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Age-Friendly Primary Health Care: An Assessment of Current Service Provision for Older Adults in Hong Kong

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Abstract: There has been no study evaluating whether primary care services are sufficiently oriented towards the older population in Hong Kong, particularly those with increasing frailty. Since primary care is a key first interface in promotion and maintenance of health in older people, an assessment of the age-friendliness of service provisions is of critical importance in optimizing the health of aging populations.

The age-friendliness of primary care services for older people was assessed using focus groups of elderly people and also of service providers who care for them. Discussion content was based on the WHO guidelines for age-friendly primary care in the following areas: Information, education and training, community-based health care management systems, and the physical environment. Desirable improvements were identified in all domains. The findings underscore the need for wider dissemination of health care needs of older people in the primary care setting.

Keywords: Primary care, health services, elderly, age-friendly

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Introduction

Population aging worldwide has resulted in increasing demand in primary care settings for screening and management of chronic diseases. As a first line of contact to health care, primary care services need to be accessible and adapted to needs of elderly people. To this end, the World Health Organization (WHO) carried out a series of national groups to solicit the views of older people themselves and their service providers on barriers to care and their suggestions for change. This initiative resulted in the development of a set of guidelines published in 2004, called *Active aging: Towards age-friendly primary health care*.¹ The review covered areas relating to information, education, communication and training, health care management systems, and the physical environment of primary care centers, accompanied by a list of toolkits useful for achieving age-friendly primary care centres.²

Hong Kong is a special administrative region of China situated on the south coast, with approximately 7 million people living in an area of 1070 square kilometres, of which 900,000 are aged 65 years and over. It has the longest life expectancies for men and women among the world, with a rapidly increasing 85+ age group. The percentage of frail elderly increases sharply from 3% among the <75 years age group to 11% for those age 75+.³ Although Hong Kong has a comprehensive range of medical and social services, partly modeled after the UK, primary care is predominantly provided by the private sector (>85%) while the government largely provides hospital services (>95%) at very low cost (Hospital Authority and Department of Health). Health care is free for those who cannot afford to pay.⁴ However, elderly people aged 60 years and over, in particular those who have increasing levels of frailty, tend to use government services, as the majority cannot afford private healthcare. Older people who have chronic diseases but are functionally independent tend to receive care in outpatient clinics run by the hospital authority, or join screening programs in elderly health clinics run by the Department of Health, while those with increasing frailty are supported by hospital authority. Many elderly people use the Accident and Emergency Department as a walk-in primary care service provider, since hospitals are conveniently located and highly accessible, are open 24 hours a day, and are free if the patient cannot afford to pay. It has been estimated that up to one-third of A&E

attendances fall into the primary care category rather than being emergency cases.⁵ The Hospital Authority provides acute and rehabilitation/convalescent beds, a geriatric day hospital, and a community geriatric outreach support to elderly people living at home as well as in residential care homes for the elderly (RCHEs).

For people aged 65 or above, comprehensive-fee-charging preventive healthcare services are offered by the Department of Health through 18 elderly health centers, and 18 visiting health teams support RCHEs. Screening services include health assessment, physical check-up, counseling, health education and some curative treatment. The visiting health teams reach out to the community and residential care settings to conduct health promotion activities for the elderly and to provide training to carers to enhance their health knowledge and skill in caring for the elderly.

An analysis of effectiveness of preventive aspects of primary care in Hong Kong shows that in spite of a comparatively low total mortality rate, the proportion of avoidable mortality particularly in the >60 age groups could still be larger than countries with higher total mortality rate, a difference that may be explained by a weak primary care system.⁶ In 2012 the government published a framework for primary care for older persons, which is predominantly focused on preventive care/screening⁷ rather than on other service provisions.

To date there has been no study evaluating whether primary care services are sufficiently oriented towards the older population, particularly those with increasing frailty. Since primary care is a key first interface in promotion and maintenance of health of older people, an assessment of the age-friendliness of service provisions is of critical importance in optimizing health of aging populations. As part of the Cadenza Project in promoting an age-friendly Hong Kong (www.cadenza.org.hk), we carried out a series of focus group interviews among service providers for elderly people and community groups of older people using the WHO guidelines.

