The Dementia Situation in Hong Kong: Context, Systems, Policies, and Services

TIP-CARD Desk Review

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Introduction

This document is a desk review that provides an in-depth understanding of the current situation in Hong Kong in relation to dementia policy and care. The information in this review is organised as narrative responses to a series of questions according to a topic guide, "In-depth Situational Analysis: Desk-Review Topic Guide" (Comas-Herrera et al., 2019) developed by the Strengthening Responses to Dementia in Developing Countries (STRiDE) project team to provide a systematic description of the current situation regarding dementia in Hong Kong. In addition to the questions designed by the STRiDE project team, the topic guide also includes questions purposively and directly drawn from the World Health Organization Global Dementia Observatory Reference Guide 2018 (World Health Organization, 2018) which provides a monitoring mechanism for the global action plan on the public health response to dementia (2017–25). All questions in this review that have been sourced from The Global Dementia Observatory (GDO) Reference Guide can be identified by the bracketed texts at the end of those questions (e.g. GDO 1x1, GDO 1x2, etc.). In this desk review, the authors aim to provide local and international readers with core information and resources for understanding the dementia landscape in Hong Kong.

Most of the information included in this review was last updated in June 2020. For enquiries regarding this review, please contact the team's post-doctoral fellow, Dr. Jacky Choy (cpchoy@hku.hk).

This review has been prepared as part of a three-year research project (2019-2022), "Tools to Inform Policy: Chinese Communities' Action in Response to Dementia (TIP-CARD)", that aims to build on existing data, fill gaps in evidence, and consolidate findings with stakeholders to provide the policy tools to inform the best strategies for dementia care in Hong Kong. TIP-CARD is led by Dr. Gloria Wong, Associate Professor in the Department of Social Work and Social Administration at The University of Hong Kong. For details of TIP-CARD, please visit our project website: https://www.tip-card.hku.hk/

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Part 1: Overall Country Context

Hong Kong, officially the Hong Kong Special Administrative Region (HKSAR) of the People's Republic of China, is a city located on the eastern side of the Pearl River Estuary in southern China. It comprises Hong Kong Island, the Kowloon Peninsula, the New Territories, Lantau Island, and over 200 outlying islands. Hong Kong is one of the most densely populated places in the world and has a humid subtropical climate. As Hong Kong was a colony of the British Empire from 1842 to 1997 and developed into a transit port for international trade, it is characterised by its combination of eastern and western cultures.

I. Population and Demographic Characteristics

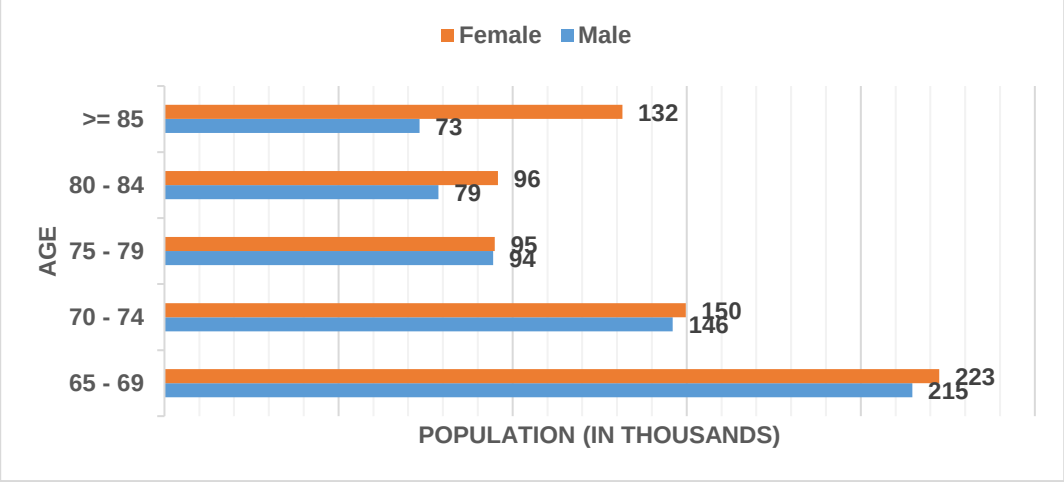
In Hong Kong, the Census and Statistics Department and the statistical units of various government bureaux and departments form the Government Statistical Service. It regulates and coordinates a network providing statistical and geographic information. It also conducts statistical surveys and operates statistical systems to produce social and economic statistics, including data series on the population, external trade, commerce and industry, labour, prices, national income, and balance of payments. In addition, since 1961, it has coordinated the Population Census every ten years, and the by-censuses held between two full Population Censuses. The last census and by-census were undertaken in June 2011 and June 2016, respectively, providing the most comprehensive sources of sociodemographic information about the population. In addition, the Hong Kong Population Projections 2017-2066 present population projections that use the most up-to-date information on fertility, mortality, and movement patterns among the population.

a. Total population size and structure

The total population of Hong Kong at the end of 2018 was 7.49 million, of which 45.7% were male and 54.3% were female (Census and Statistics Department, 2019e). Most of the population is aged between 25 and 54 years (45.3%), followed by those 65 years and over (17.3%), 55-64 years (16.2%), 0-14 years (11.5%) and 15-24 years (9.6%). In particular, the population aged 65 years and over is 1.30 million, of whom 46.7% are male and 53.3% female (Census and Statistics Department, 2019f). Figure 1 shows the population structure of those aged 65 years and over by age and gender in 2018.

Figure 1

Population structure of Hong Kong residents aged 65 years and over by age and gender in 2018



(Census and Statistics Department, 2019f).

The population of Hong Kong is ageing rapidly. The population median age increased from 40.0 years in 2007, to 42.0 years in 2012 and to 43.9 years in 2017 (Census and Statistics Department, 2018b). Furthermore, it was estimated that it would continue to increase to 50.9 years in 2036 and 54.5 years in 2066 (Census and Statistics Department, 2017b).

Along with the trend of population ageing, Hong Kong also faces an increasing dependency ratio. The total dependency ratio (number of persons aged under 15 and aged 65 and over per 1000 persons aged 15-64) was 386 in 2017 (Census and Statistics Department, 2018b), with a notable projected increase to 844 in 2066 (Census and Statistics Department, 2017b). The old-age dependency ratio (number of persons aged 65 and over per 1,000 persons aged 15-64) was 228 in 2017 (Census and Statistics Department, 2018b), with a notable projected increase to 674 in 2066 (Census and Statistics Department, 2017b).

b. Key geographical/demographic characteristics (e.g. population density, urbanisation, whether country formed of islands, etc.).

Hong Kong, a small urban city located at the south-eastern tip of China, has a total surface area of 1,106.66 km^2, comprising Hong Kong Island, the Kowloon Peninsula, and the New Territories, and including 263 outlying islands (Government of the Hong Kong Special Administrative Region, 2019a). It is one of the most densely populated places in the world, with a population density of 6,890 people per km^2 in 2018 (Census and Statistics Department, 2019h). Since 1993, Hong Kong's urban population has represented 100% of its total population (World Bank, 2018). Hong Kong is geographically and administratively divided into 18 districts. Table 1 shows the population density of Hong Kong and the population of its 18 districts in 2018.

Table 1

Population density of Hong Kong by District: 2018

	Land Area (km^2)	Population (in thousand)	Density (per km^2)
Whole city	**1,081.80**	**7,449.8**	**6,890**
By District:			
Hong Kong Island	**79.92**	**1,252.1**	**15,670**
Central and Western	12.55	245.6	19,580
Wan Chai	10.56	182.0	17,250
Eastern	17.99	551.3	30,650
Southern	38.84	273.1	7,030
Kowloon	**46.94**	**2,265.1**	**48,250**
Yau Tsim Mong	6.99	335.5	47,980
Sham Shui Po	9.36	403.5	43,110
Kowloon City	10.02	420.3	41,950
Wong Tai Sin	9.30	423.1	45,480
Kwun Tong	11.27	682.8	60,560
New Territories and Islands	**954.93**	**3,932.7**	**4,120**
Kwai Tsing	23.34	514.8	22,060
Tsuen Wan	61.94	314.7	5,080
Tuen Mun	83.06	502.7	6,050
Yuen Long	138.48	641.0	4,630
North	136.48	318.4	2,330
Tai Po	136.12	310.5	2,280
Sha Tin	68.71	685.5	9,980
Sai Kung	129.64	471.9	3,640
Islands	177.16	173.2	980

(Census and Statistics Department, 2019h).

c. Key languages and ethnic groups

The Basic Law of Hong Kong stipulates that Chinese and English are its two official languages. In 2016, Cantonese was the predominant language spoken by 88.9% of the population and widely used in education, broadcasting, government administration, legislation, the judiciary, and daily communication. English is a major working language spoken by 4.3% of the population and is widely used in commercial activities and legal matters. Putonghua is more widely used due to the increase in tourism-related commerce from the mainland, which is spoken by 1.9% of the population. The proportion of the population speaking other Chinese dialects was 3.1%, while 1.9% spoke other languages (Filipino, Indonesian, other Asian languages and other European languages) (Government of the Hong Kong Special Administrative Region, 2019a).

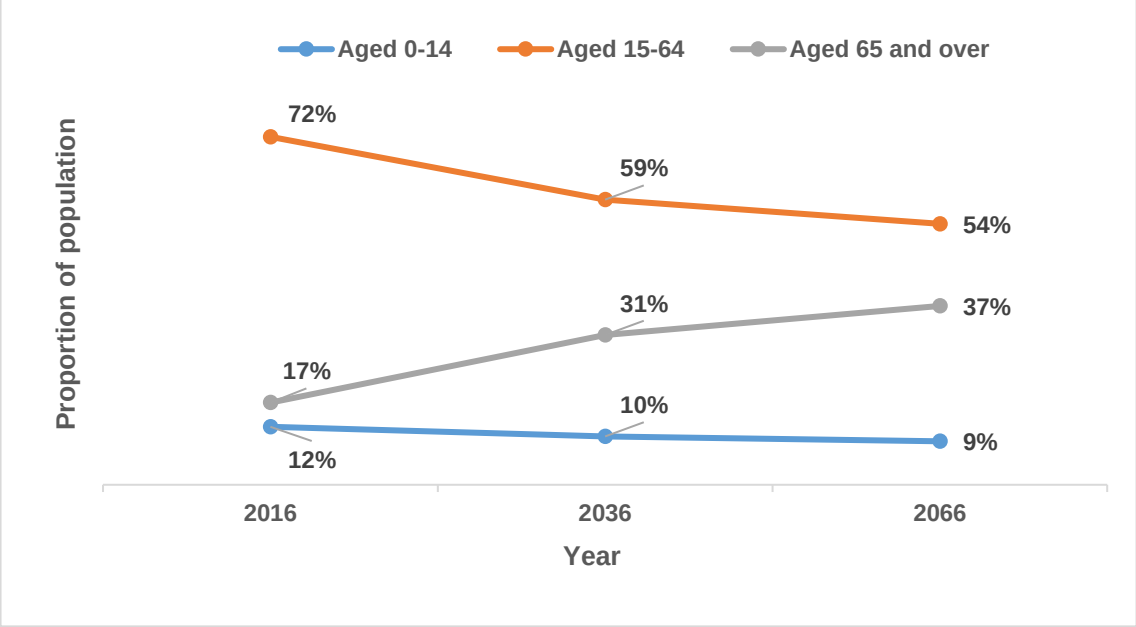
Hong Kong is an ethnically homogenous society; about 92% of the population is of Chinese descent. The non-Chinese population comprises various ethnic groups, including 31.5% Filipino, 26.2% Indonesian, 14.5% South Asian (6.2% Indian, 4.4% Nepalese, 3.1% Pakistani, 0.8% Bangladeshi and Sri-Lankan), 11.2% Mixed, 10.0% White, 1.7% Thai, 1.7% Japanese, 1.4% other Asian, 1.1% Korean, and 0.6% Black and Latin American (Government of the Hong Kong Special Administrative Region, 2019a).

d. Population projections and growth rate

The total population of Hong Kong was projected to increase from 7.34 million in mid-2016 to 8.14 million in mid-2036 and then decline to 7.72 million in mid-2066. However, the population aged 65 and over was projected to expand from 1.16 million (16.6%) in 2016, to 2.37 million (31.3%) in 2036 and further increase to 2.59 million (33.7%) in 2066. Figure 2 shows the population projection by age from 2016 to 2066 (Census and Statistics Department, 2017b).

Figure 2

Projection of population percentages by age range: 2016 - 2066



(Census and Statistics Department, 2017b).

The population growth rate of Hong Kong was 1.0% in 2018 (Census and Statistics Department, 2019g). The total fertility rate (live births per 1,000 women) was projected to decrease from 1,205 in 2016 to 1,134 in 2036 and

further to 1,166 in 2066. Table 2 shows the actual and projected age-specific and total fertility rates from 2006 to 2066 (Census and Statistics Department, 2017b).

Table 2

Actual and projected age-specific and total fertility rates: 2006 - 2066

	2006	2016	2036	2066
Total fertility rate	**984**	**1 205**	**1 134**	**1166**
By age:		*Number of live births per 1 000 women*		
15-19 years	3.2	2.7	1.3	1.4
20-24 years	25.0	17.8	16.9	17.6
25-29 years	56.5	59.1	51.0	57.0
30-34 years	71.6	93.0	87.2	88.3
35-39 years	35.1	57.3	55.9	55.9
40-44 years	5.2	11.4	12.6	12.5
45-49 years	0.3	0.7	0.7	0.6

(Census and Statistics Department, 2017b).

e. Ageing and life expectancy

The population aged 65 and over is increasing more and more rapidly. In 2018, there were 1,301,600 (17.3% of the total population) aged 65 and over, 568,600 people (7.6% of the total population) aged 75 and over, and 204,800 people (2.7% of the total population) aged 85 and over (Census and Statistics Department, 2019f). The proportion of the population aged 65 and over was projected to increase sharply to 31.1% in 2036 and further to 36.6% in 2066 (Census and Statistics Department of HKSAR, 2017).

At the same time, life expectancy among Hong Kong people is also increasing. Life expectancy at birth in Hong Kong in 2008 was 79.4 years for men and 85.5 years for women, while 2018 estimates showed an increase to 82.3 years for men and 87.7 years for women, respectively.

f. Migration (within-country and international)

Hong Kong is a small and highly dense city in which people can relocate across districts (within the city) without any application for migration. Relocation of residence within Hong Kong is common among rental households. The Census and Statistics Department regularly captures the change of residence of the population aged five years and over. In the 2016 population by-census, 10.6% (745,369 persons) had internally migrated from one district to another compared to five years previously (i.e., 2011-2016). Of these, 12.2% (90,936 persons) were aged 65 or over, comprising 44.3% males (40,264 individuals) and 55.7% females (50,672 individuals) (Census and Statistics Department, 2018a).

No official statistics record the precise number of migrants moving into or out of Hong Kong. Instead, based on the number of residents, the Census and Statistics Department constantly records the net movement of Hong Kong residents (i.e., inflow less outflow). It is important to note that this figure covers the inflow and outflow of permanent residents and non-permanent residents. Non-permanent residents moving into or out of Hong Kong are usually not migrants but one-way permit holders from mainland China, foreign domestic helpers, or individuals possessing a working or student visa. From the end of 2017 to the end of 2018, there was a net movement of 66,700 persons into Hong Kong (Census and Statistics Department, 2019g), of whom 42,300 were one-way permit holders from mainland China (Census and Statistics Department, 2019i).

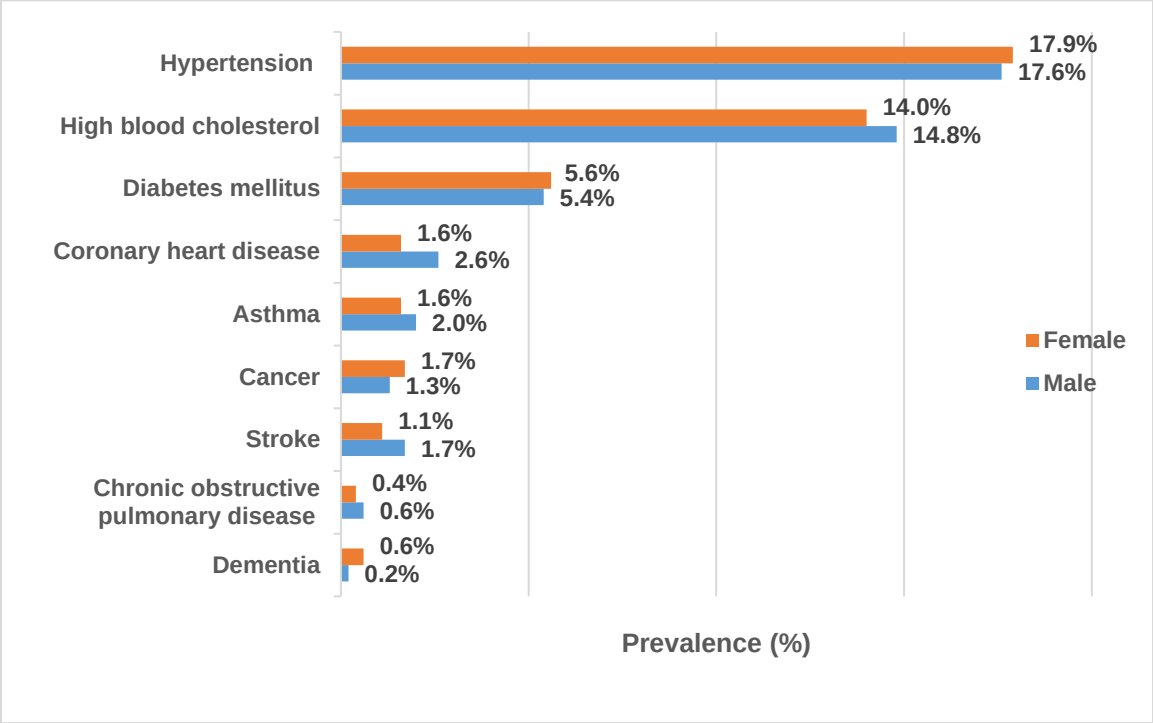
II. Epidemiological Situation

a. Prevalence and burden of significant non-communicable diseases (NCDs) or conditions

Hong Kong's Centre for Health Protection estimated that 39.6% of persons aged 15 or above reported one or more doctor-diagnosed chronic conditions in 2014/2015. The population health survey conducted by the Centre covered nine types of significant non-communicable diseases, hypertension, high blood cholesterol, diabetes mellitus, coronary heart disease, asthma, cancer, stroke, chronic obstructive pulmonary disease, and dementia. The three most self-reported conditions in 2017 were hypertension (male 17.6%, female 17.9%), high blood cholesterol (male 14.8%, female 14.0%), and diabetes mellitus (male 5.4%, female 5.6%). Figures 3 and 4 show the prevalence of self-reported chronic conditions by gender and age, respectively (Centre for Health Protection, 2017). The next round of the population health survey in Hong Kong will be conducted in 2020

Figure 3

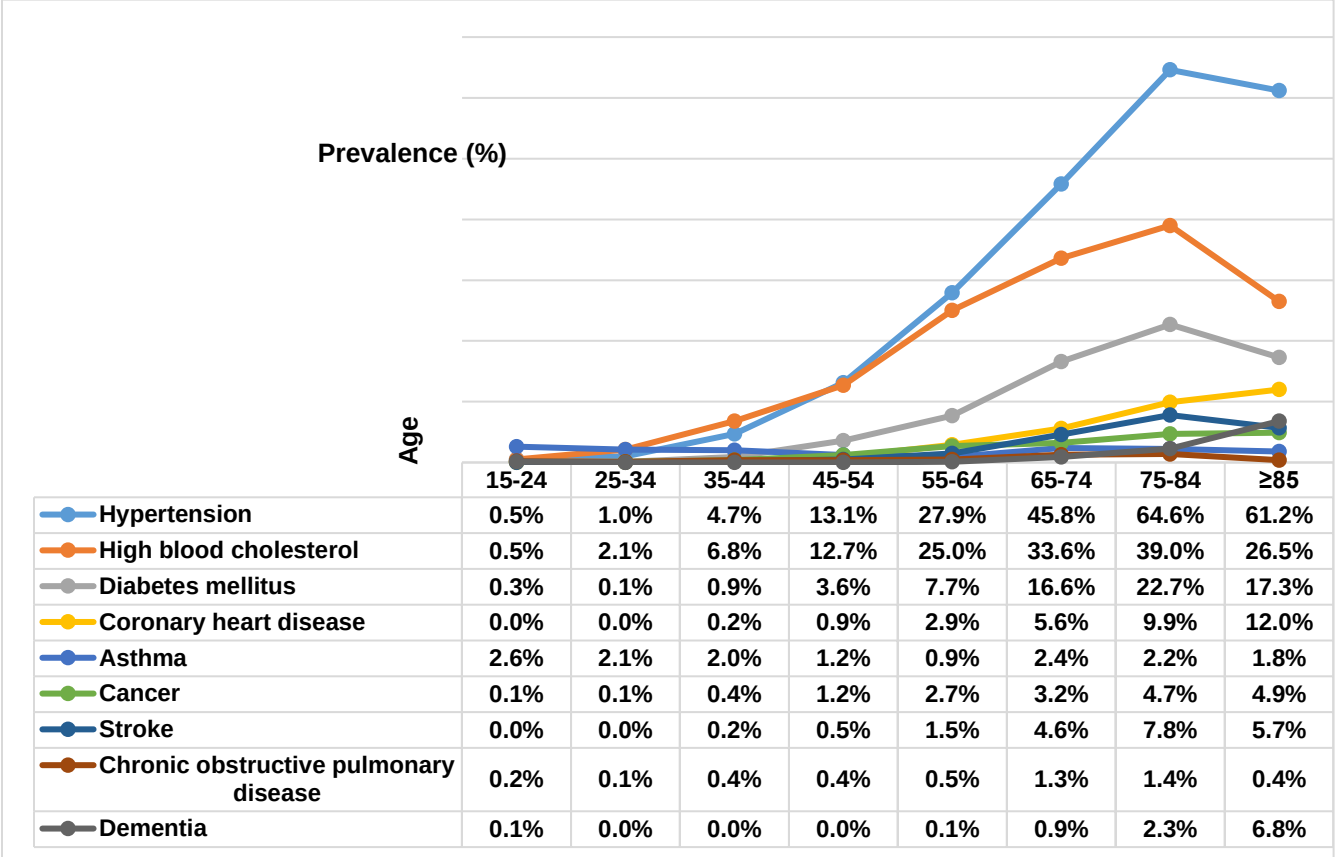
Prevalence of self-reported chronic conditions by gender



(Centre for Health Protection, 2017).

Figure 4

Prevalence of self-reported chronic conditions by age



	15-24	25-34	35-44	45-54	55-64	65-74	75-84	≥85
Hypertension	0.5%	1.0%	4.7%	13.1%	27.9%	45.8%	64.6%	61.2%
High blood cholesterol	0.5%	2.1%	6.8%	12.7%	25.0%	33.6%	39.0%	26.5%
Diabetes mellitus	0.3%	0.1%	0.9%	3.6%	7.7%	16.6%	22.7%	17.3%
Coronary heart disease	0.0%	0.0%	0.2%	0.9%	2.9%	5.6%	9.9%	12.0%
Asthma	2.6%	2.1%	2.0%	1.2%	0.9%	2.4%	2.2%	1.8%
Cancer	0.1%	0.1%	0.4%	1.2%	2.7%	3.2%	4.7%	4.9%
Stroke	0.0%	0.0%	0.2%	0.5%	1.5%	4.6%	7.8%	5.7%
Chronic obstructive pulmonary disease	0.2%	0.1%	0.4%	0.4%	0.5%	1.3%	1.4%	0.4%
Dementia	0.1%	0.0%	0.0%	0.0%	0.1%	0.9%	2.3%	6.8%

(Centre for Health Protection, 2017).

In 2017, the Department of Health reported the ten leading causes of death by gender (Table 3) (HealthyHK, 2018, July 19)The top three leading causes for both men and women were: 1. malignant neoplasms, 2. pneumonia, and 3. Heart disease. Dementia was the eighth and fifth leading cause of death for males and females, respectively.

