this – and government policy should be designed to facilitate ageing in place.

How then has Hong Kong arrived at such high rates of institutionalisation? Quite simply, filial duty to care for elderly family members is at odds with economic reality. The health system has not readily addressed support for ageing in place. Further, placements for institutions (the de facto care model when ageing in place is not supported or coordinated at a health system level) are not readily available and vary significantly in cost between public to private settings.

In the past, a parent's own savings and income may have contributed to cost, with the remaining expenses considered the responsibility of the adult child. Over time, this sense of filial duty has begun to erode, at odds with economic reality. Individuals still express filial duty towards ageing parents, as captured in a 2017 HSBC survey. 65% of respondents listed elderly parents' health and social care as a priority above their own retirement fund. 73% of respondents regularly offer financial support to parents. The economic reality, however, is that middle and working class Hong Kong citizens are facing a rising cost of living, decreasing purchasing power, and difficult choices for the finance of care for elderly family members. Adult children have changed their values from "moral obligation" to "voluntary choice."[59]

For its part, Government has failed to offer effective assistance for ageing in place and long-term care needs. Subsidised community care services (CCS) are inadequate, and there is a lack of private CCS alternatives. Community-based, integrated care should be the core of Hong Kong's public policy on ageing. This would both honour traditional Chinese values, and refocus the model of care away from institutionalisation and towards ageing in place – which is in line with international best practice.

Traditional values	Economic reality
Hong Kong's cultural norms emphasise the family's moral responsibility for taking care of older family members	• Average cost for private nursing is $750 per hour. • Average salary for a domestic helper with no professional training is $4,500 per month. • Day care in private settings averages $8,827 monthly in Hong Kong.
Working-age population believes parents' health and social care is a priority above their own retirement fund	• Only 27% of individuals over 65 have savings of any kind. • 60% of polled individuals over 65 would like to save but financially cannot afford to do so. • Median monthly income for working individuals over 65 is $10,250.
Adult children have a moral obligation to care for their elderly parents, including their long-term care	• Hong Kong is the most expensive housing market in the world. • Hong Kong's dependency ratio will increase by 130% in the next two decades. • Hong Kong's wealth gap is at its widest in decades.

3. Areas for opportunity and innovation

The aged care continuum has to be considered as a whole, to develop personalised services that focus on the individual's needs at all stages of advanced ageing

At this critical stage in Hong Kong's development, quality ageing must be prioritised as a policy agenda. The health system faces increasing demands, ushered in by demographic and epidemiologic changes, and Hong Kong's elderly population will become increasingly vulnerable. The 10 key barriers outlined in the previous section have evolved through Asia Care Group's interactions with the health system and it's stakeholders. Overcoming these challenges will prove significant to the successful evolution and expansion of aged care services.

Hong Kong is not alone in this endeavour. Countries globally seek to contain costs, reduce unnecessary hospitalisations, and promote high-quality aged care. Many countries are accomplishing this through better coordination and integration of healthcare services – an area that speaks directly to the intense system fragmentation encountered by Hong Kong's citizens. Moving forward, the patient journey has to be considered as a whole, spanning the needs of patients from 65 years-old age through the end of life.

Whilst there is no singular strategy to make aged care simple, there are specific trends and lessons from international best practice that can be adapted to drive this transformation forward in the Hong Kong context. Specific to Hong Kong, there are two prerequisites that should be in place to move an aged care agenda forward.

Firstly, the system as a whole has to move towards a unified regulation or quality framework to improve and coordinate the governance of aged care services. Secondly, stakeholders across the healthcare landscape should be open to innovative financing models that will allow for the expansion and improvement of service scope. Combined, these two action areas form the first steps to enhancing social protection and designing services that promote the autonomy and dignity of the elderly.

Beyond these two prerequisites, our market assessment of best practices and emerging innovations globally has led us to identify key stages of fragility along the patient journey. In the next pages, we will explore these areas in depth, and present corresponding opportunities and innovations for each stage on the ageing continuum.

Stages of fragility	When?	Areas for opportunity in Hong Kong
Healthy ageing	Independent people from the age of 65 onwards	1. Prevention and holistic healthy-living promotion tailored to the over 65 age range
Dependent individuals	After an episode affecting the level of dependency (e.g. post acute episode of care) or natural deterioration of the condition	2. Offer an integrated care pathway for elderly people losing their autonomy
Very dependant individuals	After a significant episode affecting the level of dependency (e.g. unable to stay at home independently for physical / clinical reasons) or natural deterioration of the condition	3. Develop a case management system for very fragile people, to improve coordination between social and care providers
End-of-life	E.g. End-stage of a disease	4. Support the person and the family during the end-of-life process
All	Across the ageing continuum	5. Reshape the future of the aged care insurance market through new financial models and innovative product design

Whilst action areas at the national level, including creation of a unifying policy framework or social welfare reform, require Government in a leading role, the innovations presented within the following pages of this chapter offer key action areas for individual stakeholders across the healthcare landscape.

Further to our review, Asia Care Group have categorised the most salient lessons from these models, and present them below with key messaging for stakeholders, community partners, and the broader healthcare community – to assist in the creation of more sustainable solutions and services for aged care.

Policy focus

- Prevention
- Standardised quality
- Stratified risk
- Support for ageing in place

Action focus

- Emphasise implementation/planning at the local level
- Coordinate actors across domains
- Actively engage first-line carers
- Support informal caregivers
- Incentivise and support the creation of new aged care protection products

Sample mechanisms that underpin models:

- Shared data
- Intersectoral collaboration
- Innovative financing

1. Prevention and healthy-living promotion for ageing individuals

1.1. Strengthening Primary Care Services — Beyond volume shift through performance measures

Healthy ageing refers to the development and maintenance of optimal physical, mental, spiritual, and social well-being and function in adults from the age of 65. People can achieve healthy ageing most easily when the social environment supports attitudes and behaviours that promote health and well-being.[61] In Hong Kong, individuals aged 65 and over are generally recognised as senior citizens, and are able to access various services offered by government departments.[62]

Since the establishment of the Primary Care Office in 2010, more focus has been placed on strengthening the primary care services in Hong Kong. Promoting public-private partnerships (PPP), strengthening preventive care, chronic disease management at the primary care level, and providing integrated services have been identified as the key goals of the Government's Elderly Health Service.[47] Various health policy initiatives have been introduced in recent years, including the development of community health centres and networks to strengthen chronic disease management, health voucher schemes to subsidise elderly care services, and the introduction of the PPP programmes.

Unfortunately, most of theses programmes have limited impact beyond volume shift. The initiatives have failed to induce any noticeable behaviour change amongst the users of primary health care services. For example, evaluation of the elderly voucher scheme suggested vouchers were mainly used for acute curative service (>80%) and not for preventive services or follow-up for chronic conditions. Similarly, patients who participated in PPP programmes reported fears about programme affordability over time.[63] The fundamental reasons have to do with the financing mechanism, in which demand-side financing (e.g. vouchers/ one-off payment given to patients) often result in induced demand or unfair pricing. In addition, under such a fee-for service mechanism, health professionals have little incentive to facilitate preventive measures.

In other countries, new provider payment models are emerging to align payment incentives with health system objectives — better quality coordination, health improvement, better efficiency — by rewarding achievement of targeted performance measures, also known as "pay-for-performance" or "pay-for-quality" models. A clear contractual framework with well-defined performance indicators, and built-in risk-sharing mechanism has been successfully employed in many international models, and has been shown to reduce moral hazards like corruption, induced demand, upcoding, and skimming.

CASE STUDY: PAY FOR PERFORMANCE INITIATIVE — ASHEVILLE PROJECT, US[64]

Background

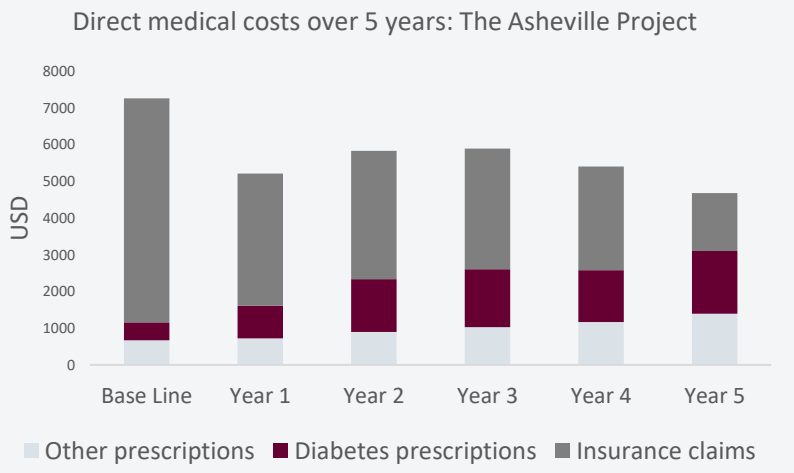
Improving the quality of care delivered whilst reining in costs is the key goal for the US Government. The Asheville Project is an important precursor of many pay-for-performance programmes in the US. This project included diabetic patients who were offered health care benefits that consisted of consultation with a community-based pharmacist. Pharmacists helped set up and track treatment goals, provided diabetes education, and empowered patient self-management of blood glucose at home. Pharmacists also have the role in referring patients to their physicians or a diabetes centre.