Subjects and Methods

Assessment of age-friendliness of primary care services was carried out using qualitative methods, through conducting focus groups followed by content analysis. Convenience sampling methods were used. The sample included hospital authority staff of all disciplines



who provide care for the elderly in a hospital affiliated with the Chinese University of Hong Kong and members of 3 randomly-selected community elderly social centers in different parts of Hong Kong. Discussion content was based on the WHO guidelines for age-friendly primary care covering 3 areas: Information, education and training, community-based health care management systems, and the physical environment (Appendix 1). One investigator conducted all focus groups in the local dialect [BM]. Discussions were directed towards the following specific areas for both groups: transport to service facilities, clinic signage and facilities, the physical environment, such as adequate seating and space for waiting areas, the consultation process, clinic fees, community outreach services, the referral system, dissemination of health knowledge, medication management, standard of care for the elderly, feedback system, and communication skills of healthcare staff.

The facilitator began each group session after explaining the purpose of the study to the participants and obtaining their written consent. Participants were then asked to discuss each point raised by the facilitator according to the WHO guidelines. The latter encouraged participants to discuss freely and took steps to involve all participants in the discussion. Rapport and participation were encouraged in a relaxed atmosphere where participants were able to exchange opinions freely. Interactions were frequent and complex. All were encouraged to elaborate on their comments when prompted by the facilitator and to express their own opinions in response to the comments of others. Uniformity of responses was not an issue as a variety of different attitudes and opinions were elicited from participants. The facilitator gave less attention and reinforcements in dialogue to the talkative or dominant participants, and more encouragements and/or invitations to express opinions to the less outspoken. Interpersonal conflict was minimized by the facilitator acknowledging both sides of the argument and swiftly moving on to the next topic of discussion. To avoid dwelling for too long on one topic, the facilitator intervened by summarizing previous points and moving on to the next topic of interest. With the participants' permission, the focus group interviews were audiotaped for data analysis.

Transcripts were reviewed and analyzed by 2 members of the research team. Recurring themes within and among groups were identified. To ensure

the descriptive validity of results, audio-recordings of focus group sessions were made that were then transcribed verbatim. Interpretative validity of results could be ensured, as the chosen themes were supported by the participants' own words. Observation field notes were referred to when selecting quotations to illustrate a theme and when making associations between themes, to ensure theoretical validity.⁸ To ensure reliability, data were analyzed by the 2 research team members respectively to know that no themes were overlooked. In case of discrepancy in opinion between the researchers, discussions were made until a consensus was reached.

The research protocol was approved by The University of Hong Kong Human Research Ethics Committee.

Results

The hospital authority group was composed of 12 hospital authority staff working in the public system, consisting of geriatricians (5), nurses (4), and allied health staff (1). Members had experience with working in various public institutions over all Hong Kong regions and also lived in different districts of Hong Kong. The group was conducted after work, and lasted 2 hours. The 3 groups, consisting of older people who attended community elderly social centers, represent older people who were more functionally independent with or without chronic conditions. The total number of participants was 28 (F:M = 22:6), with a mean age of 75.2 years (range 60–97). The numbers in each of the 3 groups were 7, 10, and 11.

The response from the focus groups is reported under 13 areas.

1. Transport to service facility

All groups reflected that an accompanying person is needed most of the time for people living at home, especially for those living in residential care homes for the elderly. The service providers group reflected that without an accompanying person, clinic attendance would be very difficult and/or impossible. They also mentioned that some older people need to rest a few times while making the journey from the transport drop-off to the clinic itself, and that provision of seating on the way to clinics would be of help.

Public transport (buses and minibuses) was the most common mode of travel discussed by the elderly



groups from old age centers. The costs were thought to be affordable; however some expressed safety concerns regarding the abrupt starting and stopping of minibuses potentially causing injury to passengers: ‘The drivers of mini buses tend to brake suddenly. I have lost balance and bumped into other seats on getting off a few times. Some are good, but each day there are at least 2 to 3 drivers who brake suddenly’.