Table 3

Ten leading causes of death by gender: 2017

Ranking	Leading cause of death	Number of Death	% of total deaths
	Males		
1	Malignant neoplasms	8,487	33.4%
2	Pneumonia	4,360	17.2%
3	Diseases of the heart	3,323	13.1%
4	Cerebrovascular diseases	1,546	6.1%
5	Chronic lower respiratory diseases	1,149	4.5%
6	External causes of morbidity and mortality	1,082	4.3%
7	Nephritis, nephrotic syndrome, and nephrosis	821	3.2%
8	**Dementia**	**557**	**2.2%**
9	Septicaemia	524	2.1%
10	Aortic aneurysm and dissection	210	0.8%
	Females		
1	Malignant neoplasms	5,867	28.7%
2	Pneumonia	3,672	17.9%
3	Diseases of heart	2,815	13.8%
4	Cerebrovascular diseases	1,578	7.7%
5	**Dementia**	**898**	**4.4%**
6	Nephritis, nephrotic syndrome, and nephrosis	838	4.1%
7	External causes of morbidity and mortality	615	3.0%
8	Septicaemia	447	2.2%
9	Chronic lower respiratory diseases	356	1.7%
10	Diabetes mellitus	215	1.1%

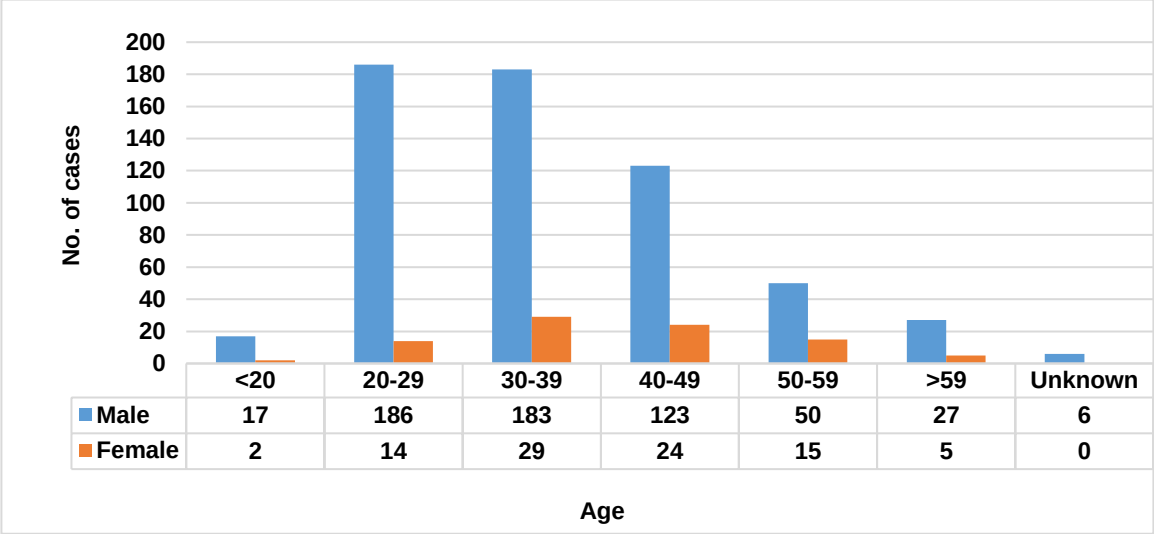
(HealthyHK, 2018, July 19).

b. Prevalence and burden of HIV/AIDS, TB and other significant communicable diseases or conditions

In 2018, 624 cases of HIV and 139 cases of AIDS were reported in Hong Kong. A cumulative total of 9,715 reports of HIV infection and 1,996 AIDS cases was identified under the voluntary and anonymous HIV/AIDS reporting system launched in 1985 by the Department of Health. In 2018, one in every 9,850 new blood donors, one in every 264 attendees in Sexually Transmitted Diseases (STD) Clinics, and one in every 110 users in methadone clinics were tested as HIV positive. Most HIV reports were male (85%) and Chinese (72%). Most infected people (78%) were diagnosed between 20 and 49 years. People infected with HIV progress to AIDS when they suffer from clinical complications of severe immunodeficiency due to HIV. The most common illnesses presented by those with AIDS are pneumocystis pneumonia and tuberculosis. Figure 5 shows the number of HIV reports by gender and age group in 2017. Figure 6 shows the number of HIV and AIDS reports in 2008, 2013 and 2018 (Virtual AIDS Office of Hong Kong, 2019, May).

Figure 5

Number of HIV reports by gender and age group: 2017

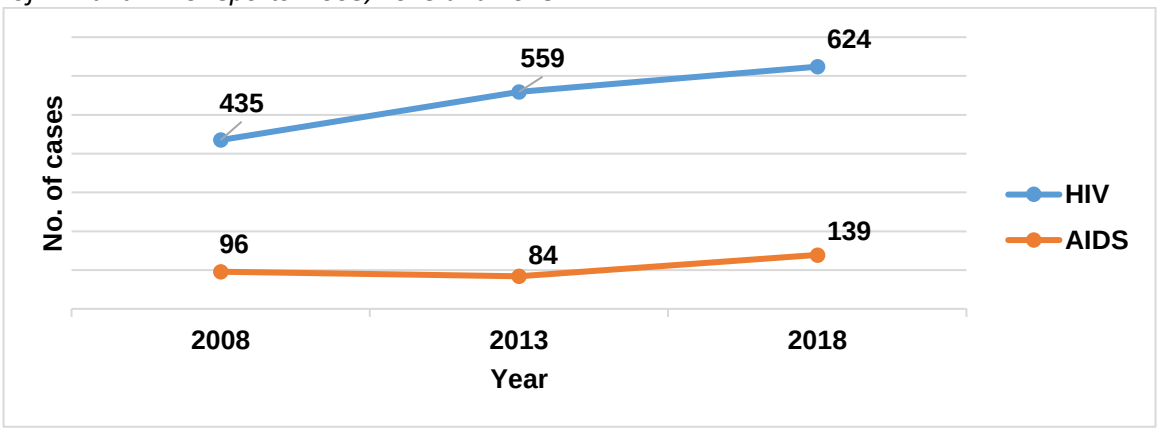


	<20	20-29	30-39	40-49	50-59	>59	Unknown
Male	17	186	183	123	50	27	6
Female	2	14	29	24	15	5	0

(Virtual AIDS Office of Hong Kong, 2019, May)

Figure 6

Number of HIV and AIDS reports: 2008, 2013 and 2018

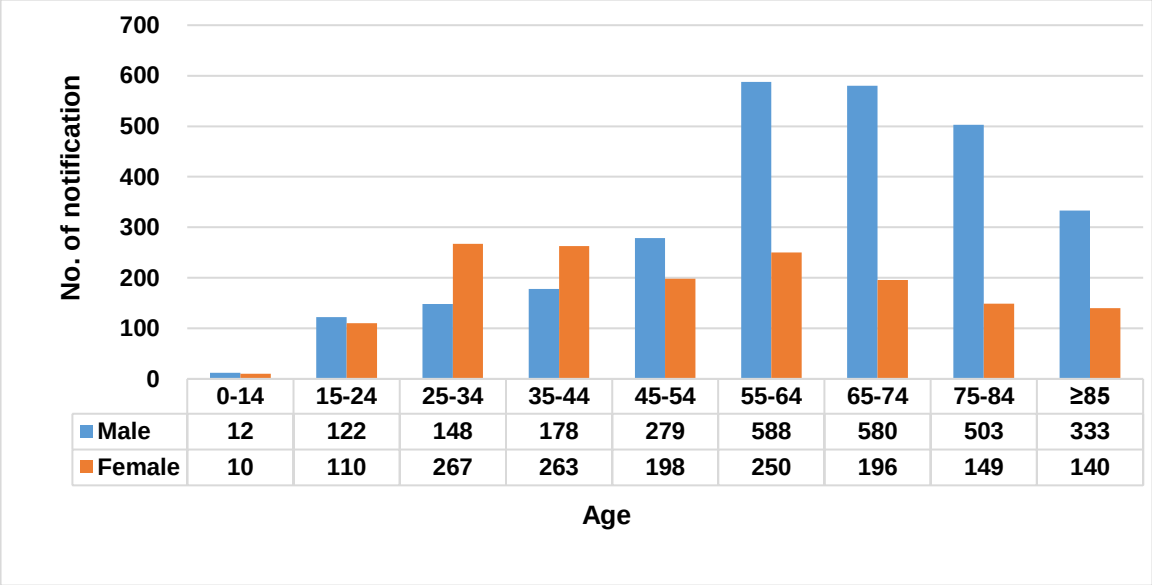


(Virtual AIDS Office of Hong Kong, 2019, May).

Tuberculosis (TB) is a significant infectious disease in Hong Kong. In 2018, there were 4,326 TB notifications with a male-to-female ratio of 1.7:1 (Centre for Health Protection, 2019, February 4a). TB is rare in children under 15 years old but is more common among older people. The total number of deaths caused by TB was 179 (132 male and 47 female). Figures 7 and 8 show the number of TB notifications and number of deaths caused by TB in 2018 by age and gender, respectively (Centre for Health Protection, 2019, February 1, 2019, February 4b) respectively.

Figure 7

Number of TB notifications by age and gender: 2018

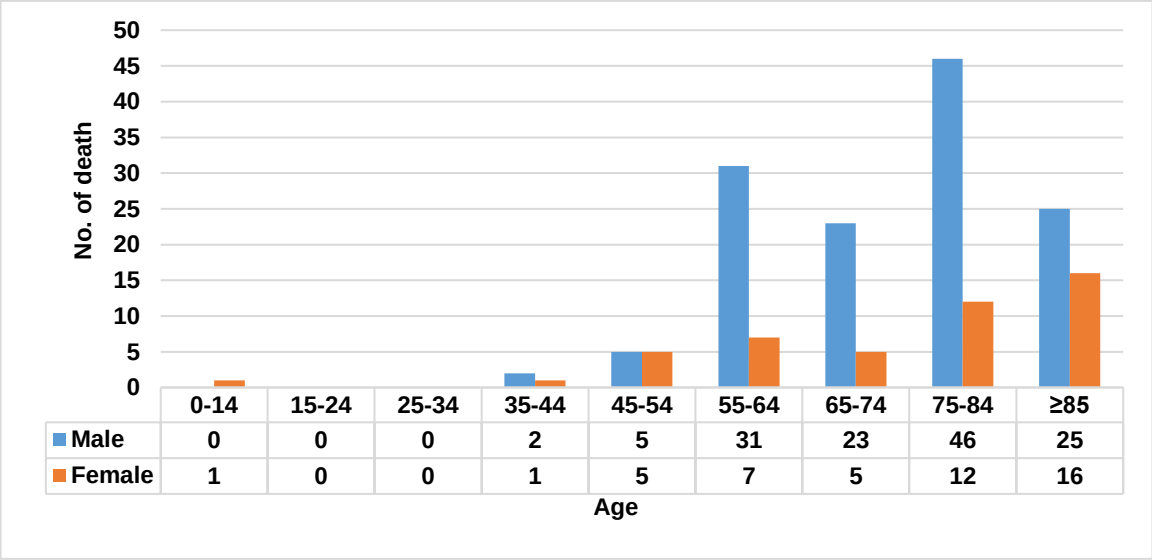


	0-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	≥85
Male	12	122	148	178	279	588	580	503	333
Female	10	110	267	263	198	250	196	149	140

(Centre for Health Protection, 2019, February 4b).

Figure 8

Number of deaths caused by TB by age and gender: 2018



	0-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	≥85
Male	0	0	0	2	5	31	23	46	25
Female	1	0	0	1	5	7	5	12	16

(Centre for Health Protection, 2019, February 1).

Seasonal influenza is a common respiratory tract infection caused by human seasonal influenza viruses. In Hong Kong, it is more common between January and April and between July and August (Centre for Health Protection, 2020, January 18). The Centre for Health Protection closely monitors the weekly number of institutional influenza-like illness outbreaks and the influenza-associated admission rate in public hospitals (Centre for Health Protection, 2020a). In 2019, there were 24,215 positive detections of seasonal influenza viruses under laboratory surveillance (Centre for Health Protection, 2020b). In the winter of 2018/2019, seasonal influenza resulted in 5,217 adult ICU admissions and 2,942 adult deaths with laboratory confirmation (Centre for Health Protection, 2020b).

The COVID-19 pandemic have been spread to Hong Kong since January 2020. Up to October 2022, there had been 5 waves of outbreak: first in January 2020, second in March 2020, third in July 2020, fourth in November 2020, and fifth (driven by the Omicron variant) in December 2021. As of 12 October 2022, there have been a total of 966653 and 849479 cases tested positive by nucleic acid tests and RATs respectively for the SARS-CoV-2 virus (Government of the Hong Kong Special Administrative Region, 2022).

c. Prevalence and burden of injury and violence (if available, please provide by age and gender groups as well as cause of injury and violence (e.g., car accidents, natural disasters)

According to the Unintentional Injury Survey 2018 report (Department of Health, 2021) conducted by the Centre for Health Protection, 4.4% of the Hong Kong population (7.22 million people) reported at least one unintentional injury that limited their normal activities in the previous 12 months. The prevalence rate was similar for both genders (males 4.7%; females 4.2%) and increased with increasing age; the lowest prevalence rate was for children aged up to 4 years (2.0%) and the highest for those aged 75 and above (7.4%). The most common causes of injury episodes were falls (39.4%), sprain (26.2%), being hit/struck (13.3%), sports (7.4%) and cutting and piercing (3.6%). For further details, please refer to:
https://www.chp.gov.hk/files/pdf/report_of_unintentional_injury_survey_2018_en.pdf.

In 2013, there were 1,860 registered injuries-related deaths, making injuries the fifth leading cause of death in Hong Kong. Among deaths related to injuries, the top three causes were intentional self-harm (53.7%), falls (12.5%) and transport accidents (7.5%). For the potential years of life lost at age 75, injuries ranked second among all causes of death (after cancer) and accounted for 15.7% of the total potential years lost. Table 4 shows the causes of death related to injuries in 2013 (Centre for Health Protection, 2015).

Table 4
Causes of death related to injuries: 2013

Leading cause of death	No. of deaths	% of total deaths
Intentional self-harm	999	53.7%
Falls	232	12.5%
Transport accidents	140	7.5%
Accidental poisoning by and exposure to noxious substances	137	7.4%
Accidental drowning and submersion	30	1.6%
Assault	27	1.5%
Exposure to smoke, fire, and flames	18	1.0%

(Centre for Health Protection, 2015).

III. Economic and Social Situation

a. Strength of the Economy: GDP (GDP per capita (nominal or PPP), growth rates, World Bank country categorization

Economically, Hong Kong is a highly developed free-market economy characterised by low taxation, virtually free-port trade and a well-established international financial market. In 2018, Hong Kong's GDP was recorded at HK$2,845.3 billion, with an annual growth rate of +5.9%. The GDP per capita was recorded at HK$381,870 with an annual growth rate of +5.1% (Census and Statistics Department, 2019c). Hong Kong has been classified as high-income by the World Bank (World Bank, 2019).

b. Composition of the economy (main productive sectors, etc.)

The four key industries in Hong Kong are 1. financial services (18.9% % of GDP in 2017); 2. tourism (4.5% of GDP in 2017); 3. trading and logistics (21.5% of GDP in 2017), and 4. professional and other producer services (12.2% of GDP in 2017). In 2017, these four industries added $1,456.6 billion to the economy (57.1% of GDP) and employed 1,780,200 persons (46.6% of total employment) (Census and Statistics Department, 2019b).

c. Debt (public and private)

Hong Kong's public debt in the form the Gross External Debt (ED) (measuring total outstanding gross external liabilities other than equity liabilities) was $12,695.3 billion in the first quarter of 2019, equivalent to 4.4 x GDP. The components of ED were attributable to the banking sector (62.0%), other sectors (22.4%) (consisting of 73.2% long-term and 26.8% short-term liabilities), and debt liabilities in direct investment (intercompany lending) (15.4%). Government ED amounted to $26.7 billion, nearly all of which consisted of long-term liabilities attributable to non-residents' holdings of debt securities issued by the Government. The Hong Kong Monetary Authority's ED amounted to $3.4 billion, of which 81.3% ($2.8 billion) comprised long-term liabilities of Exchange Fund Notes (Census and Statistics Department, 2019a).

Residential mortgage lending constitutes the major proportion of household loans (private debt) in Hong Kong, the remainder comprising personal loans such as unsecured lending through credit cards and other private purposes. The growth in household loans accelerated from 3.9% in the second half of 2018 to 6.7% in the first half of 2019, driven by stable growth in residential mortgage loans and strong growth in loans for other private purposes in private banking and wealth management customers, secured by various financial assets (i.e., stocks, mutual funds and insurance policies). With household debt growing faster than the nominal GDP, the household debt-to-GDP ratio rose to 75.5% in the second quarter of 2019 (Hong Kong Monetary Authority, 2019).

d. Poverty and inequality (Gini coefficient) (including gender inequality)

Since 2013, the Hong Kong government has officially defined the poverty line as 50% of the median monthly domestic household income. The poverty lines in 2017 for 1-person, 2-person, …, to 6-person+ households were HK$4,000, HK$9,800, HK$15,000, HK$19,900, HK$20,300, and HK$22,500 respectively (Government of the Hong Kong Special Administrative Region, 2018). Households with a monthly household income lower than the poverty line are defined as "poor households", and all members of these households are referred to as the "poor population".

The poverty situation in Hong Kong can be reflected by sets of "before-intervention" statistics and "after-intervention" statistics. "Before-intervention" poverty statistics are compiled assuming no prevailing government policies and measures, which form an objective benchmark for assessing the effectiveness of intervention. These statistics only include household members' employment earnings, investment income, and non-social-transfer cash income. "After-intervention" poverty statistics are compiled by further including the income provided by government policies and measures, such as taxation, recurrent-cash benefits, non-recurrent cash benefits, and in-kind benefits. In 2017, the poverty rate before intervention was 20.1% (1,376,600 persons). After recurrent cash intervention, the poverty rate improved to 14.7% (1,008,800 persons). Among those aged 65 and over, the poverty rate after recurrent cash intervention was 30.5% (340,000 persons) (Government of the Hong Kong Special Administrative Region, 2018).

Inequality between a society's rich and poor is often measured by the Gini coefficient, with zero indicating equality. In 2016, Hong Kong's Gini coefficient based on original monthly household income was 0.539 and that based on post-tax post-social transfer monthly household income was 0.473, the highest over the previous 45

years with an increase of 0.006 points since 2006, and worse than other developed economies such as Singapore (0.356), the United States (0.391), the United Kingdom (0.351), Australia (0.337) and Canada (0.318) (Census and Statistics Department, 2017a; Oxfam Hong Kong, 2018).

For gender inequality in income, the median monthly income of males and females in 2016 were $16,890 and $12,000, respectively, with males' income 40.8% higher. Also, a higher percentage of working women (9.1%) (excluding foreign domestic helpers) than men (4.6%) had a monthly income from their main employment below $6,000. The difference between the income of working women and men can be attributed to differences between working women and men in industrial and occupational distributions, educational attainment, working experience and nature of work. For example, proportionally more women (19.8%) than men (8.7%) worked as clerical support workers and had a relatively lower monthly income from their main employment in 2016. On the other hand, a higher proportion of men (21.2%) than women (13.1%) worked as managers and administrators and professionals and enjoyed a relatively higher monthly income (Census and Statistics Department, 2017a).

e. Environmental aspects (risks of hurricanes, earthquakes, floods, etc)

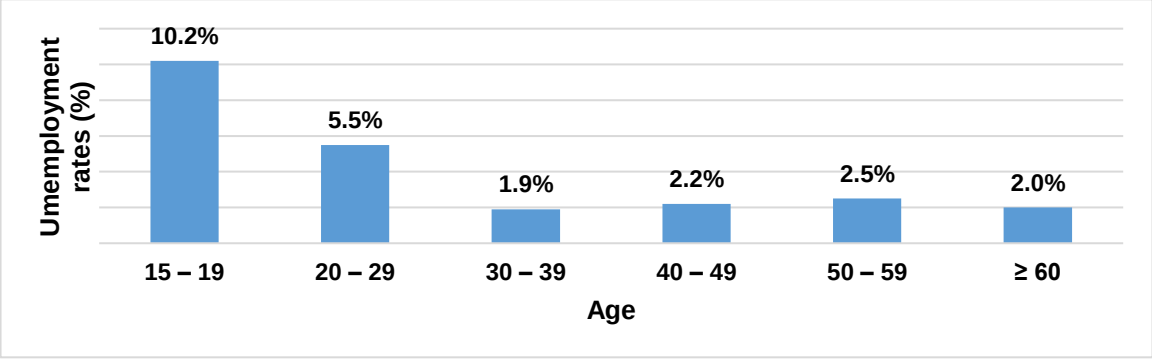
Hong Kong's climate is seasonal due to alternating wind direction between winter and summer. There are pleasant breezes, plenty of sunshine and comfortable temperatures between September and December. January and February are cloudier, with occasional cold fronts followed by dry northerly winds. March and April are milder, although there are occasional spells of high humidity. April to August is hot and humid, with occasional showers and thunderstorms. July to September is most likely to be affected by severe weather phenomena such as tropical cyclones, monsoon troughs and thunderstorms. On average, about 30 tropical cyclones form in the western North Pacific or China Seas every year, about half reaching typhoon strength. Heavy rain from tropical cyclones may last a few days, and subsequent landslips and flooding sometimes cause considerably more damage than the winds (Hong Kong Observatory, 2018). Waterspouts and hailstorms occur infrequently, snow and tornadoes are rare, and the chances of major earthquakes are very small (Hong Kong Observatory, 2018, November 27). Hong Kong is not seriously affected by tsunami (Hong Kong Observatory, 2018, November 8).

f. Employment and Unemployment Rates

In 2018, the labour force statistics estimated the unemployment rate was 2.8% (112.0 thousand people) and the underemployment rate was 1.1% (43.2 thousand people). The unemployment rates by gender for males and females were 3.2% and 2.9%, respectively. Figure 9 shows unemployment rates by age in 2018 (Census and Statistics Department, 2019i).

Figure 9

Unemployment rates by age: 2018



(Census and Statistics Department, 2019i).

g. Prevalence of the informal economy

Economic activities are highly regulated in Hong Kong and are mostly taxed. Most employers are regulated by the Companies Ordinance and Society Ordinance, and all forms of employment, including full-time, part-time, permanent and temporary, are protected by the Employment Ordinance and Employee's Compensation Ordinance. The rights and benefits of self-employed individuals without a contractual agreement are less protected, although their income is taxable. As a result, the size of Hong Kong's informal economy is very small. The two major types of informal workers in Hong Kong are foreign domestic helpers and hawkers.

Foreign domestic helpers comprise the main body of informal care workers in Hong Kong. By the end of 2018, there were a total of 386,075 foreign domestic helpers in Hong Kong, comprising 5.2% of the Hong Kong population and 9.7% of the labour force (Census and Statistics Department, 2019i). Their income is not taxable. It is important to note that, unlike other countries, the rights and benefits of foreign domestic helpers in Hong Kong are similar to local citizens, protected by the Employment Ordinance and monitored by the Immigration Department.

Hawkers are vendors selling street food and inexpensive goods. Due to concerns about the city's hygiene and health, since the 1970s, the Government began to reduce the number of hawker licenses and impose stricter restrictions on hawking activities. The number of licensed hawkers had dropped from over 70,000 in the 1940s to 50,000 in the 1970s. By the end of 2018, there were only 5,531 licensed hawkers, including fixed-pitch or itinerant (i.e., travelling) hawkers. At the same time, the Food and Environmental Hygiene Department had exerted strict control over illegal hawking activities so that there were only around 1,511 hawkers by the end of 2018 (Food and Environmental Hygiene Department, 2019, September 5).

h. Education system overview

In Hong Kong, preschool education is not free and is provided by non-profit-making and private enterprises. Primary, junior secondary and senior secondary education for 12 years is universal, mandatory and free. For post-secondary education, higher education institutions provide publicly-funded and self-financing programmes at or above sub-degree level (Education Bureau, 2019). Regarding the population's education level in 2018, the total population with no schooling / pre-primary education was 3.8% (243.9 thousand people), primary education 14.1% (920.3 thousand people), lower secondary education 15.0% (973.0 thousand people), upper secondary education 34.0% (2214.1 thousand people), post-secondary non-degree education 7.7% (503.2 thousand people), and post-secondary degree 25.4% (1651.9 thousand people). Among those aged 60 and over, the distribution of educational attainment was: 12.6% no schooling/pre-primary, 37.2% primary, 18.3% lower secondary, 21.1% upper secondary, 3.3% post-secondary non-degree, and 7.5% post-secondary degree. Table 5 shows the Hong Kong population's educational attainment by age and gender in 2018 (Census and Statistics Department, 2019h).