Results

Over 5 years of follow-up:

- The project demonstrated significant improvements in clinical outcomes.
- The mean costs of treatments decreased over 5 years, reflected as the shift of costs from insurance claims for AED visits, inpatient and physician visits to prescription claims.
- Overall, there was a total reduction of direct medical costs ranging from $1,662 to 3,356 for each patient per year.

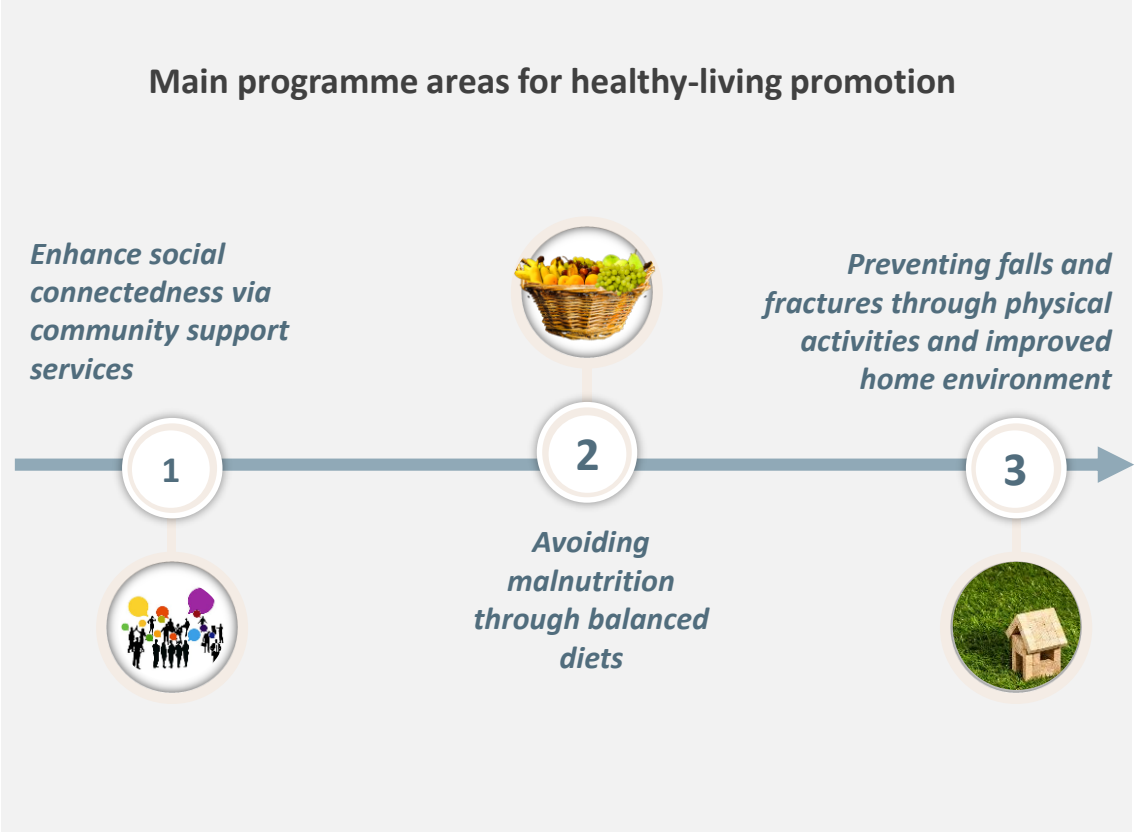
Pay-for-performance model encourages better quality of care



Source: Thomas C. (2008)

1.2. Improving prevention to promote health-living of all elderly people

For healthy and less dependent elderly individuals, prevention and holistic healthy-living promotion strategies tailored to the over 65 age range are established extensively in other developed countries. In such programmes, we identify 3 main areas that would be very beneficial to promote well-being in Hong Kong. These areas aim at reducing undesirable effects whilst enabling elderly people to remain at home as long as possible. They can be addressed at all levels and by different stakeholders in the health and care system.



1.2.a) Enhance social connectedness via community support services

Many researchers have recognised that various psychosocial aspects of life - personal histories, social relations, lifestyle, personalities, mental and cognitive processes – have significant impacts on healthy ageing. Retirement from work, the "empty nest" effect, the deaths of friends and close relatives, and the negative image of older persons in society are all limitations that can bring about a decline in older persons' social and biological functioning.[65] All these can be eased if adequate social networks and support are available to help ageing individuals.

Older people who live in societies that value them have better health outcomes. Indeed, research has shown that countries who appreciate the contribution of the elderly, view them positively, and have a later retirement age, experience lower morbidity at older ages. Health authorities in developed countries had been allocating greater resources for non-clinical services in recent years, such as healthy ageing community programmes, to prevent and minimise the impact of social isolation and chronic conditions among the older populations.

Structured referral pathways have been developed in these countries in an attempt to link elderly people with non-medical needs to sources of support within their community.[66] The opportunities for healthy living provided by the community may include: physical activity; learning new skills; volunteering; mutual aid, etc, to support for a range of health-related problems (see Case Study - Social Prescribing For Healthy Ageing, next page).

CASE STUDY: SOCIAL PRESCRIBING FOR HEALTHY AGEING – GLOUCESTERSHIRE

NHS Gloucestershire Clinical Commissioning Group

Background

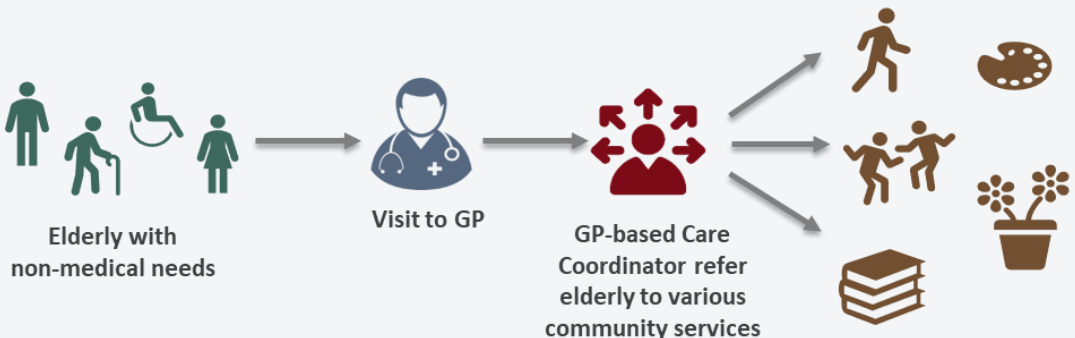
According to the UK's College of general practitioners, 20% of patient appointments are for non-medical reasons, costing the NHS £395million per year.[67] There has been a growing need to develop initiatives to manage the increase in demand for disease prevention and management services.

NHS trusts have developed various social prescribing programmes to enable a shift from a fragmented clinical-focused model of care towards a more holistic and preventative care model.

Approach

- **Referral pathways**: Social prescribing provides a pathway to refer clients to a range of non-clinical services, linking clients to support from the community to promote their wellbeing and to encourage social inclusion[68].

- **Social prescription model**. The social prescribing service in Gloucestershire is delivered through a hub coordination model, in which care coordinators based in GP practices refer patients to a range of community organisations and groups to participate in various healthy ageing activities[69]. Examples of community referrals include volunteering, further education, libraries, social or lunch clubs, self-help groups, befriending, hobby clubs, horticulture, sports clubs, nature conservation, book groups, art or dance classes, cookery, healthy eating advice, etc.



Results

In the year 2014:

- 2,047 patients were referred (median age range was 56-65, one-third were aged 75+)
- 234 different organisations were involved
- Mean mental health score increased by 3.83
- 23% reduction in A&E admission
- 21% reduction in GP appointments
- 26% reduction in GP home visits
- Return On Investment: estimated to be £1.69 return for every £1 spent by Gloucestershire Clinical Commissioning Group on social prescribing service in the first year[3]

1.2.b) Avoiding malnutrition through implementing nutrition support guidelines

Nutrition is the basis of health and an integral part of Healthy Ageing. Eat plenty of fruits and vegetables, avoid high salt and high fat food – slogans and advertisements about healthy eating for the general population -- are already overwhelming. However, specific dietary recommendations tailored to the needs of the elderly at age 65+ are still lacking.