The service provider group expressed various problems regarding public transport. They expressed that the signage is small for the visually impaired. There is inadequate modification for those who require mobility assistance such as wheelchair space, extra rails, and so on. There is a need for frequent changes of buses for some residents, and there are few buses with low platforms allowing wheelchair access.

There is a prohibition of oxygen cylinders on buses so that those with chronic obstructive pulmonary disease on long-term oxygen may not use buses. While there is special transport for those who have mobility impairment, the E-Tat minibus requires prior booking and has a long waiting list, while the privately-run Diamond cab with adaptation for wheelchair transfer only serves 1 of 3 regions in Hong Kong, and is expensive. A self-financing transport model to meet needs at an affordable cost has yet to be achieved. Many resort to taking taxis to the clinic. However, there were many negative observations regarding taxi service for older people: many will not stop if the distance is too short; some will not stop if there is a wheelchair as it is too troublesome and the wheelchair does not fit into the boot: the boot has to remain open and held in place by an elastic rope; as a result some older people have to wait for a long time by the roadside: one group member recounted the case of an elderly person who waited for 1 hour and then collapsed and had to be sent to hospital: ‘This morning I saw a patient with dementia in the clinic who took a taxi to come. Because she had to use a wheelchair, she waited for over an hour as many taxis passed her by. She collapsed and eventually arrived at the hospital by ambulance!’ Facilities for those with mobility impairment are not widely known or signposted: for example, many are not aware of the disabled permit or how to obtain them, or the option of requesting staff to help with transfer on the mass transit railway system, or the existence of E-portals that advertise special services aiding transport.

2. Signage

There was a variable response regarding clarity of signage among the elderly focus groups. Some thought the signage was adequate while some thought it was confusing and people were not helpful when asked for directions. All agree that there was no problem when one became familiar with the clinic, but all experienced difficulties when moving to a new facility. There were similar comments from the service provider group: signage may be inadequate for the visually impaired or illiterate, that additional use of picture symbols may be considered, and that more people such as volunteers are needed to help with directions. Methods of attracting people to be volunteers such as distribution of supermarket coupons were suggested, and it was stated that the glass barrier surrounding the member of staff at the Enquiries station actually represent a physical barrier to communication.

3. Clinic facilities

There were few comments regarding clinic facilities from the elderly focus groups, other than that rails could be installed. More short comings were pointed out by the service provider group: escalators were too fast for frail older people to cope and the width did not allow an accompanying person to stand on the same level, toilets may be difficult to access in that the doors may be too heavy or too narrow, the floors wet, the numbers inadequate, some corridors may be too narrow for both wheelchair and other ambulant users, and information counters were inadequate 1 member suggested the use of sliding doors for toilets to allow helper access as well, similar to some designs in Japan.

4. Physical environment

There were variable responses from the elderly groups: many pointed out that there were inadequate seats in the Accident and Emergency Departments. Most are able to identify who the doctors are by the name on the door, rather than by any uniforms: the latter were confusing. The service provider group also thought that it was difficult to distinguish between the various staff categories. Although clinics are clean and comfortable, waiting areas tend to be insufficient, and seating arrangements could be improved to allow the patients in wheelchairs to be next to the accompanying person who can be seated instead of standing by the wheelchair or sitting elsewhere while waiting.



5. Consultation process

The elderly focus group in general reflected that follow up, appointment arrangements are good, in that the doctor prints out the appointment slip after consultation and there is no need to go to another counter. However, making new appointments were very challenging and help from others was frequently needed. 'It is very difficult to make appointment by telephone. I tried several times and eventually had to ask my daughter to help.'

'I have tried several times: I have worked out that phoning at 3 PM gives you the best chance of getting an appointment for the next day'.

Waiting times are acceptable in some clinics but too long at others. The service provider group made similar comments. There was room for improvement in making new appointments, in that the current system has many barriers especially if a patient is referred to multiple specialties, when they have to queue up at many counters for each appointment; the use of telephone booking only for some clinics make it difficult for elderly, who find it difficult to respond to automated messages and prefer to come in person. Waiting times for doctor consultation and filling drug prescriptions are also very long.