Table 5

Educational attainment of Hong Kong population by age and gender: 2018

	No Schooling/ Pre-Primary	Primary	Lower Secondary	Upper Secondary	Post-Secondary Non-Degree	Post-Secondary Degree
			% (No. of people in thousand)			
			15-19 years			
Females	-	-	10.2% (14.8)	58.6% (84.8)	10.7%(15.4)	20.5% (29.7)
Males	-	-	10.6% (16.4)	63.4% (97.8)	11.3% (17.4)	14.7% (22.7)
Total	-	-	10.4% (31.2)	61.0% (182.6)	11.0% (32.8)	17.6% (52.4)
			20-29 years			
Females	0.1% (0.5)	1.0% (4.8)	4.4% (21.9)	26.4% (128.8)	14.8% (72.2)	53.3% (260.5)
Males	-	0.3% (1.5)	5.0% (21.9)	25.7% (113.2)	18.2% (80.2)	50.8% (224.3)
Total	0.1% (0.5)	0.7% (6.3)	4.7% (43.8)	26.0% (242.0)	16.4% (152.4)	52.1% (484.8)
			30-39 years			
Females	0.1% (0.9)	2.7% (19.1)	9.9% (68.8)	43.0% (299.2)	8.0% (55.3)	36.3% (252.5)
Males	0.1% (0.3)	0.6% (2.9)	10.0% (46.0)	33.6% (154.1)	11.5% (52.9)	44.2% (202.3)
Total	0.1% (1.2)	1.9% (22.0)	9.9% (114.8)	39.3% (453.3)	9.4% (108.2)	39.4% (454.8)
			40-49 years			
Females	0.5% (3.2)	7.0% (47.3)	17.6% (118.1)	44.0% (295.9)	6.4% (42.7)	24.5% (164.1)
Males	0.1% (0.6)	2.2% (10.4)	18.2% (84.9)	38.6% (179.5)	7.6% (35.5)	33.3% (155.1)
Total	0.3% (3.8)	5.1% (57.7)	17.8% (203.0)	41.8% (475.4)	6.9% (78.2)	28.1% (319.2)
			50-59 years			
Females	2.1% (13.9)	17.2% (113.9)	19.7% (130.7)	41.5% (274.3)	5.6% (36.8)	13.9% (92.1)
Males	0.6% (3.7)	11.9% (68.0)	22.7% (129.5)	37.9% (216.6)	6.5% (37.1)	20.4% (116.7)
Total	1.4% (17.6)	14.8% (181.9)	21.1% (260.2)	39.8% (490.9)	6.0% (73.9)	16.9% (208.8)
			≥60 years			
Females	18.6% (170.5)	39.8% (364.7)	15.6% (142.8)	18.4% (168.4)	2.8% (25.4)	4.8% (44.2)
Males	6.0% (50.2)	34.4% (287.5)	21.2% (177.2)	24.1% (201.5)	3.88% (32.3)	10.5% (87.9)
Total	12.6% (220.7)	37.2% (652.2)	18.3% (320.3)	21.1% (369.9)	3.3% (57.7)	7.5% (132.1)
			All			
Females	5.3% (189.0)	15.3% (549.8)	13.9% (497.1)	35.0% (1251.4)	6.9% (247.8)	23.6% (843.0)
Males	1.8% (54.9)	12.7% (370.4)	16.3% (475.9)	32.9% (962.7)	8.6% (255.4)	27.7% (808.9)
Total	3.8% (243.9)	14.1% (920.2)	15.0% (973.0)	34.0% (2214.1)	7.7% (503.2)	25.4% (1651.9)

(Census and Statistics Department, 2019h).

IV. Social Protection

a. Brief Overview of social protection schemes implemented by the government

In Hong Kong, the overall objective of social security is to provide for the basic and special needs of community members who need financial or material assistance. The government operates five social protection schemes. The Comprehensive Social Security Assistance Scheme and Social Security Allowance Scheme are the two major ones, together with the Criminal and Law Enforcement Injuries Compensation Scheme, the Traffic Accident Victims Assistance Scheme and Emergency Relief.

The Comprehensive Social Security Assistance (CSSA) Scheme aims to provide a safety net for individuals who cannot support themselves financially. It is means-tested and designed to bring recipients' income up to a prescribed level to meet their basic needs. To be eligible for CSSA, a person must satisfy the residence requirement, pass financial tests of household income and assets and additional criteria for able-bodied adults. The payments are classified into three types, standard rates, supplements, and special grants (Social Welfare Department, 2019, July 30). In 2019, the standard rates for non-disabled individuals and individuals with 100%

disability aged 65 or above were HK$3,585 and HK$4,335 per month, respectively. The long-term supplement (a major type of supplement under the scheme for persons with ill-health owing to old age, disability or medical conditions) was HK$2,445 per annum (Social Welfare Department, 2019d).

The Social Security Allowance (SSA) Scheme provides a monthly allowance to Hong Kong residents to meet special needs arising from disability or old age (Social Welfare Department, 2019, September 6). It includes (1) the Old Age Allowance (HK$1,385 per month), universal payment for adults aged 70 or over; (2) the Old Age Living Allowance (HK$2,675/HK$3,585), a means-tested benefit designed for those aged 65 or over with financial difficulties, and (3) the Disability Allowance (HK$1,770/HK$3,540) provided to those with severe disability (Social Welfare Department, 2019d).

In 2019, the number of households receiving Comprehensive Social Security Assistance, the major form of social security in Hong Kong, was 222,331 (8.5% of the total 2,628,800 domestic households). Table 6 shows the number and type of social protection scheme recipients in July 2019 (Social Welfare Department, 2019, July 30).

Table 6
Number of cases by types of social protection schemes in July 2019

Type of Scheme		Number of Cases (% of total domestic household)
Comprehensive Social Security Assistance (CSSA) Scheme[#]		222,331 (8.5%)
Portable CSSA Scheme[#]		1,178 (0.1%)
Social Security Allowance (SSA) Scheme	Old Age Allowance[#]	256,295 (9.7%)
	Higher Old Age Living Allowance[#]	498,737 (19.0%)
	Normal Old Age Living Allowance[#]	50,320 (1.9%)
	Guangdong Scheme[#]	16,011 (0.6%)
	Fujian Scheme[#]	1,617 (0.1%)
	Disability Allowance[#]	148,941 (5.7%)
Criminal and Law Enforcement Injuries Compensation Scheme		425 (0.01%)
Traffic Accident Victims Assistance Scheme		6,370 (0.2%)

[#]Individuals cannot receive more than one type of these assistance concurrently.
(Social Welfare Department, 2019, July 30).

b. Brief Overview of social protection schemes implemented by development partners or international donors

In Hong Kong, various local NGOs and charities offer conditional social protection schemes for vulnerable groups and those with emergent needs through one-off cash transfers and food aid. All these schemes target individuals or families who do not benefit from government social protection schemes. For example, the “Rainbow Fund” emergency allowance provided by the Community Chest (2020 January), the “Apple Daily Fund” emergency allowance provided by the Apple Daily Charitable Foundation (2020), “SAGE Fund for the Elderly” provided by the Hong Kong Society for the Aged (n.d.), the “Emergency Fund for Divided Families” provided by International Social Service Hong Kong Branch (n.d.), the “Food for All” food assistance service provided by Tung Wah Group of Hospitals (n.d.), and “Hotmeal” food assistance services provided by Baptist Oi Kwan Social Service (n.d.).

V. Political Situation:

a. The Political system and background

On 1 July 1997, Hong Kong exited British colonial rule and became a Special Administrative Region (SAR) of the People's Republic of China under the principle of 'One Country, Two Systems’, an arrangement allowing the city

to enjoy a high degree of autonomy, including retaining its capitalist system, independent judiciary and the rule of law, free trade, and freedom of speech. According to the Basic Law, Hong Kong's political system and autonomy would remain unchanged for 50 years until 2047. It designates a three-branch system of governance led by the Chief Executive and the Executive Council, with a two-tiered system of representative government (i.e., the Legislative Council [generally referred to as LegCo] and District Councils) and the independent judiciary (Government of the Hong Kong Special Administrative Region, 2019, May-b). The government structure is described below:

The Chief Executive and Executive Council
The Chief Executive is the head of the government, elected by a Election Committee in accordance with the Basic Law and appointed by the Central People's Government. The Chief Executive is responsible for implementing the Basic Law, signing bills and budgets, promulgating laws, making decisions on government policies, and issuing Executive Orders. The Chief Executive's period of office is five years with a possible once-only consecutive renewal. (Government of the Hong Kong Special Administrative Region, 2019, May-b).

The Executive Council assists the Chief Executive in policymaking and advises the Chief Executive on matters relating to the introduction of bills and subsidiary legislation. It comprises 16 official and 16 non-official members. The Chief Executive appoints all members from among the senior officials of the executive authorities, members of LegCo and public figures. It serves for a period no longer than the expiry of the Chief Executive's term of office (Government of the Hong Kong Special Administrative Region, 2019, May-b).

LegCo and District Councils
LegCo is the law-making body of Hong Kong, currently comprising 70 members. It also debates issues of public interest, examines and approves budgets, receives and debates the Chief Executive's policy addresses, and endorses the appointment and removal of the judges of the Court of Final Appeal and the Chief Judge of the High Court (Government of the Hong Kong Special Administrative Region, 2019, May-b). The terms of LegCo are four years.

The District Councils, currently consisting of 479 seats, undertake improvement projects, and promote recreational, cultural and community activities in their respective districts. They also advise the government on matters that affect the wellbeing of residents and the adequacy and priorities of government programmes (Government of the Hong Kong Special Administrative Region, 2019, May-b) The terms of the District Councils are also four years.

The Judiciary
The Basic Law ensures that Hong Kong remains within the common law system. It is independent from the legislative and executive branches of government, with the courts showing no bias. A jury determines the accused's guilt or innocence for the most serious types of criminal offence, requiring a majority verdict. The Court of Final Appeal is the highest appellate court and is headed by the Chief Justice (Government of the Hong Kong Special Administrative Region, 2019, May-b).

b. Brief history of the country

Hong Kong was once a fishing village with floating communities. It was colonised by the United Kingdom in 1842 and handed over to the People's Republic of China in 1997. Hong Kong is best known as a glamorous city with skyscrapers and a combination of Eastern and Western culture. It is a world-class centre of business, travel and a financial hub for international trade. (Hong Kong Tourism Board, 2019). The history of Hong Kong's development is briefly described in Table 7.

Table 7

Brief history of the development of Hong Kong

Timeline	Events
700 BC	Aboriginal fishing communities establish floating communities.
50 BC	China absorbs the entire region.
AD 960-1500s	Clans settle the area and build walled villages as protection against bandits and pirates.
1514	Portuguese traders establish a base in Tuen Mun.
Early 1800s	British merchants trade opium for Chinese silks, silver, spices, and tea.
1840-1842	Opium Wars result in China ceding Hong Kong Island in perpetuity to Britain; the Crown Colony of Hong Kong is established.
1860	Kowloon Peninsula and Stonecutters Island are ceded to Britain.
1898	The New Territories are leased to Britain for 99 years; the colony becomes an important trading port.
1911-1949	Refugees fleeing from political turbulence and warfare in Mainland China increase Hong Kong's population.
1941-1945	Japanese occupation during World War II.
1950-1970s	Immigrants from China create booming textile and light manufacturing industries; 'Made in Hong Kong' goods are exported all over the world.
1980s	Hong Kong becomes an international financial centre and joins the world's top 10 economies.
1984	China and Britain sign the Sino–British Joint Declaration on the future of Hong Kong.
1997 (July 1)	Hong Kong becomes a Special Administrative Region of the People's Republic of China.

c. The timing and description of any upcoming major elections

Although Hong Kong has a high degree of autonomy, universal suffrage is currently only granted in District Council elections and elections for half of the membership of LegCo. The Chief Executive of Hong Kong is elected through an electoral college, the majority of whose members is elected by a limited number of voters mainly within the business and professional sectors.

Election of the Chief Executive

Election for the Chief Executive is held every five years, with the last one (5th term) held on 26 March 2017. It is elected by an Election Committee, which is composed of 1,200 members from 38 subsectors, comprising (a) 1,034 members from 35 subsectors who are returned through elections; (b) 106 ex-officio members (i.e., Hong Kong deputies to the National People's Congress (NPC) and Members of LegCo under the NPC subsector and the LegCo subsector; and (c) 60 members under the Religious subsector who are nominated by six designated bodies. The term of office is five years. The next election for Chief Executive is scheduled for 2022 (Constitutional and Mainland Affairs Bureau, 2019, April 30).

LegCo election

Elections for LegCo are held every four years, with the last one held on 4 September 2016 and followed by two by-elections held on 11 March and 25 November 2018. It comprises 70 members, 35 of whom are elected directly by geographical constituencies and 35 by functional constituencies (including five elected by the District Council (second) functional constituency). The next election will be held in the year of 2020 (Government of the Hong Kong Special Administrative Region, 2019, May-b).

District Council elections

Elections for the 18 District Councils are held every four years, with the last held on 24 November 2019. The District Councils are composed of 458 members, of whom 431 are elected members, and 27 are ex-officio members (i.e., Rural Committee Chairmen in the New Territories) (District Council Election 2015, 2015, September 22). The next election will be held in 2023 (Constitutional and Mainland Affairs Bureau 2019, July 8).

d. Corruption Perception Index Score by Transparency International

The Corruption Perceptions Index measures perceived levels of public sector corruption according to experts and business people. Hong Kong was ranked 14th (out of 180 participating countries) on the Corruption Perceptions Index 2018, with a score of 76/100 (Transparency International, 2019).

e. Stability

The Political Stability Indicator measures perceptions of the likelihood that the government will be destabilized or overthrown by unconstitutional or violent means, including politically motivated violence and terrorism. The measure ranges from approximately -2.5 (weak) to 2.5 (strong) governance performance. The World Bank provides data for Hong Kong since 1996. The average value for Hong Kong was 0.85 points, ranging from a minimum of -0.22 points in 2019 and a maximum of 1.34 points in 2005. In 2020, the Political Stability indicator was 0.09, which was in the 50 percentile rank (World Bank, 2020).

Part 2: Overall Health System Context

The Health System in Hong Kong is characterised by its strong public sector operating in parallel with the complementary private sector. The public sector dominates secondary and tertiary care, and the private sector is the major provider of primary care. Public healthcare in Hong Kong is universal and heavily subsidised by the government. Through the Hospital Authority and Department of Health, a wide range of comprehensive services, including inpatient care, general outpatient and specialist outpatient clinics are provided at a reduced price to all Hong Kong residents in need. Older adults and people with chronic illnesses are the major users of public healthcare services. Due to the insufficient capacity of the public sector and rapid population ageing, there are long waiting times for most public specialist services. On the other hand, private healthcare consistently serves as an option with higher flexibility for people who can afford more at their own expense and do not want to wait for the public service. General practitioners in private clinics are the most common first points of consultation in primary care in Hong Kong. In recent years, to reduce the burden on the public healthcare systems, the government has implemented various measures to retain the public sector workforce and shift the delivery of some healthcare services from the public to the private sector.

I. Health System Organisation

a. The size of the public sector, a description of the services provided through the public health system and the proportion of the population that makes use of the public health system.

The overall structure of the public health system is shown in Figure 10 (Government of the Hong Kong Special Administrative Region, 2019b). The public health services are financed by the government and regulated by the Food and Health Bureau, Department of Health and Hospital Authority.

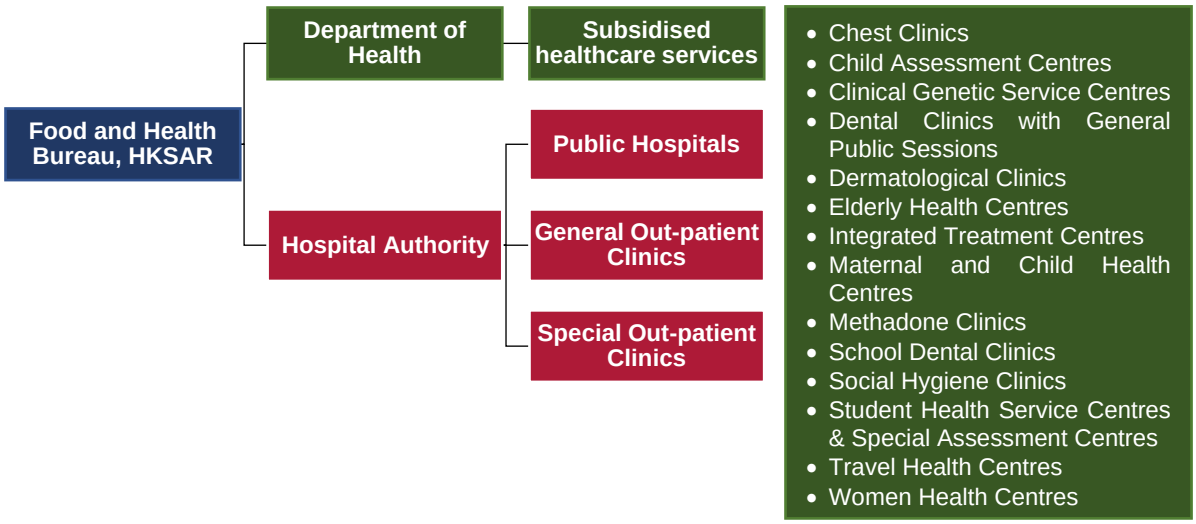
Food and Health Bureau
The Food and Health Bureau is a government policy bureau responsible for forming policies and allocating resources for health services. It ensures these policies are carried out effectively to protect and promote public health and provide lifelong holistic health care to all residents (Government of the Hong Kong Special Administrative Region, 2019b).

Department of Health
The Department of Health operates under the aegis of the Food and Health Bureau, serving as health adviser and agency to execute healthcare policies and statutory functions. It safeguards the community's health through a range of promotional, preventive, curative, and rehabilitative services. It also provides subsidised healthcare services through health centres and clinics in each district (Government of the Hong Kong Special Administrative Region, 2019b).

The Hospital Authority
The Hospital Authority is a statutory body established under the Hospital Authority Ordinance in 1990. It is accountable to the government through the Secretary of the Food and Health Bureau and provides territory-wide public hospital services. Every Hong Kong resident is eligible for subsidised healthcare services through 43 public hospitals, 73 general out-patient clinics and 49 specialist out-patient clinics operated by the Hospital Authority (Government of the Hong Kong Special Administrative Region, 2019b; Hospital Authority, 2019a).

Figure 10

Overall structure of the public health system in Hong Kong



(Government of the Hong Kong Special Administrative Region, 2019b)

The public sector provides most of the secondary and tertiary care services in Hong Kong. The public hospitals under the Health Authority manage approximately 80% of all hospital admissions, and the share of total bed-days reaches almost 90%. As at 31 March 2019, a total of 28,929 hospital beds were provided in public hospitals. Nearly all critical emergencies are tackled by public hospital accident and emergency departments (Food and Health Bureau, 2017b). Table 8 shows the use of public healthcare services under the Hospital Authority by type of service in 2018/19.

Table 8

Use of Hospital Authority public healthcare services by type of service: 2018/2019

Category	Service type	Count
Inpatient and day inpatient services	Discharges and death	1,835,869
	Live births	35,227
	Allied health attendances	6,022,405
Ambulatory services	Accident & Emergency attendance	2,157,617
	Specialist outpatient (clinical) attendances	7,901,849
	Primary care attendances	6,370,993
	Allied health attendances	2,865,372
	Geriatric day attendances	192,859
	Psychiatric day attendances	225,663
Outreach services	Home visits by community nurses	890,668
	Allied health attendances	36,003
	Geriatric outreach attendances	679,871
	Psychiatric outreach attendances	306,327
Other services	Radiodiagnostic attendances	4,109,070
	Operations undertaken inside operating theatres	196,568

(Hospital Authority, 2019b)

The Census and Statistics Department conducted a household survey on the population's use of doctor consultations, hospitalisations, and dental consultations in 2016/17. The findings of the survey are summarised in Table 9. While only 29.2% of doctor consultations took place in the public sector, 70.9% of hospital admissions were handled by public hospitals under the Hospital Authority. A further breakdown of these findings by age and gender can be found from the survey report (Census and Statistics Department, 2017, December).

Table 9

Use of doctor consultations, hospitalisations and dental consultations: 2016/2017

Doctor consultations	
Number of persons who had consulted a doctor in the last 30 days (% of total Hong Kong population)	1,529,100 (21.9%)
Total number of doctor consultations in the last 30 days	2,203,400
Distribution by sector:	
Public	29.2%
Private Western medicine practitioner	49.5%
Private Chinese medicine practitioner	18.1%
Hospitalisations	
Number of persons admitted to hospital in the last 12 months (% of total Hong Kong population)	648,100 (9.3%)
Distribution by sector:	
Public	70.9%
Private	30.7%
Dental Consultations	
Number of persons who had a dental consultation in the last 12 months (% of total Hong Kong population)	2,723,300 (39.0%)
Distribution by sector:	
Public	23.9%
Private	72.1%
Others	4.0%

(Census and Statistics Department, 2017, December)

b. The size of the private sector, a description of the services provided through the private health system and the proportion of the population that make use of the private health system.

There are 12 private hospitals and 2,146 registered private clinics in Hong Kong (Electronic Health Record Registration Office, 2019) providing hospital services, primary care and a broad range of specialist services. As of 31 March 2019, 4,657 hospital beds were provided in private hospitals (Department of Health, 2019b). The Department of Health regulates all private hospitals and clinics under the Medical Clinics Ordinance (Cap.343) on their compliance with relevant regulations by conducting inspections and handling medical incidents and complaints lodged by the public. All Western and Chinese medicine practitioners must register with the Medical Council of Hong Kong and the Chinese Medicine Council of Hong Kong, respectively (Hospital Authority, 2019a).

The private sector dominates the provision of primary care in Hong Kong, accounting for about 70% of all medical and dental visits (Food and Health Bureau, 2017b). The proportion of the population making use of doctor consultations, hospitalisations, and dental consultations in the private sector in 2016/17 is summarised in Table 9 above. Most doctor consultations (67.6%), 49.5% with Western medicine practitioners and 18.1% with Chinese

medicine practitioners occurred in the private sector. In contrast, only 30.7% of hospitalisations were handled by the private sector (Census and Statistics Department, 2017, December).

c. How are health services accessed?

Every resident in Hong Kong can access primary care services directly by walking-in or appointment. Private practitioners are distributed throughout almost all local communities for convenient access. The government established the Primary Care Directory, a web-based electronic database containing contact details, practice information and professional qualifications of primary care providers in Hong Kong. It enables the public to search for suitable family doctors, dentists and Chinese medicine practitioners in the community (Food and Health Bureau, 2019c). For public healthcare, as general outpatient clinics are usually overloaded with older adults and people with chronic illnesses requiring regular follow-up, those who cannot afford private doctor consultations or insist on using public primary care have to walk in and queue for the daily quota of appointments early in the morning or make a telephone booking for an appointment in the next 24 hours. The Telephone Appointment System of public general outpatient clinics operates 24 hours a day. In 2016, the government introduced the Electronic Health Record Sharing System (eHRSS), a territory-wide, patient-oriented electronic sharing platform for authorised public and private health practitioners to access and share participating patients' health records to enable more timely diagnosis and treatment and reduce duplicate diagnostic tests (Government of the Hong Kong Special Administrative Region, 2019, October). The public ambulance 999 service for emergency services is free for anyone in Hong Kong. For access to public or private secondary and tertiary care, a referral from a general practitioner is necessary.

i. Does primary care access act as a gatekeeper system for access to secondary and tertiary care?

Primary care is the first point of contact for continuing the healthcare pathway in Hong Kong. Primary care practitioners act as gatekeepers, making recommendations and referrals to specialists according to patients' health care needs (Kung, 2007; Ng, 2006). While there is a long waiting time for public specialist outpatient services, patients can opt for an appointment with private hospital and clinic specialists at their own expense to reduce the waiting time.

ii. Is access to health services universal? What are potential barriers? Are there specific geographical areas or population groups for which access to health care is problematic?

Hong Kong's health system provides universal access to a wide range of public healthcare services, including inpatient care, general and specialist outpatient care, health protection and promotion, prevention services, and community services. However, as in many developed countries, affordability is a significant barrier to effective use of healthcare services in Hong Kong. In particular, inequity is most apparent in access to outpatient services. Long waiting times are a huge and common issue for public specialist outpatient and accident and emergency services (Leung & Bacon-Shone, 2006; Our Hong Kong Foundation, 2018). Such long waiting times disproportionately impact patients on lower incomes who have difficulty affording private care and are left to live with diminished access to public health services (Yam et al., 2011).

II. Health System Financing

a. How is the health system financed?

The public health system is fully financed by the government from taxation, following the policy that no one in Hong Kong should be denied medical care due to lack of means. Nearly 93% of the costs involved in delivering public health services are financed by public funding. The public system thus serves as a safety net for residents

by making public health services available to all residents at an affordable price. People with financial difficulties are exempted from paying medical fees and charges for health services. Under the medical fee waiving mechanism, Comprehensive Social Security Assistance recipients and other vulnerable people who meet certain financial and social criteria are exempted from paying public health care expenses (Food and Health Bureau, 2017b).

The private health system is financed through patients' out-of-pocket payments, offering those who can afford it and are willing to pay for more flexible services at their own expense (Food and Health Bureau, 2017b). The government also provides different funds for patients in need to pay for their medical fees and charges, for example, the Samaritan Fund, the Community Care Fund Medical Assistance Programmes, and the Health Care Voucher. The Samaritan Fund provides financial assistance to needy patients for designated privately purchased medical items or new medical treatment technologies which are not covered by the standard fees and charges in public hospitals and clinics (Hospital Authority, 2020b). The Community Care Fund Medical Assistance Programmes assist patients in purchasing specified self-financed cancer drugs, ultra-expensive drugs and specified implantable medical devices for interventional procedures (Hospital Authority, 2020a). The Health Care Voucher provides $2,000 annually to people aged 65 and above choosing private health services, including preventive care (Health Care Voucher, 2019, June 26).

b. What proportion of the population is not covered by health insurance (private or public)?

Health insurance is not mandatory in Hong Kong. Residents can choose to buy private health insurance based on their own needs. In 2016, 3.26 million people (47% of the total population) were protected by private health insurance, comprising 1.48 million people with individual-based health insurance policies, 0.86 million people with group-based policies and 0.92 million people with both types of policies (Legislative Council Secretariat, 2018, July). Health insurance claims are usually used to pay for specialist services and hospitalisation in the private sector enabling patients to access healthcare services without waiting.