Poor nutritional status and undernutrition are the most important areas of concern in the elderly population. Older individuals are particularly vulnerable to malnutrition, as they are more likely to have eating-related problems (e.g. chewing problems due to lack of dentures, swallowing difficulty due to weakened muscles), and loss of appetite due to reduced sense of taste and smell.[70] Malnutrition and unintentional weight loss contribute to progressive decline in health, reduced physical and cognitive functional status, increased utilisation of health care services, premature institutionalisation, and increased mortality.[71] In some developed countries, cost related to malnutrition accounts for 11% to 15% of the total healthcare expenditure, even exceeding the cost of obesity and overweight.[72]

In Hong Kong, the prevalence of malnutrition is as high as 16% in community care facilities.[73] Nonetheless, many health care professionals overlook the consequences attributed to nutritional risk and to malnutrition.

Though various nutritional assessment and screening tools have been developed by the primary care office under the Department of Health, nutrition assessment should be a routine part of care for elderly persons, whether in the outpatient setting, acute hospitals, long-term care institutions, or community care facilities. Moreover, clearly malnutrition management protocols should be in place and a multidisciplinary approach should be adopted in addressing compromised nutritional health in the elderly.

In the UK, the implementation of the standard nutrition support protocol across various healthcare settings has been proven to be one of the most effective cost savings interventions in the NHS.[74] If a similar approach was adopted in Hong Kong, Asia Care Group analysis estimates a cost savings of $2.4 billion could be achieved annually.

CASE STUDY: Implementing the NICE clinical guidelines/quality standard on nutritional support in adults (UK)[1]

Background

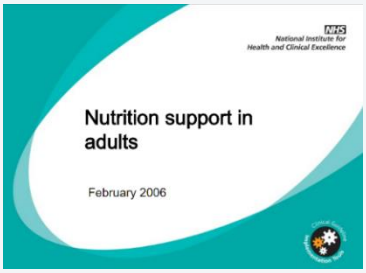
Research has shown that malnutrition increases hospital admissions, length of stay, GP visits and readmissions. Malnourished elderly also have high risk of becoming a permanent resident in care homes.

In 2015, the cost of malnutrition in England was estimated to be £19.6 billion per year. This translates to more than 15% of the total public expenditure on health and social care. About half of this is expenditure due to older people (>65 years). In fact, healthcare costs of malnutrition consistently exceed those of obesity and overweight combined.

Approach

In 2006, the NICE clinical guidelines on nutritional support in adults (CG32) and the quality standard on nutritional support in adults (QS24) were developed, accompanied the implementation of a new pathway of nutritional care among hospitals, communities and care homes. The new model of nutrition support involves three major elements:

1) Screening of malnutrition and risk of malnutrition
2) Nutrition assessment of high-risk patients
3) Nutrition support via oral nutrition supplements, enteral feeding or parenteral feeding



Source: NICE

Results

The economic budget impact analyses in 2012 indicated that the introduction of the new model of nutrition support ultimately save rather than cost money. It was also ranked as the third highest cost saving interventions associated with the implementation of NICE guidelines.

Annual Cost Saving	Amount
Reduced length of hospital stay	£100,804,424
Reduced healthcare use (Extra outpatient activity)	£11,355,100
Reduced hospital admissions	£9,717,306
Reduced GP visits	£3,866,242
Reduced outpatient visits	£906,915
Total	**£126,649,987**

1.2.c) Prevention of falls and fractures through physical activities and an improved home environment

For older individuals, fracture of the femur is a major cause of disability and mortality, and it is more likely to occur amongst osteoporotic individuals after a fall. In Hong Kong, the prevalence in the elderly who experience at least one fall in the preceding 12 months is around 18%, with 75.2% sustaining injuries.[72]

Prevention programmes aimed at reducing falls at home have proven to be successful in many countries. Beyond a reduction in the number of falls, these programmes also limit the number of urgent hospital admissions and the risk of transitioning to disability. Falls are a multifactorial event, requiring a global approach for elderly people. The risk factors below have to be taken into account:

- **The person's heath state**: equilibrium disorder, mobility reduction, muscular weakness, diseases
- **The person's behaviour**: medication, unappropriated diet, risks
- **The environment** – both at home and outside

As an example, the Province of South Holland has implemented a network for integrated falls prevention and management in order to create an integrated pathway that links prevention, screening and elderly diagnosis, personalised intervention, assessment and follow-up. The model, currently disseminated in several cities in the Netherlands, is based on early identification of seniors at higher risk of fall, who can benefit from pro-active assessment and interventions. The awareness among seniors, the public and professionals is increased and falls are also better reported.[73]

2. Offer an integrated care pathway for elderly individuals losing their autonomy

The deterioration of the dependency level requires strong coordination between the primary and secondary care services. Coordination can be improved in different ways, by developing a dedicated care management programme[73]:

- Define shared and designated referral pathways and information sharing through a comprehensive provider network.
- Designate a coordinator for the care pathway in order to provide care management support. This coordinator would be in charge of following the patient's needs and helping the patient conduct self-treatment at home through a personalised care plan. In other markets, this role is usually held by designated general practitioners.
- Once the organisational process is set, a communication tool and coordination platform can be developed to ease the communication between healthcare professionals inside the network and provide dedicated services to the patient.

People entering this pathway could also be offered services to help them stay at home, such as:

Housing environment	Post-discharge support	Hospitality services
• Home labelling process to certify that the home is adapted to an elderly person's needs • Home automation solutions - e.g. teleassistance or emergency alert in the event of fall, fatigue, etc.	• Telemonitoring services related to a disease to follow specific data and raise alerts to the right healthcare professional • Regular follow-up through phone calls or home visits, in line with the care manager	According to patient need, deliver a range of services to help the person in the day-to-day life (e.g. catering services, cleaning support, administrative services, etc.)

Examples of services that could be offered to elderly patients to support the integrated care pathway[1]

To deliver these services and strengthen coordination between stakeholders, the full potential of technology has yet to be explored.

Providers treating a patient with complex needs are able to share important data about that patient; this ensures clinicians have the information they need, when they need it. Ideally, this is accomplished by a single electronic record shared between all structures involved in the elderly patient's journey. Information has be shared with the care coordinator at major stages of the patient journey: following an hospitalisation, an entrance in the emergency department, a specialist visit.

The Basque Country in Spain mobilises resources across health, social and community settings to improve the quality of life and the health of ageing individuals in the region. Health technologies are key drivers of the process. A comprehensive clinical record, a multichannel platform and the e-prescription system, etc. connect a network of key actors and places in this model, including rural and urban areas, patient homes, hospitals, informal carers and physicians, primary care doctors, and social workers.

Part of the overall strategy, the Multi-channel health service centre, OSAREAN, offers a portfolio of services. The centre coordinates the provision of e-health services, health advice, prescription support and non-face-to-face appointments, among other activities, using Web and SMS technology.[73]

Services offered by the Basque Multi-channel health service centre

Source: O-sarean, Osakidetza, Basque Health Service

Whilst Hong Kong is currently deploying the rollout of electronic health records in the public sector, there is still an important area of opportunity to support communication across sectors (between public and private; between primary care doctors, hospitals, communities, residential services, other social services).

Information sharing can be improved easily via basic shared protocols (e.g. email sending) or, in a more ambitious programme, by developing interoperability between systems.

CASE STUDY: THE MANISES INTEGRATED HEALTHCARE MODEL[73]

Background

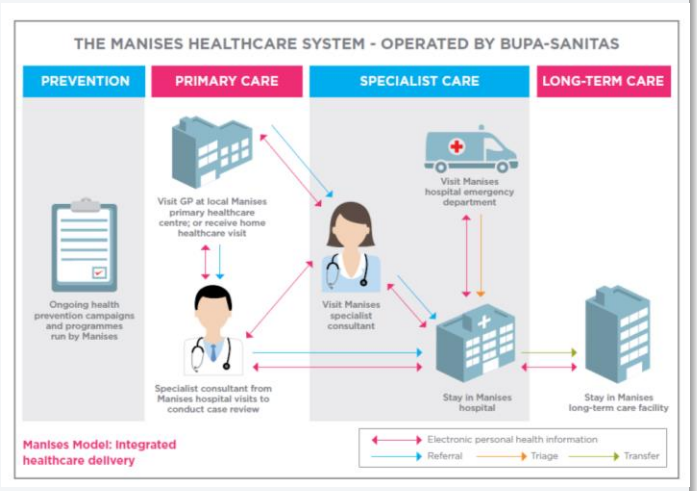
The Valencia Government first started using PPPs in healthcare in the 1990s, in response to escalating costs and budgetary constraints.