'For the elderly, a clinic appointment is like going travelling: one should bring reading material and snacks and drink, because the waiting times are long, at least a few hours'.

Missing appointments for whatever reason creates a lot of problems with continuing drug supply and the need to make a new appointment.

6. Clinic fees

In general, all groups consider the fees to be reasonable. However, some of the elderly thought the fees were expensive while the service provider group also mentioned that for those who were not receiving comprehensive social security allowance and had to pay themselves, the amount may be quite high for those with multiple chronic diseases requiring many drugs, especially if some self-financing drugs were required. One comment from the elderly focus group pointed out that this is much cheaper than main land China.

'You have to pay \$100 at Accident and Emergency Department for consultation fee; each drug costs \$10. So if you have 7 drugs it is an additional \$70. I do not

consult doctors unless I feel very bad' (Elderly from focus group).

'Outpatient consultation fee is \$60; added to this on average drug cost may be up to \$100; added to this taxi fare; and one is looking at a few hundred dollars for each clinic visit for those with multiple chronic illnesses. The elderly will consider this expensive' (Service provider group).

7. Community outreach service

The elderly focus groups commented that they were not aware of such services, and that if they existed, they should be widely advertised even if they do not need them themselves. The service providers group reflected that there was a huge gap between provision and need; that community services provided by nongovernment organizations were inadequate, in particular for dementia community care. 'The few self-financing dementia day care centers may not be affordable to many elderly people, the psycho-geriatric outreach team cannot meet existing needs, and there is a lack of respite care if one does not choose the long term residential care option' (Service provider group).

8. Referral system

There was little opinion among the elderly focus group, other than that they trust the doctors to arrange referrals. The service providers group commented on problems in the interface between the public and private sector (platform for patient data sharing operating only one way from public to private and not the reverse), and that a better system for referral from the Accident and Emergency Department's non-urgent cases could be devised.

9. Dissemination of health knowledge

The elderly focus groups thought this was adequate in clinics. The service providers group thought that the clinics were not an ideal place to carry out health promotion; rather there should be a government-media interface for special topics such as details about a particular disease, or broader topics such as pre-retirement preparations.

10. Medication management

The elderly focus group thought that if they did not understand, they will ask, but they cannot be sure



that they took medications correctly. The service providers group pointed out that package labeling needs to be improved, and that many factors exist that predispose to wrong medications being taken. ‘Many older people rely on identifying drugs by their shape and color, so that when this is changed they get confused’ (Service providers group).

11. Standard of care for the elderly

The elderly focus groups thought that doctors were good, but one commented on nursing standards based on a hospital experience of wrong drug administration on the part of nurses, that was pointed out by the patient. Service providers thought that in general, development of specialty knowledge is good, but there may be a mismatch between the rates of development of different specialties to match the speed of demographic change, while workload pressure per se may compromise standards of care even if knowledge is adequate.

12. Feedback system

None of the elderly focus group members were aware of any channels for feedback: they were grateful for the opportunity to attend the focus group sessions to reflect their opinions. Service providers commented that although channels exist in hospitals, many older people may not use it or be able to use it, and that feedback from elderly users of services may need to be actively solicited.

13. Communication skills

Elderly focus group members commented that there has been much improvement in recent years and that staff have been more patient with them during interaction; however, they still experienced abruptness and bursts of temper from staff, while some commented that ageist attitudes still exist as part of the general Hong Kong community. Service providers thought that there is room for improvement for staff who have not been trained in care of the elderly, and free web-based programs such as the training component of the Cadenza Program (www.cadenza.org.hk) may be useful.

Discussion

There are similarities and differences between the comments from the elderly groups and the service

providers groups. This is to be expected since the elderly groups consisted of older people who are still ambulant with a level of physical and cognitive function to enable them to come to the community centre to participate focus group discussions. In contrast, service providers experienced in care of the elderly would have experience of caring for community-living older people of a wide range of physical and cognitive functioning, as well as the very frail people living in residential care homes for the elderly, since they provide both in patient, outpatients, and community outreach services, of both a primary and secondary care nature. The viewpoint from the service provider group is particularly important since it would be difficult to conduct focus groups for frail older people to solicit their views: they would likely have mobility or cognitive impairments that preclude them from participating. Unfortunately, views from this sector of the population are seldom solicited: they are usually a hidden minority in society in general and their needs are not taken into account.