In April 2019, the government officially launched the Voluntary Health Insurance Scheme that aims to encourage the public to purchase health insurance to reduce long-term pressure on the public health system (Food and Health Bureau, 2019d). Hospital insurance products offered by various insurance companies meeting prescribed minimum standards are certified under the Voluntary Health Insurance Scheme. As an incentive to join the Voluntary Health Insurance Scheme, an annual tax deduction up to HK$8,000 is provided per premium paid for certified insurance plans by each insured person and their dependants (Legislative Council Secretariat, 2018, July). As of the end of September 2019, more than 300 000 insurance policies had been purchased under the Voluntary Health Insurance Scheme.

c. Are there any planned changes to the financing strategies or financing mechanisms to fund the health system (e.g. plans for social health insurance, payroll taxes etc.)?

No or none currently under public consultation.

d. Who is responsible for deciding how much funding is available for health care in your country?

The government is responsible for allocating funding for healthcare services in Hong Kong. It involves the Chief Executive, LegCo, the Financial Secretary, and the Secretary of the Food and Health Bureau, working together to ensure the equitable distribution, allocation, and utilisation of financial resources for health care services.

e. What is the process for deciding how much funding is available for health service provision in Hong Kong? (e.g., timing of budget processes and cycles).

In Hong Kong, the control and management of public finances are governed by the Public Finance Ordinance (Cap. 2). Preparation of the estimates of the government's revenue and expenditure for the upcoming financial year is the responsibility of the Financial Secretary. Approval of the Budget rests with LegCo (Legislative Council Secretariat, 2019b). The budgetary process follows the cycle outlined below in Table 10.

Table 10

Budgetary process cycle in Hong Kong.

Timeline	Budgetary process cycle
August / September (previous year)	The Chief Executive conducts the first round of Budget consultations on expenditure for the next year's Budget as part of the Policy Address consultations.
September / October (previous year)	The Financial Secretary gives out operating expenditure envelopes to bureaux and departments.
October (previous year)	Beginning of the new legislative session. The Chief Executive delivers the Policy Address.
October (previous year) to February	The Financial Secretary conducts the second round of Budget consultations on revenue for next year's Budget.
February	The Financial Secretary introduces the Appropriation Bill and the Estimates of Expenditure into LegCo. First and Second Reading of the Appropriation Bill.
February to March (following year)	The President of LegCo refers the Estimates of Expenditure to the Finance Committee for examination. The Finance Committee examines the Estimates of Expenditure. The Appropriation Bill is debated and passed by LegCo. Resumption of Second Reading debate and Third Reading of the Appropriation Bill. After passage of the Appropriation Bill, the Finance Committee examines the government's proposals to change the approved Estimates of Expenditure.
31 March (following year) June / July (following year)	End of financial year. The Financial Secretary or the Secretary for Financial Services and the Treasury introduces the Supplementary Appropriation Bill to seek approval of a supplementary appropriation for the government's services.

f. Who sets the priorities for funding?

The Government sets annual budget priorities. The Chief Executive and Financial Secretary conduct Budget consultations, Appropriation Bill, Estimates of Expenditure and Reading debates through LegCo to decide how the funding should be spent.

g. How are health budgets allocated and dispersed, across levels of the health system, in Hong Kong? Do health budgets get dispersed through geographical areas?

For each financial year, the Financial Secretary decides on the allocation of health budgets for the Hospital Authority and the Department of Health, the two main bodies in charge of public healthcare services. After receiving the budget allocated, they decide their own internal budget allocation. According to the 2019-2020 Budget, the estimated recurrent government expenditure on public healthcare services was increased by 10.9% to $80.6 billion in 2019-2020, accounting for 18.3% of the total recurrent government expenditure (2019-20 Budget, 2019a). The Government increased the recurrent financial provision for the Hospital Authority by 8% to $68.8 billion and for the Department of Health by 27.9% to $13,301 million. The government also committed to

sustain the development of public healthcare with the establishment of a $10 billion public healthcare stabilisation fund (2019-20 Budget, 2019b; Hospital Authority, 2019c).

The health budget for the Hospital Authority was further dispersed through the seven clusters (Hong Kong East, Hong Kong West, Kowloon Central, Kowloon East, Kowloon West, New Territories East, and New Territories West) responsible for different geographical areas by considering several factors, population growth, demographic changes, the incidence of chronic illness, healthcare service utilisation patterns, and organisation of services for each cluster and hospital. The recurrent budget allocations for each cluster in 2012 – 2017 are listed in Table 11. Within each cluster, the budgets are further dispersed through programme areas in response to the service needs of each cluster.

Table 11

Recurrent budget allocation for each cluster under the Hospital Authority: 2012 – 2017

Year	Hospital Authority Cluster						
	Hong Kong East	Hong Kong West	Kowloon Central	Kowloon East	Kowloon West	New Territories East	New Territories West
	(HK$ billion)						
2012-13	4.39	4.53	5.47	4.12	9.00	6.49	5.20
2013-14	4.63	4.80	5.84	4.49	9.72	6.91	5.56
2014-15	5.01	5.17	6.25	4.94	10.65	7.44	6.08
2015-16	5.37	5.56	6.65	5.28	11.46	8.13	6.71
2016-17	5.63	5.89	7.10	5.66	12.06	8.62	7.27

(Government of the Hong Kong Special Administrative Region, 2017)

h. How are health budgets allocated and dispersed, across program area, in Hong Kong?

The Department of Health budget is dispersed across its eight programme areas, the top three of which in 2019 were disease prevention (57.5%, HK$7,654.3 million), medical and dental treatment for civil servants (15.9%, HK$2,111.1 million), and statuary functions (10.9%, HK$ 1,451.9 million). Table 12 indicates estimations of its expenditure and the percentages of budget allocation in 2019 (2019-20 Budget, 2019b).

Table 12

Estimations of expenditure and percentages of allocation among eight Department of Health programmes

Programme area	Expenditure estimates (HK$ million)	Percentages of budget allocation
Statutory functions	1,451.9	10.9%
Disease prevention	7,654.3	57.5%
Health promotion	486.4	3.7%
Curative care	1,227.3	9.2%
Rehabilitation	162.2	1.2%
Treatment of drug abusers	197.2	1.5%
Medical and dental treatment for civil servants	2,111.1	15.9%
Personal management of civil servants working in hospital authority	10.4	0.1%

(2019-20 Budget, 2019b)

i. What proportion of the population purchases private health care insurance?

1.48 million people purchased private individual-based health insurance in 2016. The penetration ratio of individual-based health insurance products in the local population has surged from 20% in 2006 to 34% in 2016. Although almost all insurance policies cover inpatient care, less than three-fifths of insured persons received such care in private hospitals due to hesitation on premium transparency and budget certainty in existing products (Legislative Council Secretariat, 2018, July).

j. Are private insurance markets regulated?

The Insurance Authority is an insurance regulator independent of the government. It has modernised the regulatory infrastructure to facilitate the stable development of the Hong Kong insurance industry, provide better protection for policy holders, and comply with the International Association of Insurance Supervisors' requirements (Insurance Authority, n.d.).

k. What proportion of the population incurs out-of-pocket expenses to access health services?

In 2017/2018, 49% of current health expenditure was covered by the government, 34% by household out-of-pocket payments, and 16% via privately purchased and employer-based insurance schemes. High out-of-pocket expenses indicate a potentially catastrophic impact of ill health on family incomes in Hong Kong (Food and Health Bureau, 2019b).

l. Do remittances play an important role in the financing of health care in your country?

No, remittances are not related to financing health care in Hong Kong.

m. Does your country receive a significant amount of donations (of time, skills, or equipment) from other countries or individuals located outside of the country to support the healthcare system?

No, there are no significant donations from outside Hong Kong to support the healthcare system.

III. Health system workforce

a. Size and structure of the health workforce:

In 2019, Hong Kong had 196 doctors, 2 geriatricians, 2 neurologists, 5 psychiatrists, 99 Chinese medicine practitioners, 567 registered nurses, 190 enrolled nurses, 46 physiotherapists, 32 occupational therapists, and 326 social workers per 100,000 population (Department of Health, 2019b; Medical Council of Hong Kong, 2017; Occuptional Therapists Board, 2020, January; Physiotherapists Board, 2020, January; Social Workers Registration Board, 2019). The numbers of registered healthcare professionals and the distribution by sector are shown in Tables 13 and 14, respectively (Department of Health, 2019b; Medical Council of Hong Kong, 2017; Social Workers Registration Board, 2019); (Food and Health Bureau, 2017b).

Table 13

Registered numbers, workforce per 100,000 population and health professionals to population ratios in Hong Kong

Profession	Registered numbers	Workforce per 100,000 population	Health professionals to population ratios
Doctors	14,651	196	1:511
Geriatricians	160	2	1:46792
Neurologists	124	2	1:60376
Psychiatrists	376	5	1:19911
Chinese medicine practitioners	7,409	99	1:1010
Registered nurses	42,485	567	1:176
Enrolled nurses	14,238	190	1:526
Physiotherapists	3,476	46	1:2154
Occupational therapists	2,383	32	1:3142
Social workers	24,442	326	1:306

(Department of Health, 2019b; Medical Council of Hong Kong, 2017; Social Workers Registration Board, 2019).

Table 14

Distribution of healthcare professionals by sector at end of 2016

Profession	Public sector	Private sector
Doctors	51%	49%
Registered nurses	83%	17%
Enrolled nurses	66%	34%
Chinese medicine practitioners	12%	88%

(Food and Health Bureau, 2017b)

b. Are there any patterns (i.e. in terms of job roles, organisations, geographical locations…) of health staff vacancies (or with high turnover rate) that have been identified in the health system?

In Hong Kong, there is a general shortage in the healthcare workforce (Food and Health Bureau, 2017b). According to the Association of Hong Kong Nursing Staff, the nurse-to-patient ratio of night-shifts in public hospitals in 2013 was 1:24, meaning that each nurse needed to care for 24 patients on average. This ratio was far worse than the international standard at 1:6 (Government of the Hong Kong Special Administrative Region, 2018, April 25). In 2016-2017, there was a shortfall of 300 doctors and 600 nurses. By projection to 2030, there will be a shortage of over 1,000 doctors and 1,600 nurses (Government of the Hong Kong Special Administrative Region, 2017, July 12). The actual health service workforce requirements were projected from 138,000 in 2017 to 183,800 in 2027. The projected average annual rate of change was +2.9% (Census and Statistics Department, 2019d).

The Hospital Authority has implemented various measures to retain staff and alleviate the tight workforce situation of frontline nursing staff, including continuous recruitment of nurses, ward clerks and assistants, establishing the Special Retired and Rehire Scheme, enhancement of promotion and training opportunities, improvement of the work environment, enhancement of preceptorship support, and reinstating the annual increment mechanism (Government of the Hong Kong Special Administrative Region, 2018, April 25). To address workforce shortages in the short-term, the Hospital Authority has employed non-locally trained doctors with limited registration to practise in Hong Kong (Government of the Hong Kong Special Administrative Region, 2017, July 12). In addition, the Government has substantially increased the number of funded healthcare training places by about 60% (about 1,800 students) over the past ten years. It has also encouraged self-financing institutions to

provide more subsidised training places (about 860 students) for healthcare professionals in the 2018/19 academic year (Government of the Hong Kong Special Administrative Region, 2018, April 25).

c. Does migration (within and between countries) play a role in the availability of health care workers? What are the migration patterns?

Up to 2019, locally trained healthcare workers usually stay in Hong Kong to practice their profession. Migration does not play a significant role in the availability of healthcare workers in Hong Kong.
For doctors, up to the end of 2018, overseas-trained doctors constituted 24.9% of the total doctor supply in Hong Kong. This proportion is expected to continue to shrink due to retirement and other reasons as the criteria for overseas-trained doctors to practice in Hong Kong have become very stringent since September 1996. Among the doctors in practice, the number trained overseas who qualified after 1996 (506) is only one-sixth of the number qualifying before 1996 (3152) (Legislative Council Secretariat, 2019a). If the existing policy for employing overseas-trained doctors remains unchanged, locally-trained doctors will continue to be the main source of medical practitioners in Hong Kong. The situation is to be updated when more recent data become available

Part 3: Overview of the Long-term Care System Context

Hong Kong has a universal public long-term care system mainly implemented by the Social Welfare Department and various NGOs. Long-term care services cover both community and residential care for older adults with proven needs under a standardized care need assessment mechanism. Facing the ageing population, the government aims to promote "ageing-in-place" to encourage older adults to age at home rather than being institutionalized by strengthening the provision of community care services in recent years. However, the long-term care system is criticised for the long waiting time for subsidised services, unbalanced resources for residential over community care and heavy reliance on government finance. Partly owing to the insufficient capacity of community care, many older adults have chosen to enter residential care homes for their late life, resulting in Hong Kong's high institutionalisation rate compared with other developed countries.

I. Long-term care System Organisation

a. Does your country have a public long-term care system? If so, please provide a description of its coverage: is it a universal system (i.e. everyone who needs care is covered, irrespective of income, professional group, etc.), or residual (the public system only covers those without means to pay for their own care or without family support, or it only covers specific parts of the population)? What are potential barriers to access?

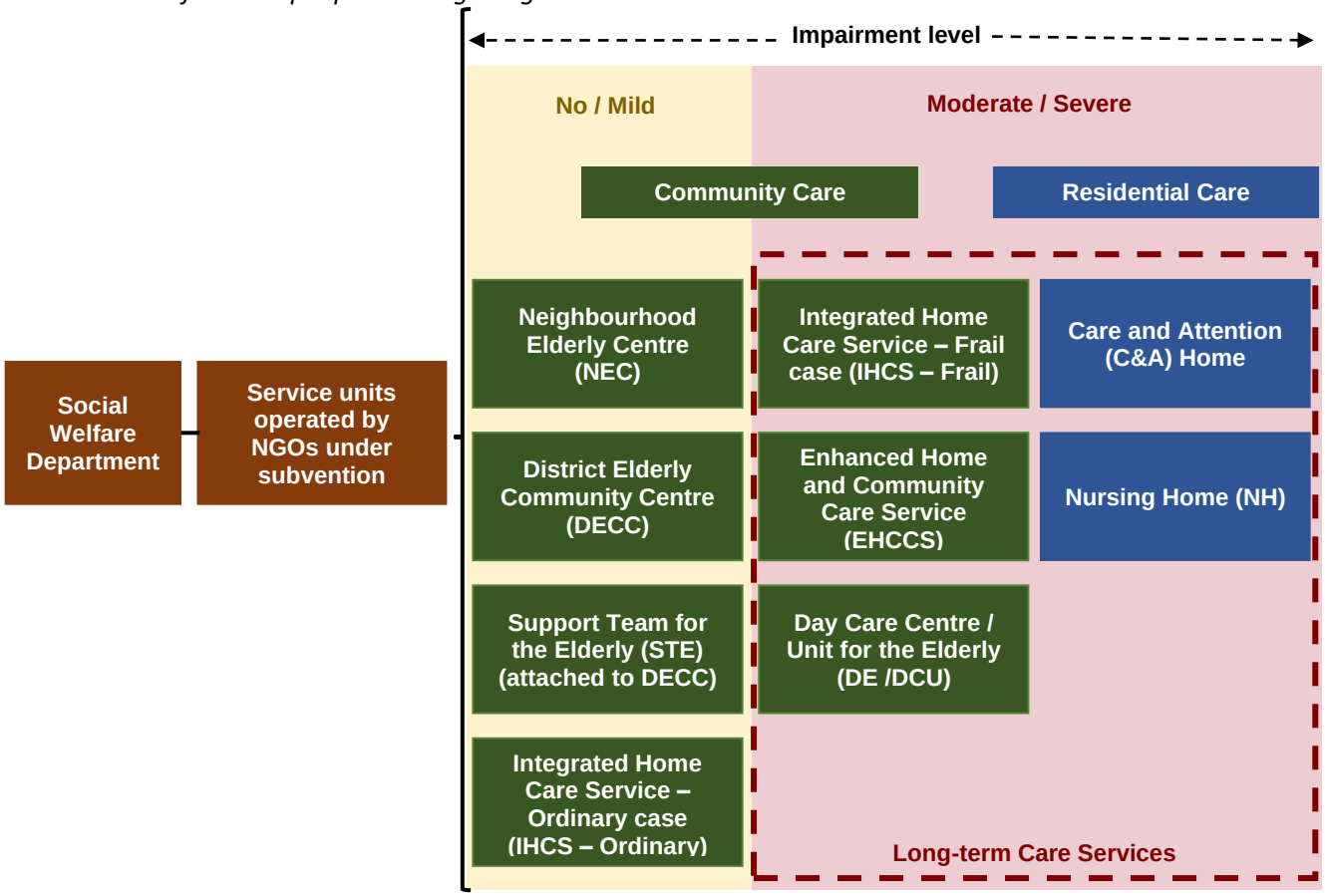
Hong Kong has a public long-term care system, a universal system building on the principle of social equity. Long-term care services in Hong Kong are regulated by the Social Welfare Department and provided by various NGOs under public subvention to citizens aged 65 and over with proven care needs assessed under the Standardised Care Need Assessment Mechanism for Elderly Services. The Mechanism covers applications for subsidised community care and residential care services. Under this Mechanism, assessors who are professionals from various disciplines, such as social workers, nurses, occupational therapists, and physiotherapists, must undergo training and accreditation to use the assessment tool. Older people are eligible for subsidised long-term care services if they are assessed as moderately or severely impaired (e.g., defined by age, physical and cognitive functional disability, and dependency) under the Standardised Care Need Assessment Mechanism for Elderly Services. If subsidised care places are not readily available, eligible older people will be placed on the Central Waiting List on a first-come-first-served basis according to their registration dates and preferences. The major potential barrier to accessing long-term care services in Hong Kong is their insufficient supply, which results in long waiting times for different types of service (Social Welfare Department, 2019a). As public long-term care services in Hong Kong are universal, nearly fully subsidised and distributed over the territory, factors such as gender, race, income, and geographical location did not contribute to barriers to access long-term care services.

b. Description of the long-term care services provided through the public long-term care system and the proportion of the population that makes use of the public long-term care system. The size of public sector.

Public services in Hong Kong for older people are broadly divided into community care and residential care services, as illustrated in Figure 11. Community care and support services are provided by 41 District Elderly Community Centres, 169 Neighbourhood Elderly Centres, 60 teams of Integrated Home Care Services, 34 teams of Enhanced Home and Community Care Services and 77 Day Care Centre/Units for the Elderly. Only Integrated Home Care Services for frail older people, Enhanced Home and Community Care Services and Day Care Centre/Units for the Elderly are categorised under long-term care services. Residential Care Services currently consist of two types of residential care homes, Care-and-attention Homes and Nursing Homes. As of 31 December 2019, there were a total of 28,160 (37% of total residential places) subsidised residential places (Social Welfare Department, 2019c).

Figure 11

Public services for older people in Hong Kong



The needs for both community and residential care services generally increase with age. Table 15 shows the distribution of community and residential care service users by age between 2012 and 2015. Around 70% of community care services and 80% of residential care services recipients were aged 80 and over (Working Group on Elderly Services Programme Plan, 2017).

Table 15

Distribution of community and residential care service users by age: 2012-2015

Age	Community Care Services			Residential Care Services		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
	%					
60-64	1.9	1.8	1.7	0.7	0.6	0.7
65-69	5.2	4.9	5.2	3.1	3.2	3.6
70-74	8.3	7.9	7.6	5.6	5.2	5.2
75-79	17.8	16.8	15.2	12.2	11.7	11.0
80-84	27.7	27.1	26.2	20.7	21.0	20.1
85+	39.2	41.4	44.1	57.8	58.2	59.3

(Working Group on Elderly Services Programme Plan, 2017)

In 2016, the total number of subsidised long-term care places was 37,957, including 11,404 community care services places and 26,553 residential care services places. It is projected that the total demand for subsidised long-term care services will increase from 59,572 places in 2016 to 77,989 places in 2030, reaching a peak of

124,609 places in 2051. With the rapid increase in the ageing population, together with the decrease in capacity of family carers in the coming decades, there will be a severe upward pressure on the demand for long-term care services, especially for residential care services (Working Group on Elderly Services Programme Plan, 2017). On 31st December 2019, a total of 10,573 applicants were on the waiting list for subsidised community care services with an average waiting time of 14-15 months (Social Welfare Department, 2020e), and 41,011 applicants for residential care services with an average waiting time of 20-22 months (Social Welfare Department, 2020i).

The Social Welfare Department also launched the Pilot Residential Care Services Scheme in Guangdong, a nearby province in mainland China, which gives elderly persons the opportunity to choose to live in subsidized residential care homes for the elderly in Shenzhen and Zhaoqing operated by two Hong Kong NGOs (Social Welfare Department, 2019, September 30).

c. Description of the services provided through the private long-term care sector (if applicable) and the proportion (and characteristics) of the population that make use of the private long-term care services. The size of the private sector.

The private sector provides both community and residential care services in Hong Kong. NGOs provide community care services on a self-financing or full cost-recovery basis. As of 31 March 2019, there were 81 self-financing Day Care Centres for the Elderly (Social Welfare Department, 2019a). Private organisations provide mostly home-based private nursing services. NGOs and private organisations provide a total of 47,644 non-subsidised residential places in private nursing homes as of 31 December 2019 (63% of the total number of residential places) (Social Welfare Department, 2019c). Currently, there is no information on the proportion and characteristics of private long-term care services users.

II. Long-term Care System Financing

a. In the public long-term care system

i. How is the public long-term care system financed?

The government is the main funding body of public long-term care services. Taxes, a land premium and investment income provide its major sources of revenue. There is no long-term care insurance in Hong Kong. On average about 80-90% of the unit service cost of subsidised long-term care is borne by the government. Service users pay only 4% of the cost of home-based community care services and 10% of centre-based community care services. Residential care service users generally pay 10-20% of the cost. In most cases, service users pay the full cost of non-subsidised services provided by self-financing NGOs and private organisations. Around 80% of the users of non-subsidised residential care service receive an indirect full subsidy from the government through the Comprehensive Social Security Assistance Scheme (Working Group on Elderly Services Programme Plan, 2017).

ii. Who is responsible for deciding how much funding is available for long-term care in your country?

The Hong Kong government is responsible for deciding the funding for long-term care services, involving the Chief Executive, LegCo, the Financial Secretary, and the Secretary for Labour and Welfare working together to ensure the equitable distribution, allocation, and utilisation of public financial resources for long-term care services.

iii. What is the process for deciding how much funding is available for long-term care service provision in Hong Kong? (e.g. timing of budget processes and cycles).

In Hong Kong, the control and management of public finances are governed by the Public Finance Ordinance (Cap. 2). Preparation of the estimates of the government's revenue and expenditure for the upcoming financial year is the responsibility of the Financial Secretary, while approval of the Budget rests with LegCo (Legislative Council Secretariat, 2019b). For an illustration of the budgetary process, please refer to Table 10 in Part 2 - II item e.

iv. Who sets the priorities for funding?

The Hong Kong government sets the budget priorities annually. The Chief Executive and Financial Secretary conduct Budget consultations, Appropriation Bill, Estimates of Expenditure and Reading debates through LegCo to make decisions on spending the funding. The Elderly Commission was established in 1997 to serve as a platform facilitating coordination among bureaux, departments and organisations to provide advice to the government (Working Group on Elderly Services Programme Plan, 2017).

v. How are long-term care budgets allocated and dispersed, across levels of the long-term care system, in Hong Kong? Do budgets get dispersed through geographical areas?

Long-term care budgets are allocated to the Social Welfare Department and then dispersed across various service providers of subsidised services in different districts and providing different types of service. Subsidised community care services are provided predominantly by non-governmental organizations (NGOs), receiving most of their funding from the government, supplemented by donations and user fees. Residential care services are delivered by a mix of NGOs and private providers. The government provides financial subsidies to NGOs through subvention with service quality monitored by the Social Welfare Department (Yuen, 2014). Despite the long standing government policy of "ageing in place", there is a significant imbalance in government expenditure on residential care ($4,793.9 million) and community care ($2,364.6 million) according to the 2017-2018 financial year report (Legislative Council Secretariat, 2019, December 13).

vi. How are long-term care budgets allocated and dispersed, across program area, in Hong Kong?

The Lump Sum Grant is the key means of subvention for long-term care services. It was introduced in 2000-2001 for voluntary adoption by NGOs. The Social Welfare Department no longer imposes rigid input controls on NGOs' staffing and salary structures or individual items of expenditure. Recurrent funding is granted to NGOs in a lump sum, and NGOs are given greater autonomy and flexibility to deploy resources and re-engineer their services to meet changing social needs. As of 1 August 2018, 164 of 169 subvented NGOs participated in the Lump Sum Grant system, the subvention for these NGOs representing over 99% of the total recurrent subvention for 2017-18 (Social Welfare Department, 2019b). Some NGOs receive large subsidies from the government, covering almost full operating expenses, capital costs and the provision of premises. Some NGOs and private providers operate on a self-financing basis. The government also has a programme to subsidize residents to stay in privately run facilities, known as the "Enhanced Bought Place Scheme" (Yuen, 2014).