Approach

- **An integrated model of care:** The model covers Manises Hospital (specialised in acute care), 20 primary care centres providing basic healthcare via multidisciplinary teams (including family doctors, nurses and social workers), two centres specialised in outpatient care, Mislata Hospital (medium-long term patients).

- **An innovative financing model**: The core principles of the Manises PPP model include: public funding, public control, public ownership, private management. Bupa-Sanitas is now responsible for managing all aspects of healthcare for the 200,000 people living in 14 towns in the Manises area, on the outskirts of Valencia.

- **Designated referral pathways and information flows**. The common e-health record facilitates information flow between providers. The model also offers telemedicine services such as tele-dermatology for a better patient experience. Professionals can also access health information and treatment options through the record.



Source: Bupa Sanitas

Results

- The design of funding enables the Valencia Government to anticipate annual healthcare costs.
- Healthcare is designed to meet population needs whilst meeting Government quality standards.
- The hospital and healthcare infrastructure remain a public asset.
- Risk-sharing increases efficiency, reduces government cost, and drives up quality of healthcare services.
- In 2013, out of 35 high quality general hospitals, Manises ranked: 2nd for the provision of outpatient surgery; 3rd for productivity, which is measured by how efficiently the hospital deploys its staff; 6th for risk-adjusted stays, which looks at the length of time it takes for a person to be discharged from hospital following their treatment; and 9th for mortality, which looks at predictors of mortality and the actual mortality rates experienced at the hospital.

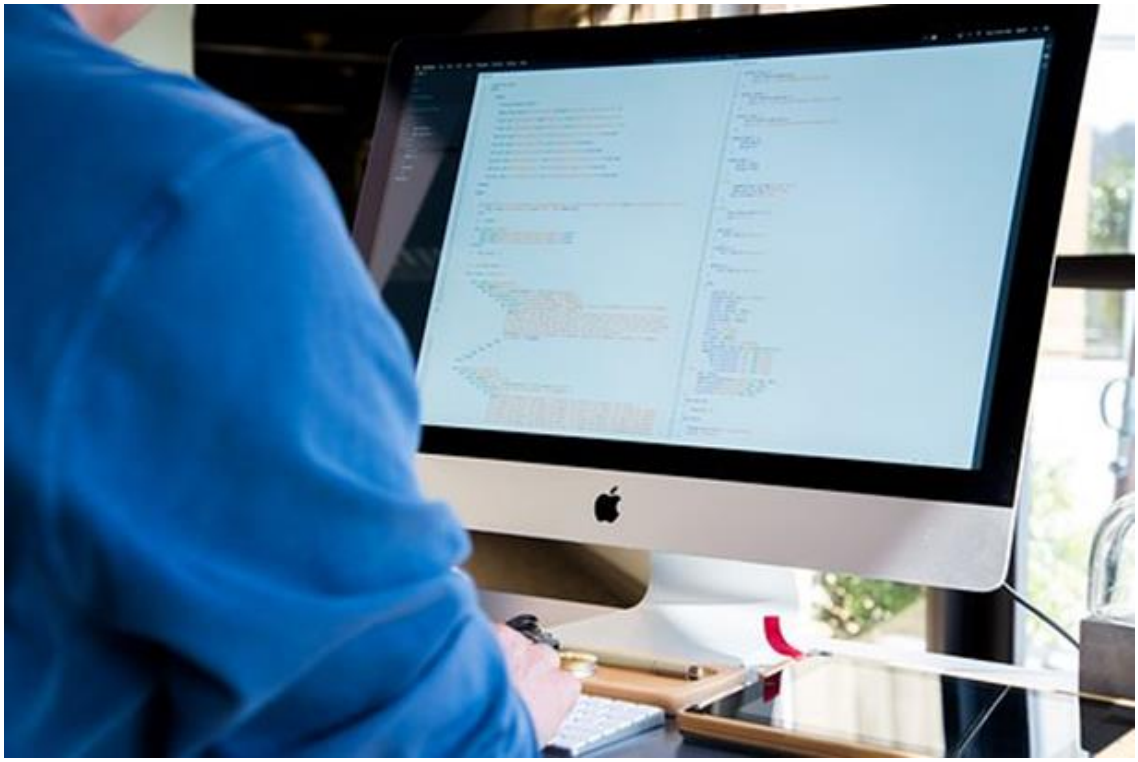
3. Develop a case management system for very fragile individuals, to improve coordination between social and care providers

Risk stratification is a prerequisite to identify the right individuals to enter a specific case management system. The level of risk (or fragility) should be assessed through a comprehensive programme with a professional / trained evaluation team, and take into account all factors affecting an elderly person's fragility (social environment, health condition, economic situation). Elderly individuals with comorbidities benefit most from such programmes.

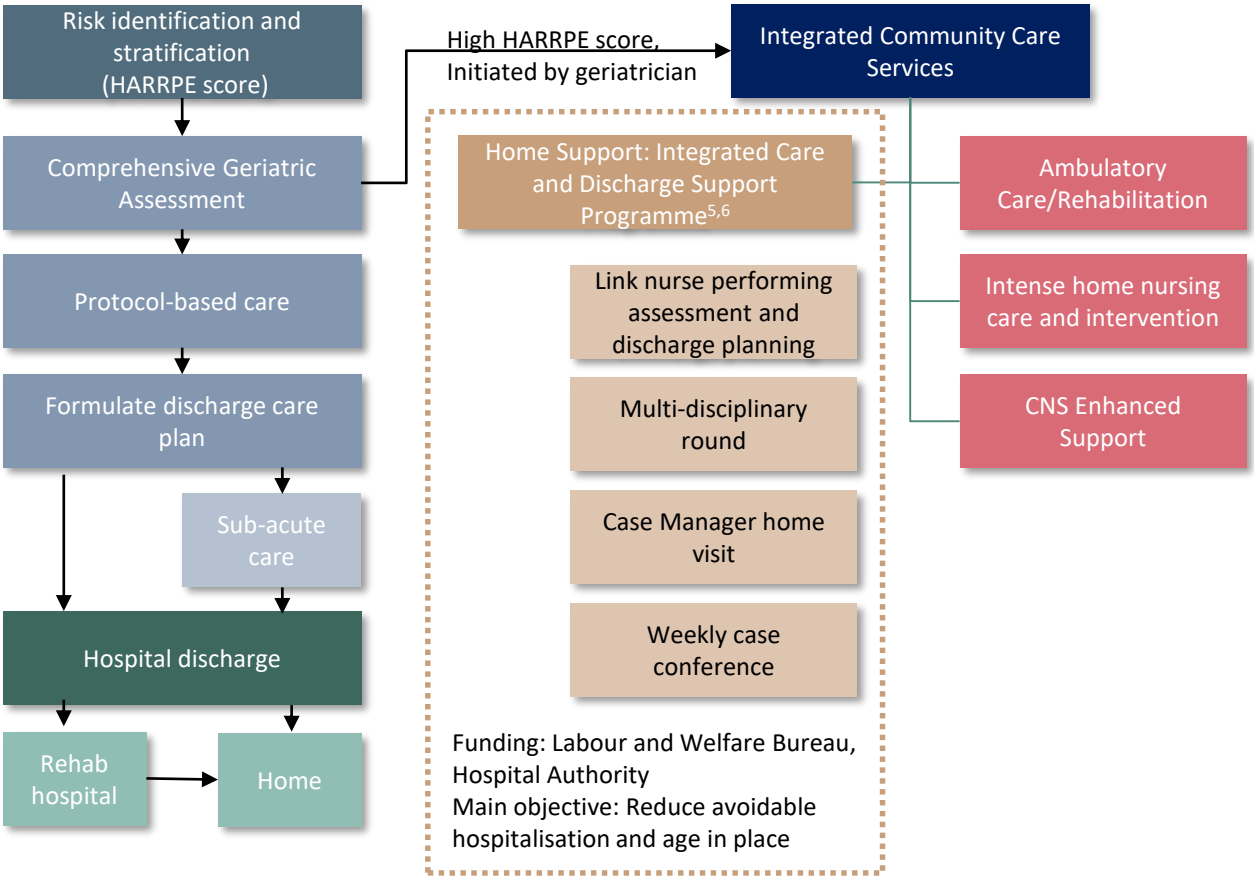
For the most complex cases, case management would help improve the coordination between both the care and health sectors, and reduce the burden on acute care systems. This includes:

- **A designated case manager**, in charge of: design and follow up of a person-centred case management plan; coordination of health and care professionals; assisting patients in navigating health and care settings.
- **Exchange of patient information**, for instance through a dedicated platform, in order to follow the level of risk and enable the case manager to build the treatment plan.