Several common themes were elicited from all groups: that older people usually need some one to accompany them to clinics, that it is difficult to find their way around if they have not attended a clinic before, that there are not enough seats in some clinics especially in accident and emergency departments, that it is difficult to identify different types of staff other than the doctor, that it is difficult to make new or ad hoc appointments, that there is uncertainty whether dispensed medications are taken correctly, that there is little awareness of feedback mechanisms; and that older people are still sometimes not treated with respect.

Some themes were only raised by the service providers group, reflecting their experience with frail older patients. The areas involve problems with transport to clinics for those with mobility disabilities, navigation issues within the healthcare facility, design inadequacies such as the number and type of toilets, waiting areas to accommodate wheelchairs and accompanying persons, long waiting times for consultation and drug collection, a system for making new appointments and referrals, inadequate community outreach support, medication management, staff training in communication with and care of older people, and the adverse impact of an overwhelming workload.



It is pertinent to ask why there are these deficiencies, when service providers were aware of them but that they still exist. There are many barriers to change. The majority of health service providers, as well as management staff, do not have an in depth understanding of management of, or have not encountered, frail older patients. At present, the latter are still in the minority, although the numbers are increasing rapidly. Professionals who are concerned need to take on an advocacy role and propose changes in competition with many other quality improvement initiatives. They are also overwhelmed by increasing demands on their time due to the rapidly increasing number of frail elderly, as well as managing complex multi-morbidity, dependency and social care issues that are common to such patients. The transport situation is also a reflection of societal marginalization of this group, and efforts in improvement frequently encounter political and financial barriers. For example, there are 2 types of taxis serving urban areas of Hong Kong: the New Territories (green taxis) and Kowloon and HK Island (red taxis). A government outpatient geriatric facility with rehabilitation services situated in a non-acute hospital in Shatin, a new town in the Eastern New Territories, is only accessible by red taxis. Yet many older people live in areas served by green taxis only. Since many of these patients have mobility limitations and may not be able to come by public transport, taxi is the only option. Yet this involves changing taxis and so doubling waiting time by the roadside. Professional staff wrote many letters to the local district council and the transport department, who replied that the taxi unions have to agree. From the latter's point of view this request means crossing boundaries that have an impact on profits and would not be entertained. The number of passengers was deemed too small for the government to take action.

Existing primary care structure was also a potential barrier to improvement, since 2 government organizations were involved: the department of health runs 18 elderly health centers with an emphasis on preventive care, while the hospital authority is mainly responsible for the rest of the clinic services, and is looking after the majority of the frail elderly population. For example, the government produced 2 policy documents: one targeting the Elderly Health Centers consisting of guidelines for screening,⁷ and one related to hospital care.⁹ No synergy exists between

the 2 service providers, and the needs of frail older people and their carers are seldom considered.

There are few reports of studies assessing the age-friendliness of primary care services for the elderly. However some of the themes are similar to findings of community-wide studies among Caucasian populations. These studies found a discrepancy between healthcare providers and older people, a major concern regarding effective communication on how to locate and access the necessary services, and the need for home-based services, health promotion and education.^{10,11} 3 other studies of older people living in the community also identified a lack of support in managing their own health, issues with access to and coping with complexities of services and managing information technologies required for access.¹²⁻¹⁴

There are limitations to this study. The number of focus groups conducted was limited by resource constraints, and the geographic location of the groups was in the New Territories, which has a lower population density compared to Kowloon and Hong Kong Island. Therefore, there may be regional variations in transport facilities. However, since the clinics are all under the hospital authority, they would have the same design and space allocation, and the same management infrastructure and staff types. Since the service provider group had rotated between different Hong Kong regions, their comments are unlikely to be applicable to 1 particular region. There is a predominance of elderly women attending the old age centers and hence the focus groups, so that it is uncertain whether inclusion of more men may generate different themes. As mentioned before, those with impaired physical and/or cognitive function were excluded from the focus groups. The strengths of the study is the inclusion of both professionals providing care to elderly people as well as the elderly themselves, so that a broad range of older people from the fit ambulant to the frail were included.