In addition, the government has from time to time, applied for funding from the Lotteries Fund to finance the development of services for older people. These included funds for the construction and setting up of contract residential care homes for older people and implementing various welfare projects and schemes for older people (e.g., the Pilot Scheme on Community Care Service Voucher for the Elderly). NGOs may also apply for grants to meet the capital costs of projects in connection with services they provide for older people (Audit Commission, 2014, October).

vii. Are some aspects of long-term care covered by the country's main health financing mechanisms?

Health insurance is not mandatory, and long-term care insurance is not available in Hong Kong. As a result, most long-term care services in Hong Kong are financed by the government. Other than the government's direct budget, long-term care is partly funded through other mechanisms but still indirectly from the government. The government finances public long-term care services by direct budget allocation. The service cost for Comprehensive Social Security Assistance Scheme recipients using private long-term care services will also be covered by the government through social security payment (i.e., indirect subsidy). Around 80% of non-subsidised residential care service users are Comprehensive Social Security Assistance Scheme recipients (Working Group on Elderly Services Programme Plan, 2017).

b. Are there private long-term care insurance products available in your country? If so, what proportion of the population purchases private long-term care insurance? Are private insurance markets regulated?

No private long-term care insurance is available in Hong Kong.

c. Is there any data on the proportion of the population that incurs out-of-pocket expenditure when purchasing long-term care services, the amounts of out-of-pocket expenditure on LTC and on the numbers of people incurring catastrophic levels of out-of-pocket expenditure?

The out-of-pocket charges for private community daycare services range from $2,300 to $7,200 per month (compared with $900 to $1,000 per month for subsidised services). The charges for private professional care services range from $160 to $200 per 45 minutes for nurse/occupational therapist/physiotherapist services, and $50 to $100 per hour for personal care worker/health worker services (compared with $5.4 to $19 per month for subsidised services). The charges for miscellaneous domiciliary care services (i.e., home cleaning, home attending, home care, meal delivery, escort services) range from $25 to $100, while some service providers offer concessionary charges for social security recipients (Sau Po Centre on Ageing, 2011).

To relieve the burden of out-of-pocket payments, the government launched a Pilot Scheme on Community Care Service Voucher for the Elderly with a maximum number of 7,000 vouchers. Older people are required to pay a co-payment amount according to the value of the service package (i.e., monthly voucher values are $9,600, $8,150, $7,260, $5,810 and $4,020) while the government will pay for the remaining amount of the service package value. Under the "affordable users pay" principle, the less the older person can afford, the more the government subsidises (Social Welfare Department, 2020, January 23).

The monthly charge for non-subsidised residential care places in self-financing homes, contract homes and private homes vary widely from $4,500 to $21,000 (compared with $1,656 to $2,060 per month for subsidised services) (Social Welfare Department, 2019, November 7). There are also additional miscellaneous charges to cover other items such as out-patient escort services ($100 to $500 per time), diapers ($5 to $10 per use / $500 to $2,400 per month), toilet paper ($2 to $5 per roll), TV electricity ($50 to $200 per month), air conditioning ($95 to $300 per month) and initial administrative fees. Medical services such as wound cleaning, blood glucose testing and medical check-ups may also being charged (Consumer Council, 2015, September 15).

The government has launched the Pilot Scheme on Residential Care Service Voucher for the Elderly with a total of 3,000 vouchers. Older people are required to pay for a scale of co-payment at eight levels according to an income and asset test (i.e., the monthly voucher value is $15,263), while the government will pay for the remaining amount of the service. Under the "affordable users pay" principle, the less that the older person can afford, the more the government subsidises (Social Welfare Department, 2020, February 3).

d. Do remittances play an important role in the financing of long-term care in your country?

No, remittances are not relevant for long-term care financing in Hong Kong.

e. Are there any planned changes (reforms) to the organisation and financing of the long-term care system?

The Social Welfare Department is currently updating the assessment tool of the Standardised Care Need Assessment Mechanism for Elderly Services and reform of the long-term care service matching mechanism.

According to the 2019 Policy Address, the government plans to provide an additional 1,000 service vouchers (total up to 8,000) under the Pilot Scheme on Community Care Service Voucher for the Elderly, and an additional 3,000 service quotas under the Integrated Home Care Services (Frail Cases) (Chief Executive, 2019, October 18).

III. Long-term Care Workforce

a. Size and structure of the long-term care workforce

The Census and Statistics Department keeps a good record of the number of employees by industry in Hong Kong. As of September 2019, the residential care services workforce comprised 33,834 people (5,777 males and 28,057 females), and the social work services workforce comprised 31,812 people (7,977 males and 23,835 females) (Census and Statistics Department, 2019, September). The type of professions in the long-term care workforce includes social workers, registered nurses, enrolled nurses, physiotherapists/physiotherapist assistants, occupational therapists/occupational therapy assistants, health workers, personal care workers, paramedical staff, and ancillary workers. Table 16 shows the number of registered professional staff in 2019 in Hong Kong.

Table 16.
Number of registered social workers, nurses, physiotherapists and occupational therapists in Hong Kong: 2019

Profession	Registered number	Workforce per 100,000 population
Social workers	24,442	326
Registered nurses	42,485	568
Enrolled nurses	14,238	190
Physiotherapists	3,476	46
Occupational therapists	2,383	32

(Nursing Council of Hong Kong, 2019; Occuptional Therapists Board, 2020, January; Physiotherapists Board, 2020, January; Social Workers Registration Board, 2019).

The Residential Care Homes (Elderly Persons) Regulation (Cap 459A) specifies minimum staffing requirements for different levels of staff in residential care homes for older people. In 2020, the staff-to-resident ratios in Care and Attention Home of nurses, health workers, personal care workers, and ancillary workers were 1:60, 1:30, 1:20/40/60, and 1:40, respectively (Social Welfare Department, 2020, January).

b. Are there recognized professional training and qualification systems for the long-term care workforce?

There is no formal training and qualification system particularly designed for the long-term care workforce in Hong Kong. Each profession has its own professional training and qualification system. Long-term care and services for older people are covered in their training to various extents. Each registered professional belongs to the professional body of their own profession (e.g., Social Workers Registration Board, Nursing Council of Hong Kong, Physiotherapists Board and Occupational Therapists Board).

For non-professional/frontline staff, the Employees Retraining Board and Vocational Training Council organise vocational education and training courses relating to the older peoples service sector, including care worker and health worker certificate courses (Government of the Hong Kong Special Administrative Region, 2019, April 3).

c. Is there a regulatory body? Or do workers belong to any professional body. Are there any guidelines published by any government agencies (re workforce training, staff/user ratio, quality monitoring, compliance etc.)

The long-term care workforce is regulated by the Social Welfare Department in Hong Kong. Each profession has its own professional registration system, as mentioned above. For all subsidized services, service operators must follow the Fund Service Agreement to receive the Government subvention. All residential care homes, including subsidised and privately funded establishments, are regulated by the Licensing Scheme for Residential Care Homes for the Elderly under The Residential Care Homes (Elderly Persons) Ordinance (Cap 459) and the Residential Care Homes (Elderly Persons) Regulation (Cap 459A) (Social Welfare Department, 2020, January 8).

d. Are there any patterns of staff vacancies (or with high turnover rate) that have been identified in the long-term care system?

Hong Kong faces a shortage of long-term care staff in professional positions such as nurses, occupational therapists and physiotherapists, and non-professional/frontline positions such as health workers and personal care workers (Working Group on Elderly Services Programme Plan, 2017). Compartmentalised funding arrangements for health care services (Food and Health Bureau) and long-term care services (Labour and Welfare Bureau) have led to frequent losses of nursing and allied health staff in long-term care services to acute care facilities due to the lack of promotion prospects for these professional staff. The lack of medical staff in long-term care facilities has also resulted in frequent high-cost hospital admissions of residents in long-term care institutions (Yuen, 2014). Moreover, Hong Kong faces a severe workforce shortage among doctors and nurses. In 2016, the number of doctors and nurses per 1,000 population (1.91 and 7.14, respectively) was relatively low compared to other developed countries, such as Singapore (2.31 and 7.20), Japan (2.52 and 9.06) and the UK (2.81 and 9.87 (Legislative Council Secretariat, 2018).

The staff vacancy rate in care homes for older people soared from about 11% to 18% in 2017 (Zhao, 2019). The number of vacancies in care services for older people nearly tripled to 2,630, accounting for 10% of the overall available positions in 2018 (Legislative Council Secretariat, 2019, August 16). The required actual workforce for nursing homes, residential care activities, and social work activities altogether was projected from 43,500 in 2017 to 56,900 in 2027. The projected average annual rate of change is +2.7% (Census and Statistics Department, 2019d). In July 2015, the Social Welfare Department launched the Navigation Scheme for Young Persons in Care Services (the Navigation Scheme) to encourage young people to work in long-term care services for older people and rehabilitation care services. As of December 2018, a total of 1,018 trainees had been recruited by service operators through the Navigation Scheme. It is expected that a total of 1,200 training places will be provided in five years, starting from 2020-2021 (Government of the Hong Kong Special Administrative Region, 2019, April 3).

e. Does migration (within and between countries) play a role in the availability of long-term care workers? What are the migration patterns?

Migration does not currently exert a major role in Hong Kong, as only private care services for older people can import non-local workers (Legislative Council Secretariat, 2019, August 16). The Labour Department has rolled out the Supplementary Labour Scheme allowing employers to import workers when they are unable to find suitable staff locally. A total of 1,510 imported care workers (mainly from mainland China) were working as care workers in private residential care homes under the scheme in 2017-2018. The government is considering the possibility

of increased flexibility to import care workers for subsidized care services for older people also (Government of the Hong Kong Special Administrative Region, 2019, April 3).

f. What are the organisation and working conditions of the LTC workforce

The employment of every Hong Kong resident is protected under the Employment Ordinance (Cap 57), including payment, paid leave, medical attention, and maternity protection.

g. Is there a clear role for volunteers within this workforce and how is this organised (shadowing paid staff, offered training etc.)

With the efforts of the Social Welfare Department, voluntary work in Hong Kong has become systemic and popular. The Social Welfare Department has spearheaded a territory-wide 'Volunteer Movement' since 1998 to encourage more people from all sectors to participate in volunteering. As of 31 March 2017, 1.32 million individuals and 3,394 organisations had registered to join volunteer services. In 2018, over 25.8 million hours of volunteer services were delivered across all kinds of community services and sources of volunteers (Volunteer Movement, n.d.).

Voluntary services currently serving older people in Hong Kong are mainly focused on non-caregiving services. There are regular, integral, and organised volunteer training activities, such as the Senior Citizen Home Safety Association, Hong Kong Jockey Club Volunteer Team, China Light Power Limited Voluntary Team, and Hong Kong Fire Services Department Volunteer Team. The volunteer services mainly focus on organising leisure and cultural activities, providing support work at voluntary organisations, conducting regular home visits, organising special projects such as home cleaning and electric equipment repairs, conducting health talks and other health promotional activities (Lau & Chan, 2018).

Part 4: Dementia Policy Context

In Hong Kong, the government has not set out any dementia-specific policy. Nevertheless, expert groups in mental health and service for older people have reviewed the existing health, social and long-term care strategies for older people with dementia. In light of population ageing, there will be an increasing economic and social burden due to dementia in the coming decades. Different stakeholders have a long-term dementia care policy and service provision plan. The Mental Health Review Report and Elderly Service Programme Plan are two documents to which we mainly refer in this chapter.

I. Governance

a. Is dementia included within the portfolio of one or more ministries in the national government? (GDO 1x1)

Dementia is formally recognised within the government's health care and long-term care portfolios as being responsible for providing healthcare services, community-based and residential care to older people with dementia.

b. Which government sector is primarily responsible for Dementia?

In Hong Kong, the government has adopted a multi-disciplinary and cross-sectoral approach to provide holistic care to people with dementia. From prevention and early detection to provision of treatment and long-term care, different government agencies, including the Food and Health Bureau, Labour and Welfare Bureau, Hospital Authority, Department of Health, and Social Welfare Department, are responsible for dementia. For healthcare, the Hospital Authority provides medical services to older people with dementia, including in-patient and out-patient care, day rehabilitation training and community support services. For long-term care, the Social Welfare Department provides a range of support to older people with dementia and their family carers, including daycare, residential care, community care, and carer support services (Food and Health Bureau, 2017a; Legislative Council Secretariat, 2017, February 21).

c. In which branch is dementia primarily included: Health, Ageing, Social services, Mental health, NCDs? (GDO 1x1x1)

Dementia is primarily included in the government's social services and mental health operational branches.

d. Is there a dementia-specific representative within the national government? (GDO 1x2)

Currently, there is no dementia-specific government unit or representative responsible for policy regarding the awareness, treatment, and care of dementia. The government sectors mentioned in questions (b and c) provide a range of services for older people, including those with dementia.

II. Dementia Policies and Plans

a. Dementia-specific Policies and Plans

i. Is there a dementia-specific national document (policy or plan) either in place or under development? (GDO 2x1)

There is no dementia-specific policy or plan in Hong Kong.

ii. When was this document updated? (GDO 2x1x1)

Not applicable.

iii. Have any resources been committed to its' implementation? If so, please also specify the amount that has been committed. (GDO 2x1x2)

Not applicable.

iv. Are there any targets or milestones for monitoring implementation included? What do these encompass? (GDO 2x1x3)

Not applicable.

v. What are the key goals/ aims of the dementia policy/plan?

Not applicable.

vi. How are people living with dementia and their care needs presented and represented in this context? Are families/carers involved in the development of the policies and plans?

Not applicable.

vii. How are policies and plans operationalized? Do they include (in addition to specific targets, indicators and timelines):

1) Resources/budgets attached to specific targets/indicators?

Not applicable.

2) Any consequences for implementing or not implementing (e.g. are there legal consequences for not providing protection against abuse of older adults)?

Not applicable.

b. Other Policies and Plans that include Dementia

i. Is dementia integrated into or covered by a different national plan (such as a mental health plan)? (GDO 2x2)

Although there is no dementia-specific strategy in the planning or provision of support services for older people with dementia, dementia is covered by the health care and long-term care policy in Hong Kong. Since 2014-2015, the government has provided a Dementia Supplement on a recurrent basis of about $230 million annually as additional support for dementia care in residential care homes to employ additional professional staff. Also, additional recurrent funding of about $22 million annually is allocated to District Elderly Community Centres to employ more social workers to strengthen the support for older people with dementia and their family carers. The Hospital Authority has also allocated additional funding of $12 million to increase the use of new anti-dementia drugs, from which about 2,700 patients have benefited (Government of the Hong Kong Special Administrative Region, 2015, June 17; Secretary for Labour and Welfare, 2017, June 27).

Apart from the existing financial allocation to services for dementia care, the government has conducted reviews on service provision for older people with dementia through an expert group, the Review Committee on Mental Health, under the aegis of the Food and Health Bureau, since 2013. Also, the Chief Executive's 2014 Policy Address announced that the Elderly Commission under the Labour and Welfare Bureau should review and strengthen medium and long-term care planning for older people, including dementia. In 2017, the Mental Health Review Report and the Elderly Services Programme Plan were submitted to the government. Subsequently, the Government has been implementing follow-up actions according to the Report's and Plan's strategic directions and recommendations (Legislative Council Secretariat, 2017, February 21).

In the 2017 Policy Address, the government announced a series of new initiatives to enhance dementia care and support at the community level, including outreaching services and an additional 1,000 Community Care Service Vouchers for the Elderly to older people with moderate or severe impairments. The Financial Secretary allocated about $2.9 billion to strengthen rehabilitation services and services for older people, including territory-wide public education on dementia, providing technology products and speech therapy in service units for older people. In addition, in 2017, the government launched the Dementia Community Support Scheme to provide multi-disciplinary community support services through medical-social collaboration for people with mild or moderate dementia and family carers (Government of the Hong Kong Special Administrative Region, 2018, July 4).

ii. Please specify in which area of dementia is covered. (GDO 2x2x1)

Dementia is covered in the areas of mental health and long-term care according to the Mental Health Review Report and the Elderly Services Programme Plan.

The Mental Health Review Report includes a chapter on dementia support services for older people Chapter 4), describing the burden of dementia, existing services for people with dementia, enhancing dementia care through person-centred and holistic care approaches, integrated community care and intervention model for dementia, and recommendations for dementia care. To reduce the existing service gaps, the Report recommends enhancing public education and prevention, primary and specialist care, post-diagnostic medical, community and residential support services, training of the care workforce, and legal protection for people with dementia and their families and carers (Food and Health Bureau, 2017a).

The Elderly Services Programme Plan includes a chapter describing services for older people in the area of long-term care (Chapter 5). The Plan makes two recommendations relating to dementia care. First, a closer medical-social collaboration should be encouraged in the provision and future development of dementia services, such as public education, carer training and staff training. Second, the Plan also recommends enhancing knowledge and skills among older people, family carers and care workers in the early detection of dementia (including mild cognitive impairment) and timely referral to appropriate services at the community care levels (Working Group on Elderly Services Programme Plan, 2017).

iii. Are there dementia-specific documents operationalized at subnational levels (i.e. for individual states, territories, provinces or regions)? If so, please also specify the number of sub-national areas that have operationalized dementia-specific documents. (GDO 2x3)

No dementia-specific document is operationalised at subnational level in Hong Kong.

iv. How is dementia framed in this context?

Dementia is framed as one of the major mental health conditions in the official mental health service review and one of the key service areas in the official service plan for older people. The Mental Health Review Report includes three main chapters on mental health services, including children and adolescents (Chapter 2), adults (Chapter 3), and dementia support services for older people (Chapter 4). Dementia is covered in one chapter in the Elderly Services Programme Plan (Chapter 5), describing the six areas of services for older people, including active ageing, community care services and carer support, residential care services, the Standardised Care Need Assessment Mechanism and case management, services for older people with dementia, and end-of-life care. Dementia is covered in one of the areas, and two corresponding recommendations are proposed among a total of 20 short, medium to long-term recommendations on care services for older people (Food and Health Bureau, 2017a; Working Group on Elderly Services Programme Plan, 2017)

III. Characteristics of Policies and Plans for Dementia

a. Do the plans and/or policies outlined above include/follow/ensure they are in line with:

i. Human rights-based approach (GDO 2x4)

The Mental Health Review Report indicates that people with dementia are under legal protection according to the Mental Health Ordinance (Cap 136) and the Enduring Powers of Attorney Ordinance (Cap 501). These ordinances guarantee and protect the rights of people with a mental illness, including dementia, throughout the process of illness and recovery. People can appoint a guardian or an attorney when they are still mentally capable. This guardian or attorney can help take care of and make decisions for their welfare and financial affairs when they become incapacitated (Food and Health Bureau, 2017a, p. 160). The wishes of people with dementia and their family members should be respected under the Ordinances (Food and Health Bureau, 2017a, p. 172).

The Elderly Services Programme Plan highlights the principle of older people's dignity. They deserve the respect of others as members of the community (Working Group on Elderly Services Programme Plan, 2017, p. 13).

ii. Equity

Equity is not clearly outlined in the existing plans. The Mental Health Review Report lists the principles identified by the World Health Organization that include embracing an equity-based approach in accessing health care and social care services for people with dementia and their family carers (Food and Health Bureau, 2017a, p. 141).
The Elderly Services Programme Plan mentions the principles of social inclusion and equal opportunity. Older people with diverse backgrounds in language, culture and religion should have equal access to all services (Working Group on Elderly Services Programme Plan, 2017, p. 14).

iii. Empowerment

The Mental Health Review Report lists the principles identified by WHO that include empowering and promoting the full and active participation of people with dementia and their family carers to overcome stigma and discrimination (Food and Health Bureau, 2017a, p. 141). It also indicates the need for information and community resources to empower carers on their competence to perform care tasks and maintain their caring roles (Food and Health Bureau, 2017a, p. 143).

The Elderly Services Programme Plan mentions the principle of active and productive ageing. It promotes the participation of older people in society and their empowerment through continuous and self-directed learning, volunteer activities, and flexible retirement mechanisms (Working Group on Elderly Services Programme Plan, 2017, pp. 22-23)

iv. Multisectoral collaboration

The Mental Health Review Report emphasizes the need to develop a more refined model for integrated community care and intervention by making better use of public and private resources for dementia care through cross-sectoral collaboration between government departments, NGOs, and the private sector. Healthcare professionals at primary and specialist levels (e.g., doctors, social workers, nurses, occupational therapists, physiotherapists, programme assistants) should be involved in the care pathway for people with dementia, including early assessment, case management and intervention (Food and Health Bureau, 2017a, pp. 175-180).

The Elderly Services Programme Plan mentions the strategic directions on promoting inter-sectoral, inter-department, inter-disciplinary and inter-agency collaboration, especially between the welfare, healthcare and housing sectors, to achieve seamless and integrated care service delivery for older people (Working Group on Elderly Services Programme Plan, 2017, p. 14).

v. Universal Health Coverage

In the Mental Health Review Report, it only lists the principles identified by WHO, including embracing universal health coverage to enable people with dementia and their family carers to access health and social care services (Food and Health Bureau, 2017a, p. 141). But these principles were not clearly reflected in its recommendations for further actions.

The Elderly Services Programme Plan recommends strengthening service coverage for older people according to their age-related needs (Working Group on Elderly Services Programme Plan, 2017, p. 21).

b. (How) does the policy reflect aspects of the sustainable development goals?

The Mental Health Review Report and the Elderly Services Programme Plan reflect one of the sustainable development goals, "Goal 3 – Good health and well-being: Ensure healthy lives and promote well-being for all at all ages". It emphasizes increasing effort to fully eradicate a wide range of non-communicable diseases and address the growing burden of different health issues, including child health, maternal health, HIV/AIDS, malaria, and other diseases. Two of the 13 targets listed in Goal 3 are related to the Mental Health Review Report and Elderly Services Programme Plan (United Nations, 2018):

- "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."

- "Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks."

c. (How) are people with dementia and their family (unpaid) carers recognised in the policy document?

The Mental Health Review Report mentions the needs of family carers identified by WHO that include information on dementia and community resources, physical care assistance, training on skills of taking care of people with dementia, respite services, emotional support, recognition, and financial assistance (Food and Health Bureau, 2017a, p. 144). Physical care assistance and emotional support are identified as the major support for family carers (Food and Health Bureau, 2017a, p. 169). The government provides subsidised support for carers, including day and residential respite services, skill training and education, an allowance for living expenses, and accessible information resources (Food and Health Bureau, 2017a, p. 159). As family carers are usually the primary carers of people with dementia, it is particularly important to help them recognise the signs of illness and provide structured advice along the continuum of care at different stages of dementia. Grief and bereavement support are also needed in the end-of-life care process (Food and Health Bureau, 2017a, p. 172).

The Elderly Services Programme Plan proposes strategic directions to increase quality of life, age-friendliness, informed choice and timely access to quality services for older people and their family carers (Working Group on Elderly Services Programme Plan, 2017, p. 13).

d. (How) is the risk of mistreatment and abuse of people with dementia incorporated into the policy?

The risk of mistreatment and abuse of people with dementia is not explicitly covered in the existing plans. The Mental Health Review Report only mentions the Department of Health's Visiting Health Teams delivering on-site education and training in community and residential care settings on a wide range of topics, including prevention of abuse of older people, building cognitive reserve and skills for caring for older people with dementia (Food and Health Bureau, 2017a, p. 41).

e. (How) does the policy encourage person-centred care?

i. Are people with dementia supported in maintaining an active role in the community?

As mentioned in the Mental Health Review Report, the government provides different types of support for people with dementia and their family carers based on the principles of ageing in place. It emphasizes increasing awareness, reducing stigma, enhancing early detection and intervention, and strengthening community support to allow people with dementia to live safely, independently and comfortably in the community (Food and Health Bureau, 2017a, p. 168). It also recommends that the government should further strengthen social care infrastructure to enable people with dementia to remain in the community for as long as possible (Food and Health Bureau, 2017a, p. 188).
The Elderly Services Programme Plan recommends enhancing community care support to achieve the principle of ageing in place and avoid unnecessary institutionalisation (Working Group on Elderly Services Programme Plan, 2017, p. 24).

ii. Are people with dementia encouraged to/ supported in maintaining self-management where possible?

As mentioned in the Mental Health Review Report, a person-centred and holistic care model must be accessible, individualised and responsive to the multiple and changing needs at different stages of dementia (Food and Health Bureau, 2017a, p. 168). The government has been working to develop a dementia-friendly community. The first step is to remove risk factors and ensure friendly housing design, such as removing harmful substances and sharp

objects, using clear signs to highlight their content and making community facilities easy to use. It also recommends educating non-healthcare professionals to understand dementia, especially police and security guards who have an important role in searching for people with dementia who go missing from home. A more accepting and supportive neighbourhood can promote self-management of people with dementia at home and in the community (Food and Health Bureau, 2017a, p. 171).

iii. Are the preferences of people with dementia encouraged to be considered in care practice and decision making?

As mentioned in the Mental Health Review Report, people with dementia and their family members can appoint a guardian or an attorney to make decisions on financial, legal, and healthcare arrangements for them under the two Ordinances of legal protection (see response to question a(i)). The Elderly Services Programme Plan mentions the principle of facilitating informed choices by adequate and updated information provided to older people to match their various needs, such as the quality, quantity, fees and location of different service units (Working Group on Elderly Services Programme Plan, 2017, p. 13).

f. (How) are aspects of care quality assurance incorporated into the policy document?