For patients staying in residential homes, dedicated services could be offered, such as communication tools / trainings to strengthen social cohesion with family members.



The Hospital Authority model named the "High Admission Risk Reduction programme for Elderly" (HARRPE) is a good example of case management, that should be enlarged in the private sector considering the increasing need for it. The objective of the programme is to identify elderly patients at high risk of readmissions. Once identified, patients will be recruited into the Integrated Care and Discharge Support, which aims to reduce the risk of AED attendance and hospital readmission through better discharge and post-discharge support[74]. Currently, only patients who have a HARRPE score will be evaluated for transitional care services before discharge.



CASE STUDY: CASE MANAGEMENT MODEL IN SPAIN, VALENCIA REGION

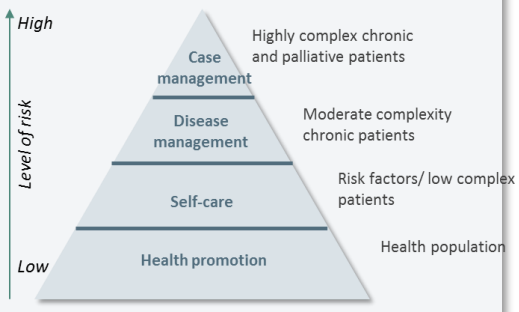
Background

Policies were developed nationally and in the Valencia region to respond to an ageing population and the rising prevalence of chronic disease and to reorient health care from acute episodes to chronic disease management. The objective was to improve care for complex patients with multiple morbidities.[73,75]

Approach

- **Targeting complex patients**. The Valencia region uses the Kaiser's risk stratification pyramid. Complex cases include patients fitting into the apex of the Pyramid (e.g. around 3% of the overall population in Valencia). They are usually patients with complex chronic diseases or in need of palliative care. Electronic medical records (EMRs) are used to stratify the population monthly into clinical risk groups (CRGs) and identify high-risk patients.

Kaiser Permanente Risk Stratification Model



Source: Kaiser Permanente

- **A new role: case manager**. Newly introduced hospital nurse case managers (HNCMs) and community nurse care managers (CNCMs) have joint responsibility for complex cases[76,77]:
  - HNCMs identify complex cases at hospitals and are responsible for planning hospital discharge to ensure continuity of care.
  - CNCMs are responsible for organizing the collaborative care process in the community and arranging home care.
- **Needs assessment.** The case management process starts with a comprehensive assessment of the patient the current informal care, and the environment. This is conducted by a multidisciplinary team that includes CNCMs. It covers medical conditions, medications, accessibility of the home, hygienic conditions, dependency levels, mental conditions, and use of technology.[76]
- **Personalised care plan**. After defining patient needs, HNCMs draft a care plan and medication review adapted to patient and family preferences. The plan can also encompass social services. Whilst primary care physicians lead the plan, both nurse care managers remain jointly responsible for monitoring the patient, interacting with professionals, and ensuring appropriateness of care.[76,77]

Results

- The model reduced the use of emergency services (-77%) and hospital admissions(-70%), between 2007 and 2010.
- The model helps health care resource optimisation and appropriateness of chronic care through healthcare integration and continuity of care.
- Primary Care Team helps promoting home care (from 15% to 58%, between 2007 and 2010), and reducing the number of "hidden patients", and achieving rates of home death of 67%, between 2009 and 2010.

4. Ensure patients can choose to end their life at home with quality of care, dignity and respect

End-of-life care aims to improve quality of life of patients and their families through physical, psychosocial and spiritual support, and it involves help from both the medical and administrative aspects, which can be delivered through hospital, hospice, elderly residential facilities or at home.

Since 2009, the Hospital Authority has launched the Home End-of-Life Care programme, in collaboration with several organisations to enable elderly patients suffering from designated chronic or long-term diseases stay in a suitable home living environment or residential care homes after medical assessment. However, this is not a common practice amongst the general elderly population.[78]

Beyond the Hospital Authority, other organisations in Hong Kong develop end of life care services with a view to enable patients to stay at home for their last days and reduce suffering. This is the case for the Jockey Club Home for Hospice, which is the first family-centred hospice providing day care, home care and inpatient service for the life-limiting patients.[79] For home care, the club provides regular visits and treatment by physicians and nurses, caregiver education and home care support through a multidisciplinary team. There are also organisations providing services like escorting/transportation for follow-up medical attendances , home care support, personal care service (e.g. meal service, sitter service, home modification), arrangement for funerals, etc.[80]

Numerous developed countries have implemented comprehensive end-of-life care programmes, emphasising on offering state-of-the art home based care.

In Australia, to reduce the high-cost acute care in hospitals, home-based care is offered through the coordination of local public health networks, integrating primary, secondary, tertiary and community health services to deliver complex and technical care. These programmes were previously difficult to conduct by GPs at their own practice.[81] Coordinated by physicians, usually GPs, the multidisciplinary team (e.g. dietitians, nurse, pharmacists, social worker and psychologist) works around the advanced care plan and patients' care needs[82].

Apart from a lower healthcare costs, palliative care programmes outside hospitals can potentially avert hospital admissions in generally overcrowded and under resourced settings and may improve the quality of life of patients in their home environments.[83]

The table below shows the estimated cost of palliative care in different settings.[83] Acute or intensive care can range from double to 20 times more expensive than palliative care services.

Type of setting	Estimated Cost ($AUD)[83]
Intensive care unit bed	$4,000 per day
Acute Hospital Bed	$1,100 per day
Inpatient palliative care facility	$950 per day
Palliative care in a hospice	$600 per day
Palliative Care in residential aged care facility (Average for high care residential aged care)	$200 per day
Palliative Care at home	No Australian estimate located
Ambulance callout	$300 - $5,000 per callout

As a national strategy, the Government plans to work with private health insurers to develop sustainable models of quality palliative care in the private sector, and a pilot study between private care providers and insurers will be discussed in the following case study.[84]

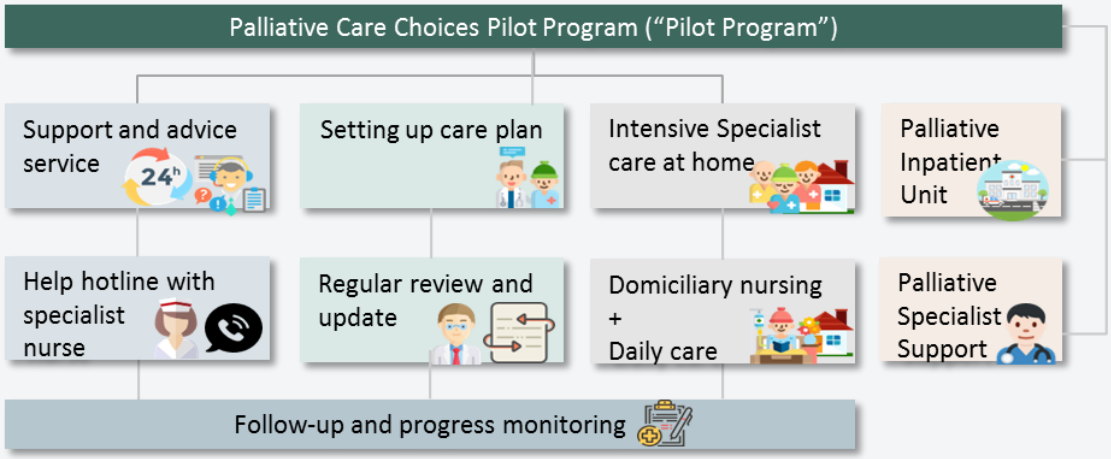
CASE STUDY: 2-YEAR PILOT SCHEME ON PALLIATIVE CARE BETWEEN INSURER AND PRIVATE HOSPITAL IN AUSTRALIA

Background

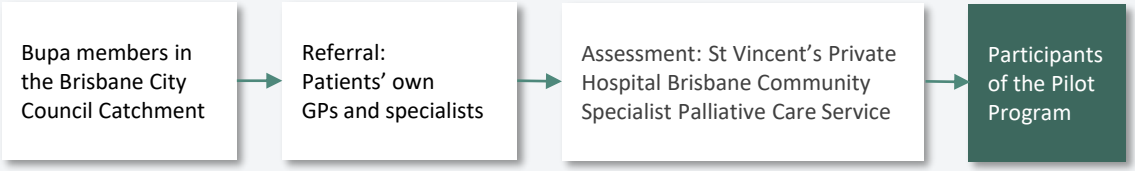
It is a national strategy to work with private health insurers to develop sustainable models of quality palliative care in the private sector. Currently, private insurance (medical or final expenses insurance) is the major source of financing in palliative care related services in both public (20.0%) and private hospitals (49.5%).[86]

Approach

Since August 2016, Bupa Australia partnered with St. Vincent's Private Hospital Brisbane to create the Palliative Care Choices pilot programme for two years.[87] It allows participating patients to receive personalised care at home during the last 6 to 12 months of their life, including medical services being delivered by the hospital as below.[88]:



Who is eligible?