The findings of this study may form the basis for various initiatives towards improving age-friendliness, such as through transport modification, development of more transport for elderly people with disabilities by non-government organizations, re-designing clinic waiting areas and toilet facilities, simplifying the appointment system, and training staff to be more aware of the needs of frail elderly people. Future studies may include administration



and management personnel as one of the focus groups, to gather their points of view.

Conclusion

In conclusion, the aim to pursue an age-friendly primary care represents an important facet of the WHO age-friendly city movement, which has gathered momentum in recent years and to which various concerned sectors in Hong Kong aspire. This study provides an assessment of how well primary care services for the elderly in Hong Kong meet their needs, using a users' perspective provided by the WHO guidelines, and highlights several areas where improvements are desirable. In the light of the rapidly aging population and the increasing number of older people who are frail, the findings underscore the need for a wider dissemination of health care needs of older people in the primary care setting.

Author Contributions

JW designed and supervised the study, carried out analysis and wrote the manuscript. BM conducted the focus groups and contributed to the manuscript writing. FY transcribed the interviews and carried out the coding and analysis. All authors reviewed and approved of the final manuscript.

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Competing Interests

Author(s) disclose no potential conflicts of interest.

Disclosures and Ethics

As a requirement of publication the authors have provided signed confirmation of their compliance with ethical and legal obligations including but not limited to compliance with ICMJE authorship and competing

interests guidelines, that the article is neither under consideration for publication nor published elsewhere, of their compliance with legal and ethical guidelines concerning human and animal research participants (if applicable), and that permission has been obtained for reproduction of any copyrighted material. This article was subject to blind, independent, expert peer review. The reviewers reported no competing interests.

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Supplementary Data

Appendix 1

Guidelines:

1. In the areas of information, education, and training:

- 1.1 All health care center staff should receive basic training in age, gender, and culturally sensitive practices that address knowledge, attitude and skills
- 1.2 All clinical staff in the health care center should receive basic training in core competencies of elder care
- 1.3 Health care centers should provide age, gender and culturally appropriate education and information on health promotion, disease management and medications for older persons as well as their informal caregivers in order to promote empowerment for health
- 1.4 Healthcare center staff should review regularly the use of all medications, including complementary therapies such as traditional medicines and practices

Guidelines:

2. In the area of community-based health care management systems:

- 2.1 Health care centers should make every effort to adapt their administrative procedures to the special needs of older persons, including older persons with low educational levels or with cognitive impairments
- 2.2 Health care center systems should be cost sensitive in order to facilitate access to needed care by low-income persons
- 2.3 Health care centers should adopt systems that support a continuum of care both within the community level and between the community and secondary and tertiary care levels
- 2.4 Health centers should put into place mechanisms that facilitate and coordinate access to social and domiciliary care services

- 2.5 All record keeping systems in health care centers should support continuity of care by keeping records on community-based, secondary and tertiary care as well as on the provision of social services for their clients
- 2.6 All relevant stakeholders, including older persons, should be part of participatory decision-making mechanisms regarding the organization of the community-based care services
- 2.7 Information on the operation of the health care center, such as opening hours, fee schedules, medication and investigation charges, and registration procedures should be provided in an age-appropriate way

Guidelines:

3. In the area of the physical environment:

- 3.1 The common principles of Universal Design should be applied to the physical environment of the health care facility whenever practical, affordable and possible
- 3.2 Safe and affordable transport to the health care center should be available for all, including older persons, whenever possible, by using a variety of community-based resources, including volunteers
- 3.3 Simple and easily readable signage should be posted throughout the health care center to facilitate orientation and personalize providers and services
- 3.4 Key health care staff should be easily identifiable using name badges and name boards
- 3.5 The health care facility should be equipped with good lighting, non-slip floor surfaces, stable furniture and clear walkways
- 3.6 The health care center facilities, including waiting areas, should be clean and comfortable throughout