As mentioned in the Mental Health Review Report, effective medical-social collaboration is essential to maintain person-centred and holistic care to ensure the quality of nursing and personal care in health and social care services (Food and Health Bureau, 2017a, p. 171).

The Elderly Services Programme Plan recommends the development of a comprehensive quality assurance system to monitor the quality of and continuously improve services for older people (Working Group on Elderly Services Programme Plan, 2017, p. 25). This plan also suggested measures to strengthen the quality of community and residential care services, reviewed the Residential Care Homes (Elderly Persons) Ordinance (Cap 459) and encouraged a public-private partnership in service provision (Working Group on Elderly Services Programme Plan, 2017, pp. 28-29).

g. (How) are health and long-term care workforce represented in the policy document?

The Mental Health Review Report recommends the government increases structured training for health and social care providers (e.g., social workers, nurses, occupational therapists, physiotherapists, programme assistants, etc.) to empower them with the necessary skills and knowledge in dementia care (Food and Health Bureau, 2017a, pp. 186-187). The Report also mentions the need for pilot programme to test the readiness of service providers on clinical effectiveness, cost economic analysis and service statistics (Food and Health Bureau, 2017a, p. 186). Regarding capacity building and workforce training, the Report recommends that structured training should be given to empower service providers to detect dementia symptoms, understand the disease trajectory and develop dementia care approaches (Food and Health Bureau, 2017a, p. 172).

The Elderly Services Programme Plan indicates the demand for long-term care services and workforce to address the increasing population of older people. Apart from ongoing measures to strengthen the workforce, it is also important to explore other sources of informal care providers, such as neighbours and volunteers, to service as "elder-sitters" to support older people in the community (Working Group on Elderly Services Programme Plan, 2017, pp. 32-34).

h. (Who) are the key actors described in the policy document? Are their roles defined?

The Mental Health Review Report proposes a seven-stage model for dementia service planning promulgated by WHO and Alzheimer's Disease International. The service needs and major service providers (i.e., key actors) in each stage of dementia care are set out below (Food and Health Bureau, 2017a, p. 151):

Stage 1: Pre-diagnosis
- Service needs: public education and prevention
- Major service providers: Department of Health, Hospital Authority, Social Welfare Department, NGOs, carers, private doctors

Stage 2: Diagnosis
- Service needs: primary and specialist care
- Major service providers: Health Authority, private doctors

Stage 3: Post-diagnostic support
- Service needs: primary and specialist care; community and information support
- Major service providers: Hospital Authority, Social Welfare Department, NGOs, carers, private doctors

Stage 4: Coordination and care management
- Service needs: primary and specialist care; community support; needs assessment
- Major service providers: Hospital Authority, Social Welfare Department, NGOs, carers, private doctors

Stage 5: Community services
- Service needs: specialist care; community support; outreach services; carer training
- Major service providers: Hospital Authority, Social Welfare Department, NGOs, Department of Health, carers

Stage 6: Continuing care
- Service needs: acute and sub-acute medical services; hospital care; community support
- Major service providers: Hospital Authority, Social Welfare Department, NGOs, carers

Stage 7: End-of-life palliative care
- Service needs: acute and sub-acute medical services; continuing and palliative care
- Major service providers: Hospital Authority, Social Welfare Department, NGOs, carers

i. (How) does the policy document support integrated care?

The Mental Health Review Report proposes an integrated community care and intervention model for people with dementia (Food and Health Bureau, 2017a, p. 171). It emphasizes the need for bilateral and integrated support by health professionals in primary and specialist care for dementia. It recommends enhancing medical-social collaboration to integrate the delivery of medical, community, residential, and psychosocial care services to provide patient-centred support and achieve the best possible long-term outcomes in dementia care (Food and Health Bureau, 2017a, pp. 175-180).

The Elderly Services Programme Plan recommends that dementia be integrated into the spectrum of services for older people and a multi-disciplinary approach to dementia adopted by closer collaboration between the healthcare system and welfare sector (Working Group on Elderly Services Programme Plan, 2017, p. 30).

j. (How) does the policy outline the interface between other aspects of care (e.g. general health care for older adults, mental health care etc.)?

The Mental Health Review Report identifies the burden of dementia, health and social care services for people with dementia and their family carers, approaches to enhance dementia care, an integrated community care and intervention model for dementia, and recommendations for dementia care (Food and Health Bureau, 2017a).

The Elderly Services Programme Plan covers the principle of active ageing, community care services and carer support, residential care services, assessment mechanism and case management, dementia care services, and end-of-life care for older people. In terms of collaboration, partnership and interfacing with other sectors, it recommends more effective partnerships between the welfare, healthcare, and housing sectors. It emphasizes the interface between multiple service providers in various sectors, including subsidised, self-financed and private services to meet older people's diverse needs and expectations (Working Group on Elderly Services Programme Plan, 2017, p. 40).

k. Does the policy document recognise potential barriers to access? Does the document suggest solutions to overcome identified barriers?

The Mental Health Review Report recognises potential barriers to accessing existing dementia care services. First, there are long waiting-times for post-diagnostic medical and community support services for dementia. There is a lack of coordination among service providers in providing stepped-down care for people with dementia. Second, the current assessment mechanism is not dementia-specific for determining suitable dementia care services. Third, diagnosis and post-diagnostic secondary or tertiary medical support of younger onset dementia is often delayed due to inadequate recognition of early stage symptoms by clinicians (Food and Health Bureau, 2017a, p. 162). To overcome these barriers, the Report recommends implementing a refined intervention model to facilitate timely intervention for people with dementia. Primary care settings can be used for effective gate-keeping, enabling stabilised dementia cases to be transferred to a community setting for ongoing management. This would help enhance secondary care capacity, shorten waiting times and ensure more effective use of specialist services (Food and Health Bureau, 2017a, p. 186).

The Elderly Services Programme Plan recommends setting up a real-time vacancy information system and district-based pre-registration system to reduce the barriers to service utilisation and facilitate timely access to services, especially for respite and emergency placement services (Working Group on Elderly Services Programme Plan, 2017, pp. 24-25). It also emphasizes the need to improve the current assessment mechanism to promote better service matching and develop a case management model ensuring better coordination among different services (Working Group on Elderly Services Programme Plan, 2017, p. 29).

l. (How) does the policy incorporate equity? (e.g. in access to care (availability, provision, costs), workforce rights, carer rights & protection)

The Mental Health Review Report mentions a wide range of subsidised support and care services provided for people with dementia and their family carers. In terms of financial risk protection, the government launched the Pilot Schemes on Living Allowance for Carers of Elderly Persons from Low-income Families in 2014. Under the scheme, a total of 4,000 carers, including carers for people with dementia, benefited in 2018 (Food and Health Bureau, 2017a, p. 159).

In terms of equitable access and affordability, the Elderly Services Programme Plan recommends strengthening the financial sustainability of services for older people by reviewing the existing co-payment and allowance schemes (Working Group on Elderly Services Programme Plan, 2017, p. 40).

m. (How) does the policy incorporate aspects of prevention and risk reduction? (e.g. link to public health initiatives, community initiatives)

The Mental Health Review Report notes that preventing dementia can be divided into three conventional levels. Primary prevention consists of public education and risk reduction measures to promote healthy lifestyles, social engagement, and cognitive reserve to delay the onset of dementia. Secondary prevention includes both pharmacological and non-pharmacological means of detection, diagnosis, intervention, and supportive services to manage the cognitive decline and progression of dementia. Tertiary prevention includes accurate and individualised needs assessment to reduce the burden on and improve the quality of life of people with dementia and their family carers (Food and Health Bureau, 2017a, p. 186).

The Elderly Services Programme Plan mentions strategic directions on strengthening health maintenance, risk reduction and illness prevention by providing suitable services for older people with mild impairments (Working Group on Elderly Services Programme Plan, 2017, p. 24).

n. (How) does the policy address aspects of sustainability? (e.g. financing, political & social commitment)

As the Mental Health Review Report acknowledges, it is important to develop effective medical-social collaboration and an intervention model to address the rising demand for dementia care services more cost-effectively and sustainably (Food and Health Bureau, 2017a, p. 186). In terms of ensuring financial sustainability and accountability, the Elderly Services Programme Plan proposes reviewing the existing funding model of public expenditure, co-payment and allowance schemes for community and residential care services for older people. It also considers exploring measures to facilitate providing self-financing services from NGOs and alternative long-term care financing options based on varying levels of older services users' needs and aspirations, and service affordability (Working Group on Elderly Services Programme Plan, 2017, p. 40).

o. If there is a policy already, who were the stakeholders involved in developing the policy? What is their role in enacting their policy? How is this monitored ((what) are there tangible outcomes)?

Currently, there is no dementia-specific policy or plan in Hong Kong.

Nevertheless, the Mental Health Review Report and Elderly Services Programme Plan provide holistic reviews and recommendations on existing services, including dementia care. They identify a number of stakeholders with different roles in cooperating to address the complex needs of dementia care from prevention and diagnosis to timely intervention and long-term care, the Food and Health Bureau, Labour and Welfare Bureau, Hospital Authority, Department of Health, Social Welfare Department and other relevant parties, such as NGOs, the private sector, formal and informal carers. The Elderly Services Programme Plan recommends that the government should have a regular track on the goals and objectives in planning, implementing and evaluating services for older people, ensuring adequate participation among stakeholders at District and territory-wide levels (Working Group on Elderly Services Programme Plan, 2017, p. 44). However, there is no explicit content regarding the specific roles of different stakeholders and how they would monitor the achievement of tangible outcomes.

p. How are targets/ milestones monitored? Is there evidence of achievements?

There is no explicit monitoring mechanism for the targets or recommendations suggested in the Mental Health Review Report or the Elderly Services Programme Plan.

The Mental Health Review Report identifies major service gaps in the current delivery model of dementia care requiring further actions for improvement. These services gaps and actions to bridge them in the seven-stage model for dementia service planning are (Food and Health Bureau, 2017a, p. 186):

1. Pre-diagnosis
    - Service gaps: awareness; knowledge; early detection
    - Actions: territory-wide epidemiological studies; public education; care worker training
2. Diagnosis
    - Service gaps: tests and scans for dementia; long waiting time; younger onset dementia
    - Actions: coordinate primary, secondary and specialist care; share electronic health records
3. Post-diagnostic support
    - Service gaps: difficulty accessing services and handling crises
    - Actions: clear referral pathways; advice on treatment options; hotline service
4. Coordination and care management
    - Service gaps: unclear coordination among service providers in the neighbourhood
    - Actions: case management; identifying special needs; database to review outcomes
5. Community services
    - Service gaps: no dementia-specific services
    - Actions: more daycare, respite, outreach and home-based services; carer training
6. Continuing care
    - Service gaps: inadequate support to promote longer living in the community
    - Actions: strengthen medical and long-term care; discharge planning; care worker training
7. End-of-life palliative care
    - Service gaps: not widely understood among the public
    - Actions: promote greater acceptance; legal issues in making informed decisions

Regarding evidence of achievement, for community services, a dementia-specific community service, the Dementia Community Support Scheme, was piloted for two years in 2017 and became regularised in 2019.

q. Are there named (key) stakeholders in the policy document? If yes, who are they and what is their role?

The Mental Health Review Report and Elderly Services Programme Plan were developed by a wide range of stakeholders from different sectors, as indicated in Table 17 (Food and Health Bureau, 2017a, p. 186).

Table 17

Stakeholders from different sectors who participated in developing the Mental Health Review Report and Elderly Services Programme Plan

Sector	Departments / Organizations	Name
Health care	Hospital Authority	Dr CHEUNG Wai-lun
	Hospital Authority	Dr CHAN Hon-wai, Felix
	Hospital Authority	Dr TSE Man-wah, Doris
	Kwai Chung Hospital	Dr SHUM Ping-shiu
	Health Services Functional Constituency	Prof Hon LEE Kok-long, Joseph
Health & social care	Haven of Hope Christian Services	Dr LAM Ching-choi
Social care (NGO)	Hong Kong Alzheimer's Disease Association	Dr DAI Lok-kwan, David
	Hong Kong Association of Gerontology	Dr LEUNG Man-fuk, Edward
	Senior Citizen Home Safety Association	Mr MA Kam-wah, Timothy
	New Life Psychiatric Rehabilitation Association	Ms YAU Sau-wai, Sania
	Hong Kong Council of Social Service	Miss CHAN Man-yee, Grace
	The Hong Kong Council of Social Service	Ms WONG Yiu-ming, Anita
	The Hong Kong Council of Social Service	Dr CHENG Lai-ling, Crystal
	Social Welfare Functional Constituency	Mr CHEUNG Kwok-che

	International Social Service Hong Kong Branch	Mr YAU How-boa, Stephen
	Po Leung Kuk	Mrs WONG WONG Yu-sum, Doris
	Hong Kong Sheng Kung Hui Welfare Council Limited	Ms CHOW Mee-tim
	Hong Kong Carers Alliances	Dr LAW Kam-chu, Gemma
Social care (Private sector)	Tung Hoi Association for the Gifted Child Limited	Mr LEE Pak-ying Richard
	Hiu Kwong Nursing Service Limited	Mr SHIE Wai-hung, Henry
	Bunhoi Group	Mr WONG Fan-foung, Jackson
	E. T. Investment Limited	Mr CHAN Chi-yuk, Kenneth
Public education & Voluntary service	The Hong Kong Association of Senior Citizens	Mrs CHAN LUI Ling-yee, Lilian
Housing	Hong Kong Housing Society	Dr CHEUNG Moon-wah
Academics	The Chinese University of Hong Kong	Prof CHIU Fung-kum, Helen
	The Chinese University of Hong Kong	Prof LAM Chiu-wa, Linda
	The University of Hong Kong	Dr LOU Wei-qun, Vivian
	The University of Hong Kong	Dr YEUNG Ka-ching
	The Hong Kong Polytechnic University	Prof FUNG Yuk-kuen, Sylvia
	City University of Hong Kong	Prof. CHONG Ming-lin, Alice
	Lingnan University	Prof CHAN Cheung-ming, Alfred

(Food and Health Bureau, 2017a; Working Group on Elderly Services Programme Plan, 2017)

r. What are the expectations of the different stakeholders who participated in developing the policy?

There is no explicit indication of the expectations of different stakeholders who participated in developing the Mental Health Review Report and the Elderly Services Programme Plan.

IV. Areas for Action included in Policies and Plans for Dementia

a. Please describe the areas for action that are included in any policies or plans for dementia in your country according to the following seven categories (GDO 2x5):

i. Dementia awareness, stigma reduction and dementia-friendly communities

The Mental Health Review Report makes two recommendations to increase public education and dementia-friendly neighbourhoods:

- "Recommendation 1 – Public education should be strengthened to promote healthy lifestyles, better understanding and awareness of dementia, encourage help-seeking behaviour and reduce stigma associated with dementia." (Food and Health Bureau, 2017a, p. 184)
- "Recommendation 7 – Social care infrastructure should be strengthened to allow persons with dementia to remain in the community for as long as possible." (Food and Health Bureau, 2017a, p. 188).

The Elderly Services Programme Plan made two recommendations to promote an age-friendly environment, healthy lifestyle, and active social participation among older people:

- "Recommendation 1 – Public education should be strengthened to promote positive image of elderly persons, enhance their status and role in society, and foster positive inter-generational relations." (Working Group on Elderly Services Programme Plan, 2017, p. 20)

- "Recommendation 3a – Promotion of healthy lifestyle should be of paramount importance in improving the quality of life of elderly persons and reducing the risk of age-related diseases." (Working Group on Elderly Services Programme Plan, 2017, p. 20)

ii. Dementia prevention and risk reduction

The Elderly Services Programme Plan recommended strengthening health maintenance, risk reduction and illness prevention:

- "Recommendation 4a – For prevention of health deterioration, provision of suitable services to elderly persons with mild impairments should be strengthened, such as through enhancing Integrated Home Care Services (Ordinary Cases) to focus on these elderly persons." (Working Group on Elderly Services Programme Plan, 2017, p. 24).

iii. Timely dementia diagnosis, post-diagnostic support and care

The Mental Health Review Report revealed inadequate expertise and capacity in early diagnosis and post-diagnostic support of dementia in the primary care setting (Food and Health Bureau, 2017a, p. 161), making five recommendations to promote timely diagnosis and intervention, and best practices in managing different stages of dementia:

- "Recommendation 3 – A common reference should be developed to support primary care professionals on the diagnosis and management of dementia." (Food and Health Bureau, 2017a, p. 186)
- "Recommendation 4 – The role of primary care in the provision of dementia care should be enhanced through capacity building." (Food and Health Bureau, 2017a, p. 186)
- "Recommendation 5 – The capacity of specialist services in the Health Authority should be strengthened to facilitate timely intervention of dementia cases through the implementation of a refined intervention model, with a view to reducing the waiting time of specialist services." (Food and Health Bureau, 2017a, p. 187)
- "Recommendation 8 – There is a need to enhance medical-social collaboration and further integrate the delivery of healthcare and social care interventions to provide patient-centred support." (Food and Health Bureau, 2017a, p. 188)
- "Recommendation 9 – End-of-life care and palliative care in the community setting should be promoted to minimise unnecessary and repeated hospitalisation." (Food and Health Bureau, 2017a, p. 189)

iv. Workforce training on dementia

The Mental Health Review Report recommends strengthening workforce training on dementia:

- "Recommendation 6 – There is also a need to increase the supply of healthcare manpower and strengthen their training. Training for healthcare and social care providers should be enhanced so that they are equipped with the necessary skills and knowledge in providing care to persons with dementia."(Food and Health Bureau, 2017a, p. 187)

The Elderly Service Programme Plan makes five recommendations to enhance staff training on dementia detection and sustain the workforce providing services for older people:

- "Recommendation 10(i) – Enhancing workers' knowledge and skills in early detection of dementia (including mild cognitive impairment cases) at elderly centres at neighbourhood level and in making timely referral to appropriate services." (Working Group on Elderly Services Programme Plan, 2017, p. 30)
- "Recommendation 10(ii) – Strengthening training in early detection, management and care of dementia in elderly service units, particularly in community care services." (Working Group on Elderly Services Programme Plan, 2017, p. 30)
- "Recommendation 12a – Measures to improve recruitment, retention, working condition, and career development of staff in elderly service should be explored." (Working Group on Elderly Services Programme Plan, 2017, p. 32)
- "Recommendation 12b – The structure of professional staff should be fine-tuned to enable more flexible staff deployment and maximisation of staff input." (Working Group on Elderly Services Programme Plan, 2017, p. 33)
- "Recommendation 12d – There should be ongoing monitoring and evaluation of the manpower measures." (Working Group on Elderly Services Programme Plan, 2017, p. 34)

v. Support for dementia carers and families

As mentioned in the Mental Health Review Report, coordinated medical and social care services for both individuals with dementia and family carers are essential elements for promoting the ultimate goal of ageing in place. It recommends enhancing support for family carers to allow them to engage in other aspects of their lives and continue in their caring role effectively:

- "Recommendation 10 – Support for carers should be enhanced. This includes providing them with structured and accessible information, skills to assist in caring, respite to enable engagement in other activities so that they can continue in their role effectively." (Food and Health Bureau, 2017a, p. 189).

The Elderly Services Programme Plan makes four recommendations promoting greater flexibility, variety, and choices of supportive services, such as an expansion of services to cover odd hours and holidays to meet specific caring needs among older people and their family carers:

- "Recommendation 5a – Designated respite places and casual vacancies should be fully utilised to strengthen the support to carers. Improvement should be made to facilitate timely access to service." (Working Group on Elderly Services Programme Plan, 2017, p. 25)
- "Recommendation 5b – Transitional care support to elderly persons discharged from hospitals should be enhanced to assist them to stay in the community and prevent premature institutionalisation." (Working Group on Elderly Services Programme Plan, 2017, p. 25)
- "Recommendation 5c – Emergency placement services should continue to target on elderly persons with urgent care needs and under unforeseen or crisis situation, such as those with immediate care needs due to social reasons." (Working Group on Elderly Services Programme Plan, 2017, p. 26)
- "Recommendation 5e – Day respite that integrates formal and informal system of care at neighbourhood level should be strengthened." (Working Group on Elderly Services Programme Plan, 2017, p. 26)

vi. Improved monitoring or information systems for dementia

The Elderly Services Programme Plan proposes setting up a real-time vacancy information system and District-based pre-registration system to reduce the barriers to service utilisation and facilitate timely access to services,

especially for respite and emergency placements (Working Group on Elderly Services Programme Plan, 2017, p. 24). It also makes two recommendations to improve the information systems for care services for older people, including dementia:

- "Recommendation 18a – An integrated service provider interface with the Long Term Care Services Delivery System (LDS) built on the LDS data base with enhanced Standardised Care Need Assessment Mechanism for Elderly Services (SCNAMES) functions is to be explored." (Working Group on Elderly Services Programme Plan, 2017, p. 41)
- "Recommendation 18c – Use of Information and Communication Technology (ICT) should be expanded to enhance the quality of care delivery." (Working Group on Elderly Services Programme Plan, 2017, p. 42)

vii. Dementia research and innovation

The Mental Health Review Report recommends increasing application of innovative technology in the daily operation of service units serving older people and the provision of dementia care services. Long- term, it is helpful to attract young professionals to join the dementia care workforce (Food and Health Bureau, 2017a, p. 190). It also recommends future dementia research:

- "Recommendation 2 – Territory-wide prevalence studies of dementia should be conducted regularly to inform service planning." (Food and Health Bureau, 2017a, p. 185)

The Elderly Services Programme Plan identifies the need for further study on the service demands relating to older people with mild impairment (Working Group on Elderly Services Programme Plan, 2017, p. 24) and recommends further research to investigate the demand for services for older people:

- "Recommendation 5d – Further study on the demand for respite, transitional care and emergency placement services should be considered. Moreover, the possibility of better using non-subsidised places to provide such services should be explored." (Working Group on Elderly Services Programme Plan, 2017, p. 26)

V. Legislation

a. Is there dementia-specific legislation in your country either at the national or sub-national level? (GDO 3x1)

There is no dementia-specific legislation in Hong Kong. Currently, there are other laws related and applied to protect the rights of people with impaired mental capacity, including people living with dementia.

b. Are there provisions in other laws related to, or that apply to, protecting the rights of people with dementia? If so, please describe these laws and indicate whether they comply with international human rights standards according to the following criteria (GDO 3x2 and 3x3):

i. Provisions exist which promote supported decision-making, the ability for people with dementia (or all persons) to nominate a trusted person or network of persons for discussing issues and making decisions.

There is universal legislation supporting the decision-making of people with mental incapability. The Enduring Powers of Attorney Ordinance (Cap. 501) allows a person who is mentally capable to appoint an attorney to take care of their financial affairs if they become mentally incapacitated (Department of Justice, 2013).

ii. Provisions exist which provide for procedures to enable people with dementia (or all persons) to protect their rights (safeguards against exploitation, violence, or abuse) and to file appeals and complaints to an independent legal body.

There is universal legislation protecting the rights of people with mental incapability. The Mental Health Ordinance (Cap. 136) guarantees and protects the rights of people with mental illness throughout their illness and recovery, including those with dementia. A guardian or a committee may be appointed to help take care of the property and affairs and medical and health care of mentally incapacitated individuals (Department of Justice, 2019b).

iii. Provisions exist which promote the transition of dementia care to community-based services.

There is no dementia-specific or universal legislation promoting the transition of dementia care to community-based services.

iv. Provisions exist which provide for regular inspections of human rights conditions (safeguards against exploitation, violence, or abuse) and/or care quality by an independent body in facilities where people with dementia reside.

There is universal legislation inspecting the human rights conditions or care quality for older people. The Domestic and Cohabitation Relationships Violence Ordinance (Cap. 189) in the Procedural Guidelines for Handling Elder Abuse Cases (Revised 2019) unifies the definition and equips various professionals for handling suspected abuse of older people (Social Welfare Department, 2020, February 26).

v. Provisions exist which aim to end coercive practices, including seclusion and mechanical/ physical/ chemical restraints for people with dementia (or all persons).