Results

In an submission to the Productivity Commission, Bupa planned to analyse the findings of this pilot programme, review the possibility of service expansion, and fund palliative care services to deliver better home care options – pending positive outcomes. Preliminary finding, they suggest early referral to palliative care in the pilot programme was associated with less aggressive care at end of life, improvements in quality of life, longer survival, and more efficient use of health care dollars.[88,90]

Patients experienced the satisfaction of receiving care at home in their last months of life, upon their own choice, with the support for their own family and carer.[89]

Case Study Characteristics							
Characteristics	**Social Prescribing for Health ageing** **UK**	**NICE Nutrition Support Guideline** **UK**	**Basque Multichannel Health Service Centre** **Spain**	**Manises Integrated Healthcare Model** **Spain**	**HARPE programme** **Hong Kong**	**Integrated Care Model for Complex Cases** **Spain**	**Bupa Palliative Care Pilot** **Australia**
Model Focus							
Prevention	✓	✓	✓	✓	✓	✓	N.A.
Standardised Quality	×	✓	×	✓	×	N.A.	×
Risk Stratification	×	✓	×	N.A.	✓	✓	×
Ageing in Place	✓	N.A.	✓	N.A.	N.A.	✓	✓
Action Focus							
Implementation/ planning at local level	✓	✓	✓	✓	✓	✓	✓
Coordinate actors across domains	✓	✓	✓	✓	✓	✓	✓
Actively engage first-line carers	✓	✓	✓	✓	✓	✓	✓
Support informal caregivers	✓	✓	✓	×	✓	✓	✓
Underpinning Mechanisms							
Shared data	N.A.	N.A.	✓	✓	✓	✓	N.A.
Intersectoral Collaboration	✓	✓	✓	✓	✓	✓	✓
Innovative financing	✓	×	×	✓	×	N.A.	✓
Area of Fragility Addressed							
Healthy Elderly	✓	✓	✓	✓	×	✓	N.A.
Dependent Individuals	✓	✓	✓	✓	✓	✓	N.A.
Very Dependent Individuals	×	✓	✓	✓	✓	✓	N.A.
End-of-life	×	✓	N.A.	N.A.	N.A.	✓	✓

5. Reshape the future of the aged care insurance market through new financial models and innovative product design

There is significant need and manifest demand for aged care products in Hong Kong. However, there are relatively few aged care protection products and financing models that support individuals to enjoy their elderly years. Most insurers have been deterred from exploring the aged care market due to concerns over potential product profitability. However, utilising emerging innovations, working in partnership with Government and community-based providers and altering provider contacting models, could support viable and novel products to emerge.

The future of ageing: new products across the life course

Insurers have it within their power to shape the future of aged care products across the life course. Throughout markets, we find examples of products that deliver protection to ageing individuals. Spanning General Insurance, Life Insurance, and Medical Reimbursement – these emerging products often straddle the line between asset management and health protection. Insurers have several tools at their disposal that allow for such innovation. With control over product architecture, insurers can build-in incentives and managed care tools that shift the focus to prevention, incorporate elements of risk management, and contribute to the structuring of integrated care models. These tools, when properly implemented, offset the costs of ageing.

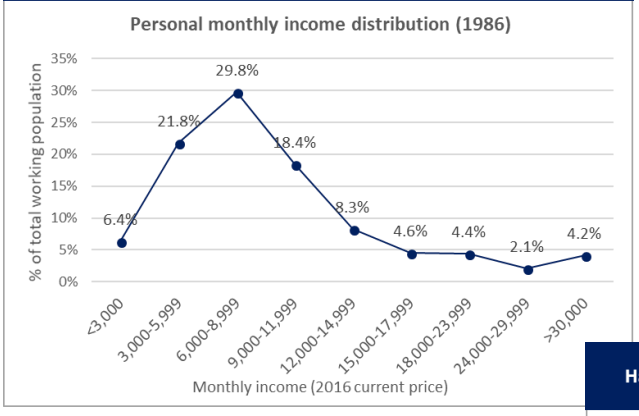
Insurer solutions are within reach to offset the cost of aged care

Risk management in healthcare begins with stratification. Payors who want to change the cost structure and improve health outcomes must design interventions that target at-risk, high-cost patients who need to be carefully and proactively managed. Individuals in advanced age often confront chronic disease and comorbidities, which, when poorly managed, drive up both healthcare utilisation and cost. In Section 2, Asia Care Group presented a series of case studies that included elements of prevention, risk management, managed care, and care integration. In the respective markets, the UK, Spain and Australia, these interventions yielded both improved clinical outcomes and reduced healthcare expenditure.

Hong Kong's socioeconomic profiling is changing

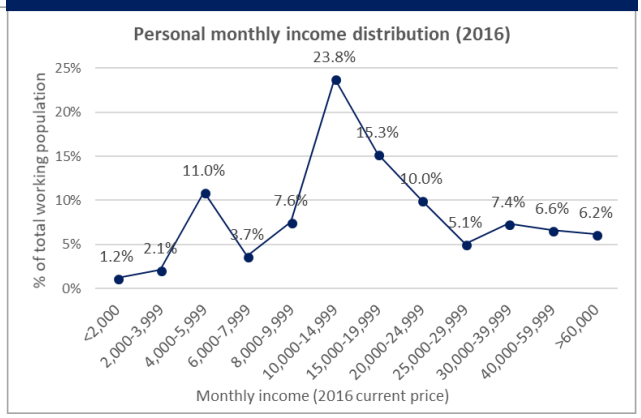
In the past 30 years, there has been a significant uplift in the monthly income level of the working population, and average monthly income is now approximately 27,000 HKD. Patients now, more than ever, are demanding high quality, personalised and timely healthcare services – for themselves and their families – and are willing to pay a premium for private medical services. The population is also more aware of the importance of prevention and screening, with an increased emphasis on promotion and primary care services.

Half of the working population was earning $3,000 to $8,999 in 1986.



Source: Census and Statistics Department (2017), Asia Care Group Analysis

Half of the population was earning $10,000 to $19,999 in 2016.



There is an appetite for new solutions across families

Much of the discussion around aged care focuses on the individual. In the context of the local population, solutions should be positioned more broadly. A 2017 survey by the Hong Kong Council of Social Service found that most respondents want to age in place and receive long-term care (LTC) at home.[53] Around 80% of respondents expressed a willingness to save for future long-term care costs, and over 65% of respondents listed personal/partner's savings as a source for future LTC funding.[53] Forty percent of individuals 65 and over listed family as a source of funding for LTC needs.[53]

These findings are representative of the greater trend in financing health and long-term care needs for ageing individuals. In Hong Kong, responsibility is shared between the individual and the family. At the moment, there is a largely untapped market of consumers for future asset management and social protection products: the individual consumer across the life course, and the supporting family members.

Individuals who want protection in their retirement years.

Families who want to save for the future medical expenses of ageing parents.

Incentivising change across the insurance market

Innovative insurers will recognise the potential of the aged care market, and help shape its product development; a forward-thinking Government will understand the value and potential gains of a growing market for aged care products and support insurers in this endeavour. Government can do this by providing support and incentives to private insurance companies to develop aged care products, so individuals are better protected and, in turn, there is increased liquidity in the aged care sector. This will help stimulate the development of new services, which are not based on outdated institutionalised models. Incentives should also be offered to companies or individuals to invest in such insurance products, which may be accomplished through a tax break initiative.

Precedent exists for aged care products across markets, both in terms of incentives and in product design. In France, indemnity products in which policyholders must meet criteria regarding level of dependency and waiting time are the dominant model for the market. In Germany, two dominant schemes exist: compulsory private long-term care insurance for individuals who have opted out of the social health insurance, and a supplemental voluntary private long-term care insurance for eligible citizens to assist with expenses that fall outside the provision of social programmes. In Asia, there are examples from Japan, where private long-term care policies exist in the form of principal plans, and also as riders to main Life/Medical cover.

