EDITORIALS

A STARTING POINT FOR RESTORING PUBLIC-PRIVATE INTERFACE FOR ELDERLY CARE

In the past decades, healthcare expenditure has escalated all over the world. Hong Kong is no exception. Public medical expenditure has increased from HK$13,000 million in 1992/93 to $35,000 million in 2001/02. This is largely attributed to the increase in non-communicable diseases (NCDs) which refer mainly to chronic diseases. NCD is characterized by its associated disability and handicap, and the need of secondary or tertiary prevention on its recurrence or complications among sufferers. Elders are victims of NCDs and are high utilizers of healthcare services. In the year 2000-2001, a total of 47.2% public hospital bed days were occupied by patients aged 65 or above. It is expected that with ageing population and increase in prevalence of NCDs, there will be increasing chronic disease burdens. Demand on follow up of patients with chronic illness as typified by senior patients will continue to increase. Services provision from specialist Geriatrician alone will be insufficient for the demand. General Practitioners and Family Physicians should be called upon to assist our care of elderly who have chronic diseases.

One of the problems of the healthcare system in Hong Kong is the imbalance between public and private shares. This is particularly true for management of chronic diseases of which most elderly patients with chronic diseases are followed up in the public sector. This is largely attributed to the price differential between public and private sectors. For the cost of HK$60 per consultation and $10 per pharmaceutical item, a patient can enjoy full range of investigations and medications for several months. In the private sector, the average consultation fee will be $100 which is exclusive of investigations nor medications. Assuming that the quality of care is similar between public and private sector, it is understandable that patients will be attracted into the public sector.

The escalating elderly population and its associated volume of NCDs posed a major financial burden to the Government. The ultimate solution rests on appropriate healthcare financing direction. In 1998, the commissioned Harvard Report has made projection on the demand, and recommendations opened up for discussion. One of the recommendations from the Report is the setting up of a MediSave Fund, of which 1% of salary will be saved for future medical care. This would be reserved for medical and long term care beyond age 65. The Report was shelved after some debate and there was no alternative suggestion on Long Term Healthcare Financing.

Nevertheless, even if the Harvard Report has been implemented, there is still a time lag of which the government has to shoulder the healthcare budget of the current 10% elderly age 65 or above. With existing volume and budget constraint, the public sector has great difficulties in coping with. Can the private sector help in the healthcare of our senior citizens? There are several issues to address:

(I) The expected role of the primary care clinician trained in elderly care

In UK, an average general practitioner has several roles when an elderly person is registered under his / her care. He acts as health promoter to promote Active Ageing. He practises as clinician in health screening of common conditions among the senior citizens, and treatment of chronic diseases so as to delay the occurrence of complications. In this proposed model, a local trained practitioner should be an advocator for Active Aging, and an assessor of geriatrics screening which includes Comprehensive Geriatrics Evaluation. He should also have close liaison with the regional Geriatrics team so as to arrange fast track Specialist review / rehabilitation course whenever necessary. Upon settling the active problem of the elder, patient should be referred back from specialist to the trained primary care clinician for continuation of care plan.

(II) Is an average General Practitioner / Family Physician equipped on elderly care?

In Hong Kong, Geriatrics training in undergraduate started in the 1980s. Classical teaching schedule in the 1980s and 90s was 4 one-hour lectures on Geriatrics Giants and 4 half-day clinical sessions in hospital. Over the past few years,

there was changing curriculum in the two medical schools. We have yet to see the performance of the new graduates in their understanding on elderly care. Most would agree that the past curriculum provided inadequate knowledge and skills in elderly care, and even little in community-based geriatrics care. The academics, professional bodies and services providers are not slow in realizing it. Both University of Hong Kong and Chinese University of Hong Kong have organized quotable postgraduate degree courses (Postgraduate Diploma in Community Geriatrics and Master in Clinical Gerontology respectively) for medical practitioners to equip them on the area. Although not mandatory, Family Physician trainees under Hospital Authority (HA) are encouraged to have experiences in community elderly care during their third or fourth year of community based training. Visiting Medical Officers (VMOs) to residential homes under the CGAT-VMO Partnership scheme are also given opportunity to attend in-services training organized by regional Community Geriatrics Teams (CGATs). We hope these new breeds could cumulate in number, be able to practise in such a way and functions as primary care clinician to our senior citizen in the community.

(III) Potential financial implications

As discussed previously, one of the problems in the healthcare system is the price differential between public and private sectors, and that drains more and more patients into the public sectors. With more patients being drawn into the public sector, quality care cannot be maintained unless government continues to pump more money in. This is something not affordable by any Government anywhere in the world. There is also a set point when the system collapses. In a commercial metropolitan like Hong Kong, one cannot expect a clinician to do the job free of charge. How should the financial aspects be addressed?

For the past 30 years, "No person should be deprived of appropriate medical care just because of poverty" remains the motto of the Government's public health care policy. Few could deny that the goal has been achieved, and that this policy direction should be upheld. If one uses this policy as benchmark, the bottom line will be that government will ultimately be responsible for medical care of patients who cannot financially support themselves. A non-controversial group that will rely on public medical services is those Comprehensive Social Security Assistance Scheme (CSSA) recipients, of which they cannot afford costly private medical care, and that Government has committed for their healthcare. As a starting point or a pilot, the government / HA may consider contracting out those CSSA recipients, age ≥ 70 or 75, and with chronic diseases to interested Family Physician (FP) / General Practitioners (GP) who have quotable postgraduate training in Elderly care. The FP / GP will be paid on a yearly basis for their care of the patient based on a calculated average yearly medical expenses. With the huge database, HA should be able to estimate that amount. In essence, this involves the transfer of medical subsidiary from Government to the qualified FP / GP instead of from Government to HA only, and will be a cost neutral exercise. A minimum, affordable consultation fees (for example, HK$50) may also be charged to avoid the problem of induced demand. Certainly the exact fee paid per consultation, and the subsidiary pay to the FP / GP is up to discussion.

(IV) Will the care of the socially deprived elderly be sacrificed?

With this proposal, the FP / GP will be responsible to the healthcare of the elderly and on areas as suggested in (I) above. With the set required postgraduate training on elderly care, a specific description on the expected role (with or without "protocol"), continuous interaction between the GP/ FP on management plan of the elder with regional specialist Geriatrician team, quality of care should not be compromised. It is expected that quality care may even be improved with improved coordination between hospital specialist and FP / GP, with assessment in time at FP / GP surgery (instead of waiting for few weeks / months for public services), and with continuation of care by a designated person (FP / GP). As the GP / FP will most likely be in the their nearby estate, it will be even more convenient to patients.

The above is just a brainstorming idea. Admittedly more have to be done to investigate on its feasibility. Yet there is one thing for certain — we need collective ideas to address on how to deliver quality healthcare to our elderly in a sustainable manner. Quality healthcare that embraces through primary prevention (Active Ageing), screening and case finding (Comprehensive Geriatrics Evaluation) and curative treatment (secondary prevention). It does not matter if it is a totally different suggestion that buds out after discussion. There is only one thing for certain - the need to act before it is too late!

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