Universal legislation monitors the use of coercive practices in mental health care or the care of older people. The Mental Health Ordinance (Cap. 136) regulates the conditions and circumstances under which mechanical means of restraint or seclusion may be applied to patients (Department of Justice, 2019b). The Residential Care Homes (Elderly Persons) Regulation (Cap. 459A) requires a residential home manager to maintain records of any action taken, including the use of force or mechanical restraint, to prevent or restrain a resident from injuring themself or others, damaging property, or creating a disturbance (Department of Justice, 2020).

c. Is there specific legislation pertaining to the following (GDO 3x4):

i. Advance care directives

There is no dementia-specific or universal legislation pertaining to advance care directives in Hong Kong. Since 2010, the Hospital Authority has implemented advance directives through administrative measures under the common law. Based on patient self-determination, a standard form along with a detailed guideline for clinicians is used for making advance directives, mainly covering the refusal of life-sustaining treatments. Signatures of two witnesses including a doctor are required on the form. Since 2012, the Clinical Management System of the Hospital Authority has marked advance directives witnessed by Health Authority doctors as a reminder to assist clinical communication. Currently, advance directives cover (a) terminal illness; (b) patients in a persistent vegetative state or a state of irreversible coma; or (c) other specified end-stage irreversible life-limiting conditions, which include patients with irreversible loss of major cerebral function and extremely poor functional status, end-stage renal failure, end-stage motor neuron disease, and end-stage chronic obstructive pulmonary disease. People who have severe dementia are covered in (c). However, the public response to advance directives has been lukewarm

due to low public awareness, the reluctance of doctors to certify them, and other implementation issues. Between 2012 and 2018, only 5,561 advance directives were made. In 2019, the Food and Health Bureau launched a three-month public consultation, and the Consultation Report on the legislative proposal was released in July 2020 (Food and Health Bureau, 2020). The government is currently working out the details of the proposed legislative changes and the bill about advance directives to the Legislative Council. Yet, there is no announced timeline regarding the proposed legislation.

ii. Provisions which aim to end discrimination against people with dementia (including in the workplace)

There is universal legislation pertaining to the discrimination of people with a disability, including mental incapability. The Disability Discrimination Ordinance (Cap. 487) protects people with a disability in different areas, including employment, education, provision of goods, services and facilities, access, disposal and management of premises, participation in clubs and sporting activities, and activities of the government (Department of Justice, 2015).

iii. Provisions which aim to end discrimination against family carers

There is universal legislation pertaining to the discrimination of people on the basis of family status, which includes their responsibility for the care of immediate family members. The Family Status Discrimination Ordinance (Cap. 527) protects people based on family status in different areas, including employment, education, provision of goods, services and facilities, disposal and management of premises, eligibility to vote for and to be elected or appointed to advisory bodies, participation in clubs, and activities of the government (Department of Justice, 2018).

d. Additional STRiDE questions:

i. Are there provisions to protect the rights of family and other unpaid carers?

There is no dementia-specific or universal legislation protecting the rights of family and other unpaid carers in Hong Kong. The Employment Ordinance (Cap. 57) is the main legislation governing employment conditions in Hong Kong, which does not apply to domestic helpers, carers, or other personal helpers who dwell free of charge in their employing household (Department of Justice, 2019a).

ii. Does the legal system in Hong Kong place the responsibility of older parents directly on their off-spring (either in the law or specifically in various policies)?

No dementia-specific or universal legislation or policy places the caregiving responsibility for older parents directly on their offspring in Hong Kong. A filial responsibility law was proposed by the Provisional Legislative Council in 1998, but was voted down due to the lack of support from older parents concerned about its possible adverse effect on family harmony (Ting et al., 2009). There is controversy about enacting filial support legislation to share the burden of caring for older dependent people between their adult children and the government. Currently, an individual supporting a parent or grandparent is entitled to a salary tax deduction through the Dependent Parent and Dependent Grandparent Allowance and Elderly Residential Care Expenses (Inland Revenue Department, 2020, February). Although industrialisation and urbanisation have reduced the availability of family care, family members remain the major care providers for older people in Hong Kong (Sum & Chou, 2001).

iii. How is curatorship/power of attorney obtained? Is curatorship/power of attorney awarded on a temporary basis only?

Two legal procedures protect the property and affairs of mentally incapacitated persons and their carers. According to the Enduring Powers of Attorney Ordinance (Cap. 501), a "committee", normally a relative, professional, or official solicitor, can be appointed through the court when an older person has dementia and becomes unable to manage their financial affairs. According to the Mental Health Ordinance (Cap. 136), an application by a relative, social worker or medical practitioner must be made to the guardianship board for dealing with the welfare and physical care of mentally incapacitated people. The guardian has significant power over the mentally incapacitated person, including their residence, and medical and dental treatment (Ko, 2019, March 26).

VI. Clinical Guidelines, Standards and Protocols for Dementia

a. Are there standards, guidelines, or protocols for dementia? (GDO 4x1)

A guideline provides common reference to primary health care professionals working in preventive care for older people in Hong Kong. Dementia is covered in "Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings: Module on Cognitive Impairment" (Department of Health, 2017).

b. Are they national or subnational standards/ guidelines/ protocols? (GDO 4x1x1)

This reference framework is a national guideline developed by the government's Department of Health.

c. Are they approved by government? (GDO 4x1x2)

This reference framework is approved by the government and provided by the Primary Healthcare Office of the Food and Health Bureau.

d. What areas are covered by standards, guidelines, and protocols? (GDO 4x2)

i. Prevention and risk reduction of dementia

Two chapters in the guideline cover risk reduction and prevention of dementia (Chapter 1.3 & Chapter 4.4). The modifiable and non-modifiable risk factors identified for cognitive impairment include the following (Department of Health, 2017, p. 9):

Modifiable risk factors
Lifestyle
- Smoking
- Alcohol consumption
- Physical inactivity
- Low participation in cognitive activities
- Social isolation

Vascular risk
- Hypertension
- Diabetes mellitus
- Overweight and obesity
- Stroke

Others

- Depression
- Drugs use
- Low education attainment
- Head injury

Non-modifiable risk factors

- Advancing age
- Family history
- Genetics
- Gender

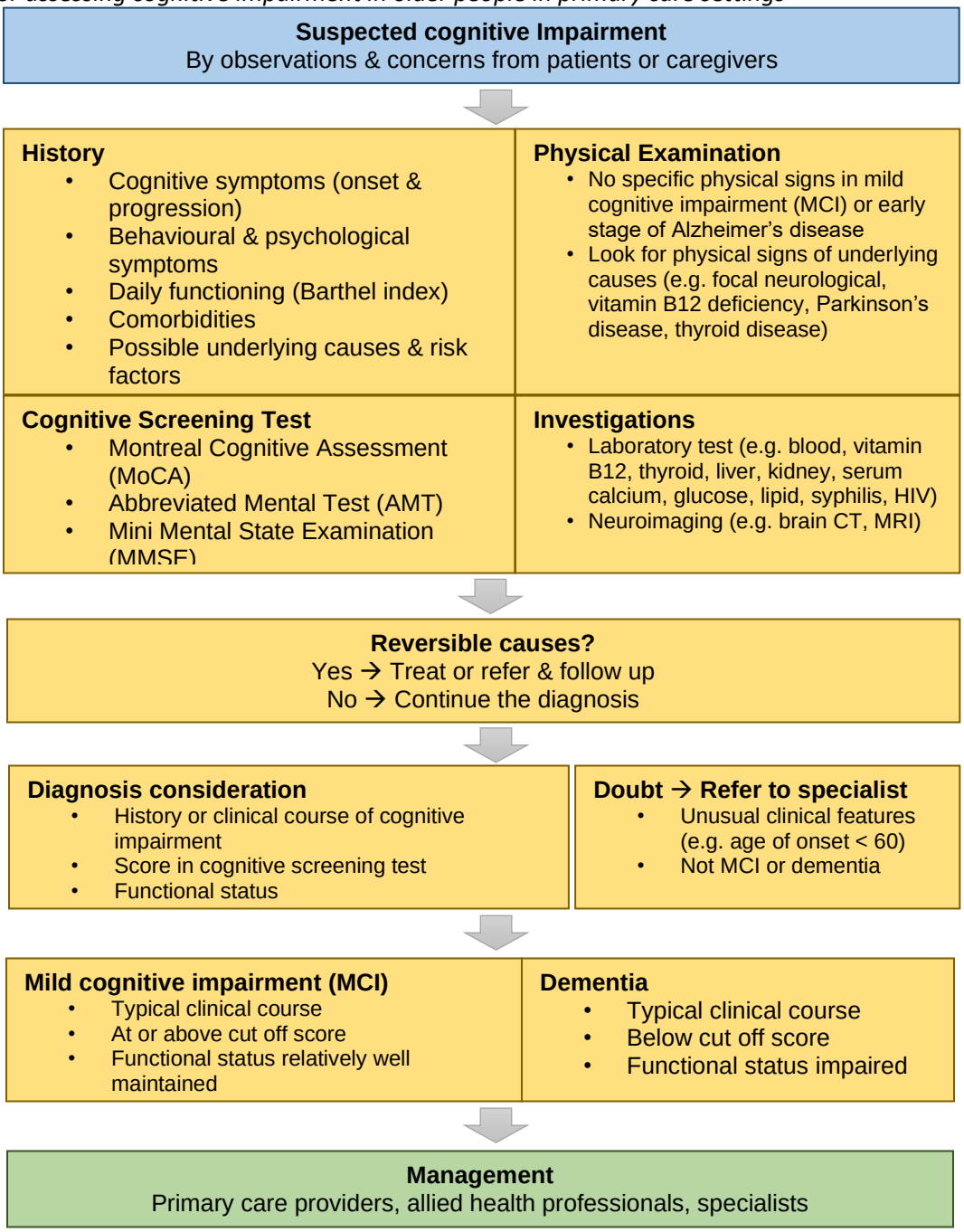
Advice is provided on enhancing cognitive reserve and reducing the modifiable risks of dementia to prevent cognitive impairment. These include stopping smoking, healthy eating, staying physically and socially active, participating in intellectual and leisure activities, preventing head injury, avoiding excessive alcohol use, maintaining optimal levels of health indicators (e.g., body weight, waistline, blood pressure, blood sugar and blood cholesterol), and collaborating with care providers on the management of other medical conditions (e.g., heart diseases, stroke and depression). Avoiding the long-term use of hypnotics, practicing Tai Chi, early detection of cognitive impairment, and seeking medical advice are also noted as important in preventing cognitive impairment (Department of Health, 2017, p. 32).

ii. Diagnosis of dementia

The guideline recognises dementia as a progressive and mostly irreversible cognitive decline that causes functional impairment in daily activities. There are four major subtypes of dementia, Alzheimer's disease, vascular dementia, mixed dementia, and other subtypes such as dementia with Lewy bodies, frontotemporal dementia and Parkinson's disease dementia (Food and Health Bureau, 2017a, p. 7). One chapter in the guideline covers the diagnosis of dementia (Chapter 3). The assessment of cognitive impairment in primary care settings should include history, physical examination, cognitive screening, appropriate investigations, and review of medication that may adversely affect cognitive functions (Food and Health Bureau, 2017a, p. 12). Figure 12 illustrates the algorithm for assessing cognitive impairment in older people in primary care settings (Food and Health Bureau, 2017a, p. 13).

Figure 12

Algorithm for assessing cognitive impairment in older people in primary care settings



(Food and Health Bureau, 2017a, p. 13)

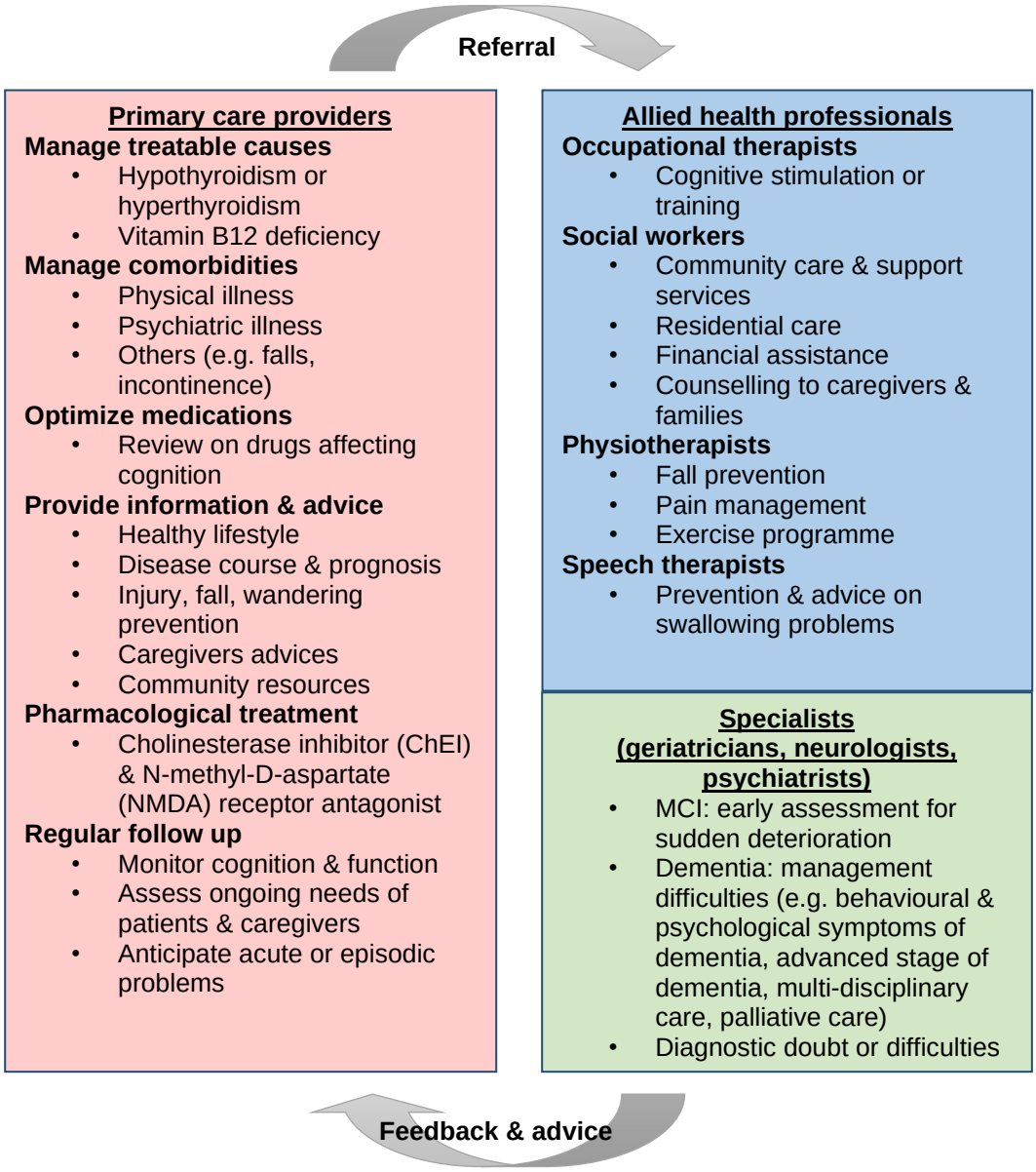
iii. Management of dementia (including treatment, medication management, non-cognitive symptoms and comorbidities)

One chapter in the guideline covers the management of dementia (Chapter 4). Management of cognitive impairment in primary care settings requires a multi-disciplinary team approach to achieve the goals of improving quality of life, maximising functional performance, and addressing the mood and behaviour of the older person.

The algorithm for managing cognitive impairment in older people in primary care settings is shown in Figure 13 (Food and Health Bureau, 2017a, p. 22).

Figure 13

Algorithm for managing cognitive impairment in older people in primary care settings



(Food and Health Bureau, 2017a, p. 22)

The chapter on progressive cognitive symptoms management (Chapter 4.3.1) covers pharmacological treatments for symptomatic relief in dementia, especially Alzheimer's disease. These include Cholinesterase inhibitors (ChEI) (e.g., Donepezil, Rivastigmine, Galantamine) and N-methyl-D-aspartate (NMDA) receptor antagonists (e.g., Memantine) (Food and Health Bureau, 2017a, pp. 29-30). These medicines are included in the Hospital Authority Drug Formulary in Hong Kong (Government of the Hong Kong Special Administrative Region, 2015, February 25).

iv. Other post-diagnostic supports of people with dementia.

One chapter in the guideline covers post-diagnostic support of people with dementia and their family carers (Chapter 5). Primary care providers should provide an individualised management plan to address the changing needs at different stages of dementia, which usually follow a slow deterioration and functional dependence along the journey of dementia care from diagnosis to end-of-life (Department of Health, 2017, p. 33).

v. Advance care directives, power of attorney or guardianship

The chapter on information and advice provision (Chapter 4.2.5) recognises the importance of long-term care and advanced care planning at an early stage. Clinicians should explain and discuss with people with dementia and their families the legal provisions for medical, financial, and legal decision-making. Advance care directives and enduring powers of attorney should be made when the older person is mentally capable. Guardianship Orders should be used to promote the interests of the mentally incapacitated person who can only grant limited powers to a guardian (Department of Health, 2017, p. 26).

vi. Palliative and end-of-life care

The chapter on specialist referral (Chapter 4.2.7) mentions the need for palliative and end-of-life care to address the complicated care needs at these advanced stages of dementia (Department of Health, 2017, p. 28). The chapter on the dementia care journey (Chapter 5) suggests some possible end-of-life interventions. Primary care providers should liaise with secondary care providers to provide palliative care and follow the advance care plan, if any. Primary care providers should provide caregivers and families with education, bereavement support, follow-up on mood problems and referral to support groups when needed (Food and Health Bureau, 2017a, p. 34).

vii. Care in nursing and residential care facilities

The guideline does not specifically mention care in nursing and residential care facilities. The chapter on behavioural and psychological management (Chapter 4.3.2) mentions that the leading reason for assisted living in nursing and residential care homes is mainly related to caregiving stress resulting from behavioural and psychological symptoms of dementia (Food and Health Bureau, 2017a, p. 30). Close monitoring by health professionals in nursing and residential care homes can reduce the continuous use of antipsychotics to treat the behavioural and psychological symptoms of dementia (Food and Health Bureau, 2017a, p. 32).

viii. Care in hospitals

The guideline does not specifically mention care in hospitals. The chapter on progressive cognitive symptoms management (Chapter 4.3.1) mentions the provision of structured activity training in public hospitals and community centres for people with dementia. These include the daily use of memory aids, cognitive stimulation games, lifestyle readjustment, body-mind interaction activities, breathing and muscle relaxation exercises, and online self-help resources. Timely referral to health professionals should be made according to the progress of cognitive decline of people with dementia, especially those requiring medical attention (Department of Health, 2017, p. 29).

e. Additional STRiDE questions:

i. Who developed the guidelines, and when were they developed?

This guideline was developed by the Department of Health in 2017, with support from the Advisory Group on Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings, Hong Kong College of Psychiatrists, Hong Kong Geriatrics Society, and Hospital Authority (Department of Health, 2017, p. 1).

ii. What are the expectations of different stakeholders in relation to the guidelines?

There is no available information about the expectations of different stakeholders in relation to the guideline.

iii. Besides clinical standards or guidelines, is the use of traditional medicine and healers to manage or treat dementia common?

This is not clear. Some Chinese medical practitioners offer traditional Chinese herbal medicine and acupuncture to relieve the symptoms of dementia, maintain cognitive function and cope with the side effects of Western medication. However, no information is available about how common it is.

iv. If yes, what is commonly used?

Most probably traditional Chinese herbal medicine and acupuncture, although there is no reliable source of information reflecting how common they are and whether other types of traditional medicine are used.

v. How are medicines or practices communicated and accessed?

Along with cognitive function decline and increased behavioural and psychological symptoms, primary care providers should refer to specialists (e.g., geriatricians, psychiatrists, neurologists) for specific pharmacological treatments when necessary. Pharmacological treatments should be used with caution taking into account the expectations of patients and families, possible side effects, and other health problems experienced by patients (Department of Health, 2017, p. 29).

VII. Dementia Care Coordination

a. Is there a mechanism to coordinate care across sectors in government for people with dementia? Examples of care coordination models include integrated care pathways, care networks, multidisciplinary or interdisciplinary teams and case management. (GDO 5x1)

The Mental Health Review Report proposed a medical-social collaboration model to outline the strategies, care and support needed along the continuum of care levels and care settings (Figure 14) (Food and Health Bureau, 2017a, p. 181).

With reference to this model, a mechanism of care coordination across the healthcare and social care sector was developed and implemented, the Dementia Care Support Scheme, piloted in 2017 and regularised in 2020. The scheme, steered by the Food and Health Bureau in collaboration with the Hospital Authority, Social Welfare Department, and NGO-operated District Elderly Community Centres, aims to provide support services to older people with mild or moderate dementia in the community through medical-social collaboration. A multidisciplinary team involving nurses, social workers, occupational therapists, and physiotherapists from both sectors was formed to formulate and provide individualised care and support to people with dementia and their family carers.

Figure 14

Medical-social collaboration model in dementia care

	Mild dementia	Moderate dementia	Severe dementia
Care level	Primary (stable cases) → Specialised (complicated cases)		
Strategy	• Early diagnosis & intervention	• Stabilisation of symptoms • Behavioural management • Maintenance at home or in the community	• Maintenance of quality of life
Medical care	**Visiting physicians & primary care physicians (public or private)** • Diagnosis & intervention • Care planning • Regular follow-up • Referral to specialist care for complicated cases	**Visiting physicians & primary care physicians (public or private)** • Specialist care for BPSD or physical comorbidities • Regular follow-up • Review care plan • Structured interventions	**Visiting physicians, community geriatric assessment teams (CGATs) & psychogeriatric assessment teams (PGTs)** • Regular follow-up • Maintenance of interventions • Prepare for end-of-life care
Social care	**Community elderly care service units** • Structured day care or home care • Cognitive training • Physical reconditioning • Carer support & education	**Designated community dementia care units** • Dementia specific day care, home care & community support • Advance care planning • Carer support • Prepare for residential or institution care	**Dementia residential care units** • Maintenance of care • Prepare for end-of-life care • Carer support
Care setting	Home & community (80%)		Residential (20%)

(Food and Health Bureau, 2017a, p. 181).

Other than the Dementia Care Support Scheme, there is no established mechanism of care coordination specifically for dementia. Professional training on dementia care coordination and case management is available (e.g., dementia care planner) in some NGOs (for details, please refer to Part 7 - II 1)f), but no cross-sectoral coordination mechanism exists. One government scheme, the Community Care Voucher Scheme, piloted a case management model in the care of older people, but it has not been regularised and is not dementia-specific.

b. Which of the following sectors are included in the coordinated planning and resourcing of care for people with dementia across the continuum of care? (GDO 5x1x1)

i. Health

In the public sector, the Food and Health Bureau, Hospital Authority, and Department of Health are involved. It has been suggested that the role of private GPs and public primary care physicians in making diagnoses should be strengthened. However, this recommendation has not yet been officially or widely implemented.

ii. Social

The Labour and Welfare Bureau, Social Welfare Department, and NGOs operating care services for older people under government subvention are involved.

iii. Education

The education sector is not currently involved. The Mental Health Review Report suggested involving schools to improve public understanding and attitudes towards dementia. However, this suggestion has not progressed, and the education sector is not involved in coordinated planning and resourcing care for people with dementia.

iv. Employment

No.

v. Justice

No.

vi. Housing

The Mental Health Review Report recommended building a dementia-friendly community. Examples of measures included removing harmful substances and sharp objects from daily surroundings, mounting clear signs at the right height, using contrast to highlight or conceal, making things such as the contents of cupboards visible and easy to understand. However, these suggestions have not been progressed, and the housing sector is not currently involved in coordinated planning and resourcing of care for people with dementia.

vii. Civil Society

The Mental Health Review Report advocated an adequate supply of multi-disciplinary healthcare professionals and skilled social care personnel to provide different types of care to meet the varying needs and rising demand for dementia care. However, there was no clear subsequent coordinated workforce planning and training involving the major professional training organisations and universities, and civil society is not currently involved in coordinated planning and resourcing of care for people with dementia.

viii. Transport

No.

ix. Private sector

No

x. Other?

No.

c. Is the coordinated planning and resourcing of care for people with dementia implemented at the national or sub-national level, or both? (GDO 5x1x2)

The Dementia Care Support Scheme is implemented territory-wide in Hong Kong.

d. Do formal agreements and/or joint plans exist across sectors in government for people with dementia? (GDO 5x1x3)

Formal agreements and joint plans exist across different government sectors to implement the Dementia Community Support Scheme, involving the Food and Health Bureau, Social Welfare Department, and Hospital Authority (Food and Health Bureau, 2017a, p. 25).

e. What are the components of care coordination? (NB: this is not a comprehensive list) (GDO 5x2x1)

i. Multi or interdisciplinary teams

In the Dementia Community Support Scheme, doctors and nurses in public hospitals, and social workers, nurses, occupational therapists, and physiotherapists in District Elderly Community Centres comprise multi-disciplinary teams.

ii. Task shifting/sharing

The Dementia Community Support Scheme illustrates task sharing in post-diagnostic community support for people with dementia, in which the social care and healthcare sectors share community support functions.

iii. Responsive referral protocols or pathways

The Dementia Community Support Scheme describes the referral protocol pathways between the Hospital Authority and District Elderly Community Centres. Other than this, no coordinated referral protocols or pathways have been established.

iv. Continuity of information

No.

v. Provider continuity

No.

vi. Community-based approach

The Dementia Community Support Scheme is a community-based approach in which care and support services are mainly provided by NGO centres in the community. Nurses are allocated to the Dementia Community Support Scheme teams in these centres to deal with some nursing and medical needs and reduce the need for hospital and clinic visits.

vii. Other?

Not applicable.

f. Is care coordination between multiple governmental sectors occurring at Primary, secondary or tertiary level care? (GDO 5x2x2)

Care coordination in the Dementia Community Support Scheme occurs mainly at the secondary levels of care.

g. Additional STRiDE questions:

i. How are the different aspects of care coordination (covered in the section above) organised? For example, if task sharing is being pursued, who trains whom, who supervises whom?