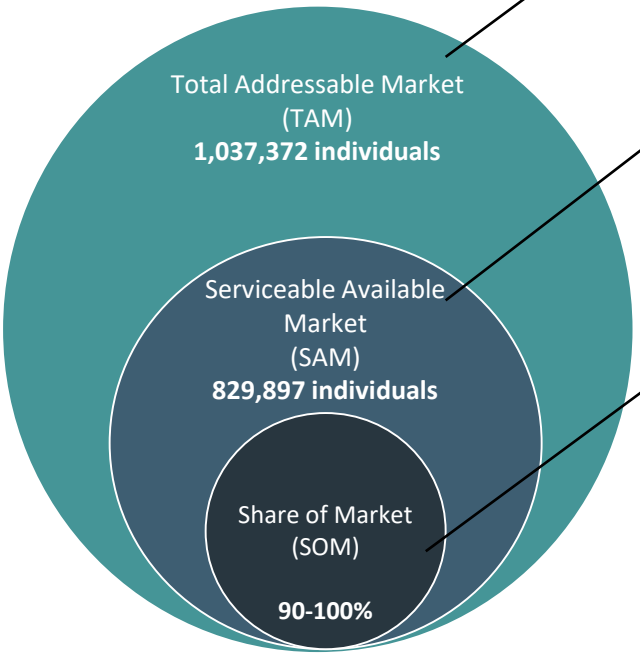
Aged care: a market ripe for growth

Aged care protection products can take many forms. Under the category of social protection, these products offer ageing individuals increased access to quality care, new models of care integration, exposure to risk stratification, and the tools of case management and an individually-tailored plan of care. As a form of asset management, aged care products have evolved across markets as integrated health management services, financial planning, pensions and investment funds, and corporate wellness products for an ageing workforce. Whether structured as reimbursement or indemnity, principal plans or riders, it is clear that these innovations address the needs of changing societies. Asia Care Group analysis reveals that this market in Hong Kong is ripe for growth, representing more than one million individuals and their families. The potential for development in this product space warrants the attention and consideration of Hong Kong's stakeholders, who are tasked with shaping the future of healthcare and healthy ageing.

Monthly Income (HKD)	Product Tolerable Pricing Range (HKD)
$40,000	$2,000 - $4,000
$50,000	$2,500 - $5,000
$60,000	$3,000 - $6,000
$70,000	$3,500 - $7,000
$80,000	$4,000 - $8,000
$90,000	$4,500 - $9,000
>$100,000	5,000 – 10,000+

Willingness to pay

Individuals in the SAM are willing to spend between 5-10% of their total monthly income on aged care products and protection.



Individuals between the ages of 40-64 with a monthly income above $40,000 (roughly 14% of today's population).

80% of respondents in the 40-64 age range expressed a desire to save for future health expenses and long-term care needs.

66% of individuals in the SAM rely on personal/partner's savings to finance future healthcare costs.

28% of individuals in the SAM will have purchased some form of PHI to finance health needs.

SOM is estimated to be between 90-100% as there is currently no market competition in the space of aged care protection products and financing models.

Source: Thematic Household Survey (2016), Hong Kong Council of Social Service (2017), Asia Care Group Analysis

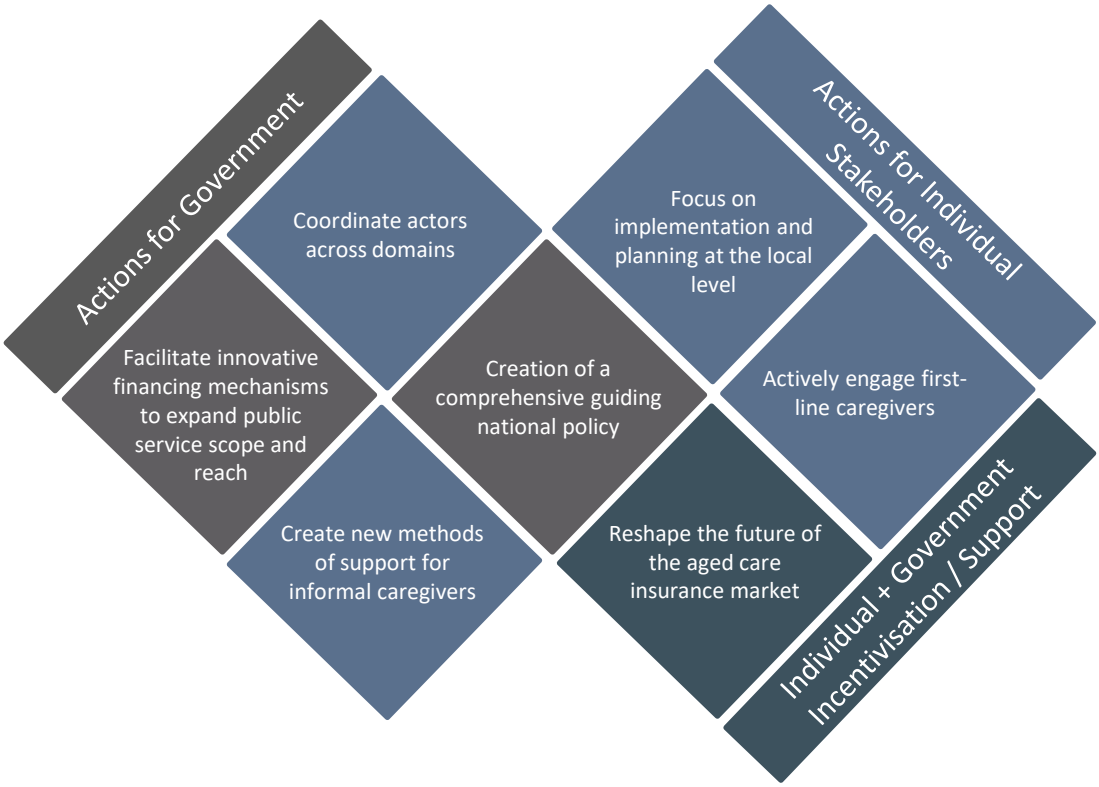
4. Conclusion

Action areas at national level

Government efforts to support quality aged care have fallen short for myriad reasons. The moment of crisis is ever-approaching, and action is critical now more than ever. The most pressing action area for Government will centre upon the creation of a comprehensive guiding policy framework – one that focuses on prevention, creates quality standards, puts in place a mechanism for risk stratification, and focuses the model of care away from institutionalisation and towards ageing in place. A second action area for Government centres upon the exploration of new financing mechanisms to ensure better financial protection, broaden the availability of financing for the future, and expand service scope and reach.

Action areas for Individual Stakeholders

Meanwhile, there are individual-level action areas that can be pursued in parallel to, or in the absence of national reform. Several payors and providers are moving towards the infrastructure of managed care networks, albeit without the title. These stakeholders are in early pilot stages of creating platforms for robust data collection, early experiments with intersectoral collaboration, and are beginning to forge new partnerships that explore innovate financing mechanisms. By considering the 10 key barriers explored in this document, and drawing from the pertinent trends observed in international models of quality aged care, Asia Care Group have outlined four key action areas for individual stakeholders that will prove the most beneficial in driving forward and aged care agenda. These include: focus on implementation and planning at the local level; coordinate actors across domains; actively engage first-line carers; and, create new methods of support for informal carers. The international case studies explored in the previous chapter highlight how several of these action areas can be successfully implemented and readily adapted. The remaining action area for individual stakeholders, which can be accelerated by incentivisation and support from Government, is to reshape the future of the aged care insurance market through new financial models and innovative product design. Combined, these 7 action areas form the basis of a roadmap forward – and offer innumerable areas for opportunity and investment across the main stages of frailty and ageing.



The need to stimulate the provider ecosystem

Whilst all stakeholders from the health and care sectors are concerned with the areas for opportunity we have identified, most of our recommendations will rely on the stimulation of provider networks. This can be facilitated by Government towards one or all Hong Kong providers (through commissioning and finance), or driven forward by insurers towards a specific set of providers – through contracting and product design -- as shown in the synthesis table below.

Stages of fragility	Areas for opportunity in Hong Kong	Recommendations	Stakeholders to drive change		
			Government	Providers	Insurers
Healthy ageing	1. Prevention and holistic healthy-living promotion tailored to the over 65 age range	• Develop new mechanisms towards pay-for-performance or pay-for-quality mechanisms, to successfully strengthen the primary care sector	✓		✓
		• Develop targeted prevention programmes for elderly people on social connectedness, nutrition, falls prevention	✓	✓	✓
Dependent individuals	2. Offer an integrated care pathway for elderly people losing their autonomy	• Improve coordination between the primary and secondary care services with: designated referral pathways, clear information flows	✓		✓
		• Provide care management support programme	✓		✓
		• Develop communication capabilities across sectors	✓		✓
		• Provide a set of services to improve housing environment, post-discharge and hospitality		✓	✓

Stages of fragility	Areas for opportunity in Hong Kong	Recommendations	Stakeholders to drive change		
			Government	Providers	Insurers
Very dependant individuals	3. Develop a case management system for very fragile people, to improve coordination between social and care providers	• Enlarge the application of risk stratification with the elderly people segment	✓		✓
		• For the most complex cases, develop a case management programme: designated case manager, strong information sharing, person-centred care plan design and follow-up	✓		✓
		• Improve communication and social cohesion within residential services		✓	✓
End-of-life situation	4. Support the person and the family during the end-of-life process	• Develop comprehensive palliative care programmes enabling individuals to stay home: involvement of a multidisciplinary team, support services (e.g. escorting/ transportation, personal care…)	✓	✓	✓
All	5. Reshape the future of the aged care insurance market through new financial models and innovative product design	• Create a range of asset management and social protection products that target ageing individuals and their families • Support and incentivise growth in the private insurance sector	✓		✓

About us

At Asia Care Group, we have a simple goal; to support healthcare organisations with their most pressing challenges in order to create more efficient and effective healthcare systems for the populations of this diverse region. Our firm is the first of its kind to offer consulting services solely to the healthcare sector. We pride ourselves on our deep industry knowledge and, importantly, our passion for leading change in the healthcare industry.

Collectively, our consultants have worked across four continents with some of the largest healthcare organisations in the world. We pride ourselves on being skilful strategists and problem-solvers that work hand-in-hand with clients on their most pressing challenges. We are recognised as thought-leaders, innovators and occasionally mavericks – always leading change in the healthcare communities we serve.

Thalia Georgiou
Head of Healthcare Advisory

Organisation Profile - Asia Care Group

Our practice focuses exclusively on supporting healthcare entities across to develop sustainable systems for their populations. We do this through the integration of key services, as we recognise that complex problems often require more than one area of expertise. Our approach is widely regarded in the healthcare community, and we count some of the region's largest health insurers, health providers and Governments as our clients. We have three main service lines, listed below, and a team of healthcare experts who work together to develop solutions to our clients.

HEALTH SYSTEM FINANCING AND ECONOMICS

In both public and private systems, healthcare financing models are changing. Governments, Insurers and providers are all concerned with how resources are generated, allocated and the performance achieved. We specialise in supporting clients to assess the economic, clinical and operational effects of different models of health financing. We also work with providers to help them understand and prepare for payment reform, such as the introduction of payment-for outcomes or packaged pricing.

Some of our areas of expertise:

- Health system financing strategy
- Hospital viability and financial reviews
- Provider payment reform
- Healthcare pricing reviews

HEALTHCARE STRATEGY AND CHANGE

The challenges facing healthcare organisations today are perhaps greater than at any point in history. Populations across Asia are living longer than ever before, but lifestyle changes mean this achievement often entails many years living with chronic diseases. Health systems, presented with the challenge of managing this paradigm shift, are embarking on far-reaching reform. We specialise in helping clients - from Governments to Insurers and Providers - prepare for what lies ahead. We work on policy and regulation, system strengthening and growth and investment strategy.

Some of our areas of expertise:

- Health system reform and policy development
- Healthcare regulation
- Growth, Investment and Market-entry strategy
- Health system strengthening

TRANSFORMATION AND TURNAROUND

Designing and delivering care that meets the changing expectations of both policymakers, patients and in some cases - investors, is a continual challenge. The drive for high-quality, accessible care at lower prices entails a transformative approach; reshaping services to meet the needs of a 21st century population. We work with both providers and purchasers to redesign services. unlocking value and helping ensuring services are fit for today and tomorrow. We also specialise in working with organisations that face operational, clinical and financial problems and support wholesale turnaround of services.

Some of our areas of expertise:

- Clinical service planning
- Service transformation
- Organisational restructuring and development
- Financial, clinical and operational turnaround

5. *Appendix*

Abbreviations

NCDs	Non-communicable diseases
GDP	Gross Domestic Product
HA	Hospital Authority
ESPP	Elderly Services programme Plan
CCS	Community Care Services
SWD	Social Welfare Department
NGOs	Non-governmental Organisations
FDH	Foreign Domestic Helpers
RCS	Residential Care Services
AD	Advance Directives
ACP	Advance Care Planning
DNR	Do Not Resuscitate
OOP	Out-of-pocket
NHPPS	Nursing Home Place Purchase Scheme
EBPS	Enhanced Bought Places Scheme
RCHE	Residential Care Homes for the Elderly
CVA	Cardiovascular Accidents
CPR	Cardiopulmonary resuscitation
AED/A&E	Accident and Emergency Department
IV	Intravenous
ACSCs	Ambulatory Care Sensitive Conditions
CUHK	Chinese University of Hong Kong
ALOS	Average Length of Stay
MPF	Mandatory Provident Fund
PHI	Private Health Insurance
LTC	Long Term Care
NHS	National Health Service
GP	General Practitioner
PPP	Public-private partnership
HARRPE	High Admission Risk Reduction programme for Elderly
EMRs	Electronic medical records
CRGs	Clinical Risk Groups
HNCMs	Hospital Nurse Case Managers
CNCMs	Community Nurse Case Managers

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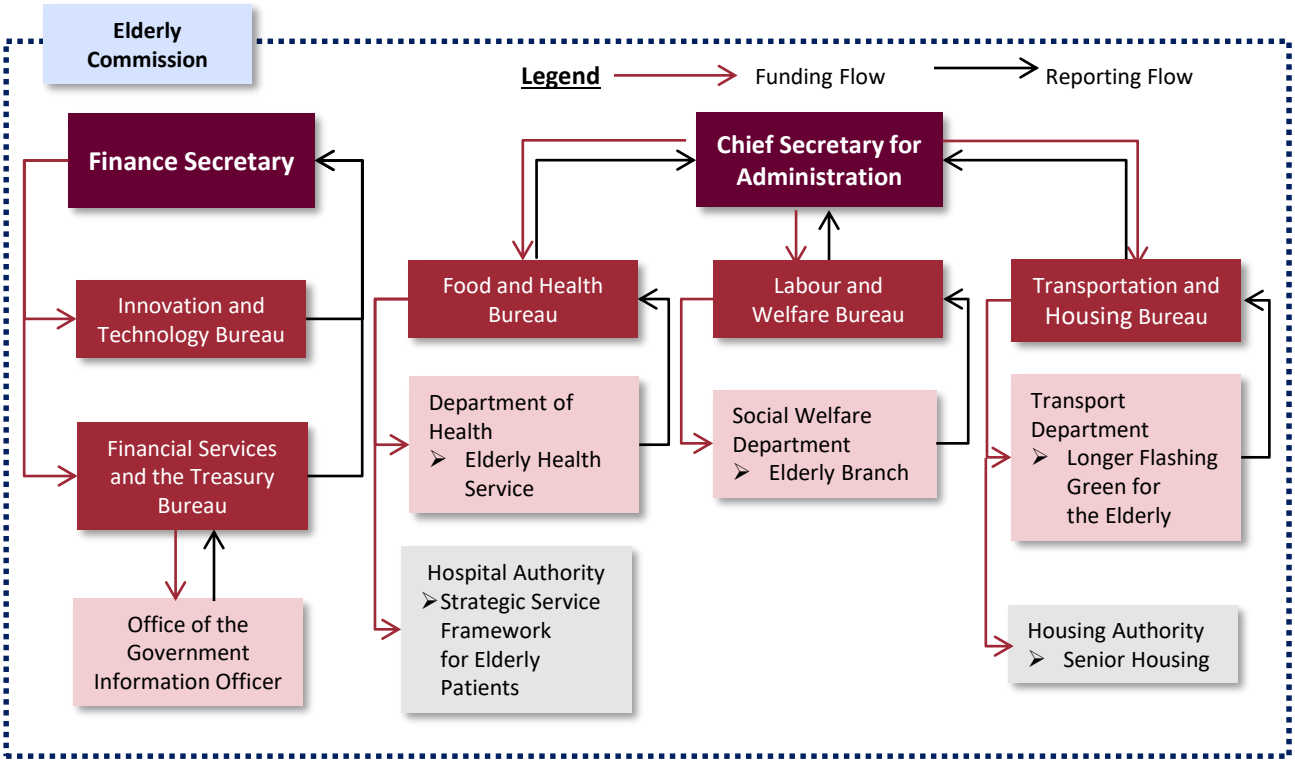
Illustration: Introduction section

The Elderly Commission has no financial authority and its power is relegated to liaising with various Government bodies who confront competing priorities



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