The government promotes a coordinated cross-sectoral and multi-disciplinary approach to dementia care. Health professionals and care workers are trained by academic institutions to provide quality care regulated by the government sectors, as well as collaborations with NGOs and other sectors. The Dementia Community Support Scheme is an example of care coordination between the Social Welfare Department, Hospital Authority, and NGOs, working together to organise and provide community support services to people with mild or moderate dementia and their family carers. The supervisory roles and corresponding responsibilities of these parties are listed below (Food and Health Bureau, 2017a, pp. 25-26):

Social Welfare Department

- Supervisory role of care coordination
- Referral of people with suspected indicators of early dementia in the community

Hospital Authority

- Referral of suitable patients with mild or moderate dementia
- Primary care doctors (e.g., general practitioners) to provide medical support to stable patients through public-private partnership

NGOs

- 20 subvented District Elderly Community Centres
- Health and social professionals provide support to people with dementia in participating District Elderly Community Centres

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VIII. The Policy Process

a. What changes in policy in relation to dementia are expected in the next 5 years?

Concerned about long waiting time and inadequate provision of health and social care services for people with dementia, some stakeholders have recommended the government strengthen the existing dementia care service model and develop a dementia-specific policy in Hong Kong. They suggest putting more effort into public education to raise awareness and reduce stigma, health assessment and early diagnosis in primary care settings, long-term care and intervention to achieve ageing in place, and carers training to reduce the caregiving burden (Legislative Council Secretariat, 2017, February 21).

b. Is there evidence of ongoing developments that indicate a change in policy or financing for dementia in the future?

The government has been reviewing existing strategies for dementia care, budget allocation and workforce enhancement. It implemented the Dementia Community Support Scheme in 2017. Also, the Social Welfare Department coordinates with relevant departments to reserve sites to provide more daycare and residential care units for older people. The government also pledged to continue the public consultation on advanced care directives, a major concern regarding end-of-life care for older people, including those with dementia. Based on the Mental Health Review Report and the Elderly Services Programme Plan, it is expected that the government will continue to serve as a platform facilitating coordination among bureaux, departments, and organisations, and regularly review the progress of change in relevant policies and financing for dementia in the future. However, no clear information or specific evidence could be found at the time of this desk review (March-June 2020).

c. By whom and by what process are they driven by? What are the motivations?

No clear information or specific evidence could be found at the time of this review.

d. Are the expected policy changes, likely to result in any of the following:
   i. A new or a revised National Dementia Plan?
   ii. Dementia being included in another National Plan or policy, such as ageing, or NCDs?
   iii. Do you expect any policy changes, perhaps in relation to wider health services reform, or long-term care or social protection, which may result in increased availability of care, treatment and support?

No clear information or specific evidence could be found in relation to these questions at the time of this review.

e. Can new clinical guidelines covering dementia be expected?

No clear information or specific evidence could be found at the time of this review.

f. Who are the key stakeholders who can bring about a policy change in relation to dementia in your country (if possible, please provide names and position)?

A wide range of stakeholders is involved in generating a policy change in relation to dementia in Hong Kong, including people with dementia, family carers, social and health service providers, academics, philanthropists, policy advisors, government officials, and the general public. The key government departments, NGOs and other sectors related to dementia are outlined in Table 17 in section III.

Part 5: Dementia Awareness and Stigma

I. Awareness of Dementia

a. Was at least one functioning dementia public awareness campaign to improve understanding and reduce stigma and discrimination carried out during the past year in your country? (GDO 13x1)

2018 – 2021
A three-year public education programme, "Dementia Friendly Community Campaign", was launched by the Social Welfare Department in September 2018. The aim of the campaign is to advocate public awareness and understanding of dementia and build a dementia-friendly community for people with dementia and their families (Social Welfare Department, 2019 August 28). The campaign comprises of different activities, including a set of public TV and radio announcements, a designated webpage (https://www.swd.gov.hk/dementiacampaign/en/index.html), an 8-epsiode television docudrama and radio content on dementia, dementia-related movie screening and sharing, a district programmes on public education, cognitive stimulation, carer support activities, and information sessions on Dementia Friends and workshops on Dementia Friends Ambassadors.

2018 – 2021
"Dementia-Friendly Community in Southern District" is a district-based campaign funded by the government's Community Investment and Inclusion Fund and implemented by the NGO Christian Family Service Centre, in the Southern District, one of Hong Kong's 18 districts. This campaign aims to establish a collaborative platform and dementia-friendly community care among various organisations, businesses, residents, and carers in the District. Its main activities include volunteer training, registration of recognised dementia-friendly businesses, a free dementia screening service and home safety assessment for older adults (Christian Family Service Centre, 2020).

b. Please describe all known public awareness campaigns for dementia and specify for each: the name of the campaign, the delivery channel (i.e. tv, radio, print etc), the audience, funding (government/public or NGO) and the area of implementation (i.e. national, sub-national, or a specific area)? (GDO 13x2)

Other than the campaigns mentioned above, we conducted a search to identify all the local public awareness campaigns for dementia with information available online. These campaigns are funded and implemented by a wide range of charitable institutions and NGOs. Details of these campaigns are summarised below (in chronological order):

2007 – ongoing
The "Love-your-brain" website (www.loveyourbrain.org.hk), funded by the Community Chest charity and developed by the Hong Kong Society for the Aged, an NGO, was launched in 2007 as the first brain health website for a Chinese population worldwide. The website serves as a 'brain fitness gym' which offers different brain-stimulating games tailored to the needs of Chinese older adults. In addition, it provides an online information hub to increase the general public's understanding and awareness of the onset of dementia and ways to promote brain health.

2011 – 2012
The "Active Prevention and Early Detection of Cognitive Impairment" project, funded by the charity Simon K. Y. Lee Foundation and implemented by academia and local NGOs, was a territory-wide education campaign from 2011 to 2012 to communicate information about dementia to the public. It aimed to raise community awareness of dementia and promote the message of early detection and intervention through various channels, including

talks, street exhibitions, carer training, counsellor and volunteer training, TV infotainment, newspaper columns, and radio programmes (Simon K. Y. Lee Foundation).

2012 – 2013
The "Brain Health Public Education Campaign", funded by the Hong Kong Jockey Club Charities Trust and implemented by the Jockey Club Centre for Positive Ageing (JCCPA) and CADENZA: A Jockey Club Initiative for Seniors, was a territory-wide campaign on public brain health promotion between September 2012 and May 2013. The campaign promoted a healthy lifestyle for dementia prevention and alleviating the impact of cognitive impairment. The educational messages were disseminated through talks, game design workshops, a competition, and a one-day community carnival. In addition, educational leaflets and books were distributed to primary and secondary school students, and a promotion video was broadcasted through public channels (Hong Kong Jockey Club, 2012 August 28).

2013 – ongoing
The "Jockey Club Charles Kao Brain Health Mobile Services" is a brain health promotional vehicle funded by the charities The Hong Kong Jockey Club Charities Trust and Charles K. Kao Foundation for Alzheimer's Disease and operated by the NGO, St. James' Settlement, since 2013. This vehicle has provided territory-wide public education programmes to raise awareness among the general public about dementia through exhibitions, talks, and promotional videos. It also provides preliminary assessments for older adults at risk of dementia, medical referral, and support to people with dementia and carers (St. James Settlements', 2020).

2013 – ongoing
The "Brain Health Education Programme", launched by the Charles K. Kao Foundation in partnership with Hong Kong Alzheimer's Disease Association, Hong Kong Repertory Theatre and Fantasy Puppet Theatre and sponsored by Shun Hing Education and Charity Fund and Providence Foundation Limited, is an ongoing project consisting of multiple series of brain health education programmes launched in 2013. Its delivery channels include educational talks, game booths in primary and secondary schools and distribution of educational kits to teachers (1st series; 2013 -2014), interactive dramas performed in secondary schools (2nd series; 2013 – 2017), puppet shows for primary schools (3rd series; 2013 – 2020), and, more recently, an ethnography drama workshop and showcase performance encouraging students to study the lives of people with dementia and then showcase their learnings in the format of drama to their fellow students (Charles K Kao Foundation for Alzheimer's Disease).

2014 – 2018
The "Dementia Concern Campaign" and "Jockey Club Dementia Friendly Communities Campaign", a 16-month and a 2-year territory-wide campaigns funded by the Hong Kong Jockey Club Charities Trust and implemented by the Jockey Club Centre for Positive Ageing in 2014 and 2016, respectively, aimed to promote a positive attitude and acceptance towards people with dementia among the public, particularly frontline staff in different fields (such as security guards, drivers, and bank tellers). Through talks, interactive workshops, tailor-made education and training programmes, the campaign encouraged frontline staff who would come across older people in their work to co-create a dementia-friendly community by providing appropriate support and assistance to people with dementia in their workplaces and neighbourhood (Hong Kong Jockey Club, 2014; Jockey Club Centre for Positive Ageing, 2018).

2015 – 2018
"Project Sunrise" is a district-based campaign in Tsuen Wan and Kwun Tong, two of Hong Kong's 18 districts, funded by the charitable foundation Lee Hysan Foundation from 2015 to 2018. Implemented by the Hong Kong Alzheimer's Disease Association and the Christian Family Service Centre, the project emphasized education and early detection across different target audiences, including the general public, employees in different service

industries and general practitioners via public talks, staff training and workshops, educational cue cards to raise awareness and increase early detection of dementia symptoms in the community.

c. What population groups outside the health and long-term care sector receive training and education in dementia? (GDO 15x1 and 15x2)

Dementia training and education is currently not mandatorily covered in the formal training of the other sectors. However, various NGOs and academic institutions actively promote training programmes to other sectors to build a more dementia-friendly environment in Hong Kong. For instance, under the Dementia Friends Hong Kong initiative (https://www.dementiafriends.hk/en/), the Hong Kong Alzheimer's Disease Association tailored the dementia training content in terms of depth and scenarios for different target groups to equip workforces in other sectors with knowledge about dementia and skills to communicate with people with dementia. Any companies or organisations interested in this initiative could register as a Supporting Partner of Dementia Friends Hong Kong and attend an information session to understand more about dementia.

i. Volunteers

Most community care service units for older people, such as District Elderly Community Centres and Neighbourhood Elderly Centres, provide volunteer training. Dementia is a common topic covered in their regular volunteer training to increase public awareness about dementia and equip volunteers with the skills for home visits, simple homemaking and escorting people with dementia to medical appointments.

ii. Police and fire services

The Hong Kong Police Force is registered as a dementia-friendly organization and has participated in training workshops on dementia that include information on dementia symptoms, communication skills, techniques to handle people with dementia and ways to help missing individuals who have dementia. (https://www.police.gov.hk/offbeat/1044/eng/2939.html)

The Hong Kong Police also has a set of guidelines to help communication with mentally incapacitated people, which encompasses people with dementia (Hong Kong Police Force, 2020).

The Fire Service provides no information indicating that it has received education or training on dementia.

iii. First responders / paramedics

Paramedics under the Auxiliary Medical Service have received training on dementia. However, details of the training provided cannot be found.

iv. Judges, solicitors, notaries

Individuals with dementia are under the umbrella term, mentally incapacitated persons, in the Mental Health Ordinance in Hong Kong. Through formal law education, it is believed that legal professionals in Hong Kong are equipped with knowledge of the legal procedures for defining mentally incapacitated persons. However, such training and education are not specifically about dementia.

v. Community/city workers (e.g. public transport staff, librarians)

Only a few companies/public services organisations have provided dementia training to their staff. The Mass Transit Railway (a significant public transport provider in Hong Kong) arranged four batches of staff to attend the 'Get to Know Dementia' Training Course during 2018–2019, delivered by the Hong Kong Medical Association.
http://www.hkma.org/communityhealthacademy/06.htm
http://www.hkma.org/communityhealthacademy/04_01.htm

The Hong Kong Electric Company is registered as a dementia-friendly organisation under Dementia Friends Hong Kong and has arranged talks about dementia for its staff.
https://www.hkelectric.com/en/MediaResources/PressReleases/Pages/%E6%B8%AF%E7%87%88%E6%88%90%E9%A6%96%E6%89%B9%E3%80%8C%E8%AA%8D%E7%9F%A5%E5%8F%8B%E5%96%84%E3%80%8D%E4%BC%81%E6%A5%AD--%E3%80%8C%E9%80%81%E6%9A%96%E6%A8%82%E7%A4%BE%E7%BE%A4%E3%80%8D%E5%8A%A9%E6%8E%A8%E5%BB%A3%E9%A0%90%E9%98%B2%E8%85%A6%E9%80%80%E5%8C%96.aspx

The Hong Kong Medical Association also provided five batches of the "Get to Know Dementia' training course to security personnel in several public housing estates in the Eastern District in 2017.
http://www.hkma.org/communityhealthacademy/01.htm

vi. School children

Although it is not part of the formal school curriculum, many primary and secondary school children have received education about dementia through educational talks, interactive drama performances, puppet shows and drama workshops under the "Brain Health Education Programme" promoted by the Charles K. Kao Foundation (Charles K Kao Foundation for Alzheimer's Disease).

vii. Bankers, financial service staff

HSBC, one of the largest banks providing local retail banking services, is the first bank to register with Dementia Friends in Hong Kong. With the help of the Hong Kong Alzheimer's Disease Association, the bank trained and deployed dementia-specialist staff, Dementia Friends Ambassadors, in their branches to support people with dementia and their carers in daily financial matters.
(https://www.about.hsbc.com.hk/-/media/hong-kong/en/news-and-media/190516-basic-banking-account-eng.pdf)

viii. Retail and hospitality staff (e.g. restaurants, grocery stores)

Some retail businesses have also registered as Dementia Friends in Hong Kong, including PARKnSHOP, a supermarket chain, Watsons, a health and beauty retail chain store and Fortress, a major retailer of electronics and home appliances. Furthermore, Fairwood, a local fast food restaurant chain, invited the Hong Kong Medical Association to deliver two batches of dementia training to its frontline staff.
http://www.hkma.org/communityhealthacademy/06.htm

d. Please describe the cultural/societal perceptions of dementia (including gender factors) in your country.

Previous local studies show that the negative image of dementia and the burden of caring for a person with dementia were factors standing in the way of Chinese older adults with early dementia from seeking help from a

doctor (Chan, 2012). An additional local study also found that a stigmatizing attitude was a barrier to help-seeking (Cheng et al., 2011).

Most nurses and personal care workers working in long-term care of people with dementia found it challenging. Nevertheless, they had a positive attitude towards further training in dementia and demonstrated commitment to working in dementia care (Lee, 2012).

Surveys on the perception of the general public and primary care physicians on dementia diagnosis and intervention suggest both groups have a similar perception. A recently-conducted study shows an accepting and proactive attitude towards early diagnosis of dementia to seek prompt intervention and support among a majority of Chinese in Hong Kong (Lam et al., 2019). In the same study, practical issues and legal concerns were reported as the most and least fearful consequences associated with dementia, respectively. Most respondents identified cognitive impairment as a symptom of dementia; however, respondents had inadequate knowledge that behavioural disturbance could also be a possible sign of dementia. On the other hand, in view of the added benefits of early treatment to people with dementia and carers, primary care physicians also show a positive attitude towards early detection and diagnosis of dementia (Leung et al., 2020).

e. Is there any evidence of current or changing perceptions of dementia in your country? If so, what is motivating these changes?

The Jockey Club Centre for Positive Ageing conducted public surveys in 2005 and 2015 (Jockey Club Centre for Positive Ageing, 2015) to examine the change in knowledge about dementia in Hong Kong. The comparison showed a changing perception of dementia, including improved knowledge and awareness of dementia and a reduction in misconceptions. The findings also indicated that respondents paid more attention to the signs of early dementia and became more willing to bring their family to consultations with a physician when dementia symptoms emerged.

This change in public perception could be attributed to multiple factors. First, in 2010, a working group comprised of ten medical professional bodies and other dementia campaigns had suggested changing the Chinese terminology for dementia to alter people's perceptions of those with dementia. The original Chinese terminology for dementia was equivalent to 'insanity' and 'idiocy'; in other words, a demeaning term. Medical professionals believed the negative connotation of the Chinese terminology largely contributed to the stigmatizing attitude towards dementia, which resulted in delays in seeking medical consultations and a refusal to accept diagnosis among the general public (Working Group on New Chinese Terminology for Dementia and Cognitive Impairment, 2011). In 2012, the working group proposed a new term signifying dementia as a cognitive disorder, attempting to reduce its stigmatizing connotation (Chiu & Li, 2012). The new Chinese terminology for dementia was found to be more acceptable, and the vast majority (87%) supported the substitution of the old term (Chiu et al., 2014). The new Chinese name for dementia is now widely adopted by the media, medical professionals, the general public, and the government.

Second, Professor Charles K Kao, former Professor in the Chinese University of Hong Kong and the Nobel Laureate in Physics in 2009, known as the "Father of Fibre Optics", battled against Alzheimer's disease since 2002. This significantly raised public awareness about dementia and led the public to stop viewing dementia as taboo. In addition, Charles K Kao and his spouse founded a foundation in 2010, The Charles K Kao Foundation, to raise public awareness about dementia and disseminate tips on caring for the brain.

Third, local movies featured dementia (such as *Happiness* in 2016, *The Tail Before* in 2018) and television dramas (*Forensic Heroes IV*, *Lo and Behold*) that generated awareness about the disease, enhanced understanding of people with dementia and their care needs. Apart from that, a few celebrities shared their stories and experiences

of caring for a family member diagnosed with dementia (such as Kara Wai Ying-Hung, Nina Paw Hee-Ching, and Kearen Pang).

Lastly, various dementia awareness campaigns conducted by different sectors and organizations have targeted different audience groups in the past decade. These include, but are not limited to, students, frontline workers, and caregivers, and have deepened public understanding of dementia and influenced perceptions of dementia.

f. What factors predominantly affect perceptions about dementia in your country: individual, family, community, society, government.

Findings from a local study indicate that brief exposure to dementia information could lead to stigma reduction and suggested the significance of community education in reducing barriers to early detection and treatment of dementia (Cheng et al., 2011). On the other hand, renaming the Chinese term for dementia in 2012 also altered how people in Hong Kong perceive dementia. A survey of 466 people with dementia and carers revealed that half thought the old Chinese name for dementia caused them to be stigmatized (Chiu et al., 2014).

g. What aspects does the training you described under question c cover?

The content of training varies across different organizers and target populations. In general, it covers attitudes towards dementia, knowledge and understanding about dementia, brain health knowledge for dementia prevention, communication skills with people with dementia, and coping with the impact of dementia with a positive attitude. The content of training and simulation activities for frontline staff who might encounter people with dementia in their workplace, such as police, banks and restaurants, were tailored to the needs of the organisation to equip their frontline staff with the skills to handle potentially difficult situations concerning dementia specific to their workplace (Jockey Club Centre for Positive Ageing, 2018).

h. In question a. you provided information on dementia public awareness campaigns. Have these (or earlier) campaigns be evaluated? Is there evidence of impact?

One of the major goals of the three-year Dementia Friendly Community Campaign is for 10,000 members of the general public to register as Dementia Friends Hong Kong during 2019 – 2021. As of March 2020, there were already more than 15,400 Dementia Friends in Hong Kong, far exceeding the initial target (Hong Kong Alzheimer's Disease Association, 2020b). Other than the number of registered Dementia Friends, no other sources of evaluation or evidence of impact have been identified.

i. Are there initiatives to improve the accessibility of the physical and social environment, including people with dementia? If so, which of these dimensions do they cover? (GDO 14.1 &14.2)

In view of rapid population ageing in Hong Kong, a five-year charity-funded project, 'The Jockey Club Age-friendly City Project', was launched in 2015. In partnership with four academic institutions, the project envisions Hong Kong evolving as an age-friendly city by evaluating territory-wide age-friendliness according to the age-friendly city domains identified by the World Health Organization (World Health Organization, 2007) and suggesting a suitable framework for relevant stakeholders to follow and act on. As this project is still ongoing at the time of review, the actions derived from it are yet to be confirmed. For details of the action plan and suggestions, please refer to its report on age-friendliness: https://www.jcafc.hk/uploads/docs/Cross-district-report-of-baseline-assessment-on-age-friendliness-(18-districts).pdf (Jockey Club Institute of Ageing CUHK et al., 2019).

i. Accessibility of public spaces and buildings

Suggestions for the accessibility of public spaces and buildings are listed under the domain "Outdoor Spaces and Buildings" in the Jockey Club Age-friendly City Project.

ii. Accessibility of public transportation vehicles

Suggestions for accessibility in public transport are listed under the domain "Transportation" in the Jockey Club Age-friendly City Project

iii. Assistance with home modification

Suggestions for assistance with home modification are listed under the domain "Housing" in the Jockey Club Age-friendly City Project

Furthermore, in 2005, Hong Kong Housing Society set up an Elderly Resources Centre and Age-friendly home website, offering an experimental tour and professional consultation service to advise on suitable home products and modifications for older people, including people with dementia and their carers. (Hong Kong Housing Society, 2020b) Other than a regular age-friendly product update, its website (http://www.hkhselderly.com/afh/?lang=en) also helps to evaluate a home environment's age-friendliness by completing a 20-item assessment and making suggestions based on the result.

iv. Assistive technology to compensate for loss of capacity

The Gerontech and Innovation Expo cum Summit, an annual Gerontech fair hosted by the government and the Hong Kong Council of Social Service, was launched in 2017, allowing companies to display their newly-developed gerontechnology products and equipment designed to enhance the quality of life of older people, including people with dementia (Gerontech and Innovation Expo cum Summit, 2020).

The Government has also established the Innovation and Technology Fund for Application in Elderly and Rehabilitation Care in 2018 to provide subsidies for purchasing, renting and trial usage of innovative technology products in rehabilitation service units and service units for older people. Organizations providing community care or rehabilitation services to disabled people and/or older people (including people with dementia) may apply for this funding (Social Welfare Department, 2020, February 4).

v. Availability of community places where older people can meet

Suggestions regarding the availability of community places where older people can meet are listed under the domain "Outdoor Spaces and Buildings" in the Jockey Club Age-friendly City Project.

vi. Availability of social opportunities as well as accessible information on leisure and social activities

Suggestions regarding the availability of social opportunities and accessible information on leisure and social activities are listed under the domain "Social participation and Communication and Information" in the Jockey Club Age-friendly City Project.

Part 6: Epidemiology of and Information Systems for Dementia

Dementia is one of the top ten leading causes of death in Hong Kong. In 2009, it was estimated that over 100,000 adults aged over 60 had dementia, which was expected to triple in three decades. At the same time, dementia is associated with a high prevalence of other significant non-communicable diseases, such as hypertension, diabetes mellitus, heart disease, stroke, hearing loss, obesity, and depression. However, the government had not regularly monitored the prevalence of dementia. The latest population-based study on dementia prevalence was conducted in 2005 – 2006.

I. Information Systems for Dementia

a. Is the number of people with dementia routinely monitored in your country? (GDO 16x1)
   i. By the Ministry/Department of Health?
   ii. By the Ministry/Department of Social Development/other?
   iii. By research-led institutions?
   iv. By non-governmental organizations?

The number of people with dementia is occasionally but not routinely monitored in Hong Kong. The Government has commissioned a Hong Kong Mental Morbidity Survey for Older People (Chinese University of Hong Kong, 2022), which is ongoing with results expected by end of 2022 or early 2023. Although there is no official statistics about dementia yet, different NGOs and research institutions investigate and monitor the prevalence, needs for service and care burden among people with dementia and their family carers (Government of the Hong Kong Special Administrative Region, 2015, June 17).

b. For each source, please describe what indicators are gathered, and what year the most recent estimates are available for. If no data is routinely monitored, please also mention this.

Jointly conducted by the Elderly Health Service of the Department of Health and the Department of Psychiatry of the Chinese University of Hong Kong, the population-based study of 2005-2006 provides the most up-to-date estimates of dementia prevalence in Hong Kong (Elderly Commission, 2006).

For the ongoing Hong Kong Mental Morbidity Survey for Older People, preliminary findings have been published in its mid-term progress update. For details, please visit:
https://rfs2.healthbureau.gov.hk/images/jsn_is_thumbs/images/past_event/Health_Research_Symposium_2021/Materials/HRS2021_T4a_powerpoint.pdf

c. For each source, please outline what data sources are used to routinely monitor people living with dementia in your country (Clinical records/ household surveys/ administrative data/ facility surveys or records/ other?) (GDO 16x1x1)

The population-based study was a one-time thematic household survey to identify the prevalence of dementia, the proportion of different severity levels and subtypes of dementia among 6,100 people aged 60 or above living in the community (Elderly Commission, 2006).

d. For each source, please specify if the estimates are available electronically? (GDO 16x1x2)

Estimates about dementia can be found on the website of the Department of Health (Elderly Commission, 2006) and in a published article, "Prevalence of very mild and mild dementia in community-dwelling older Chinese people in Hong Kong" (Lam et al., 2008).

e. For each source, please specify if the estimates can be disaggregated by gender, geographical area or by type of dementia. (GDO 16x1x3)

In the population-based study, the prevalence of dementia is disaggregated by gender, age, severity, and subtypes of dementia.

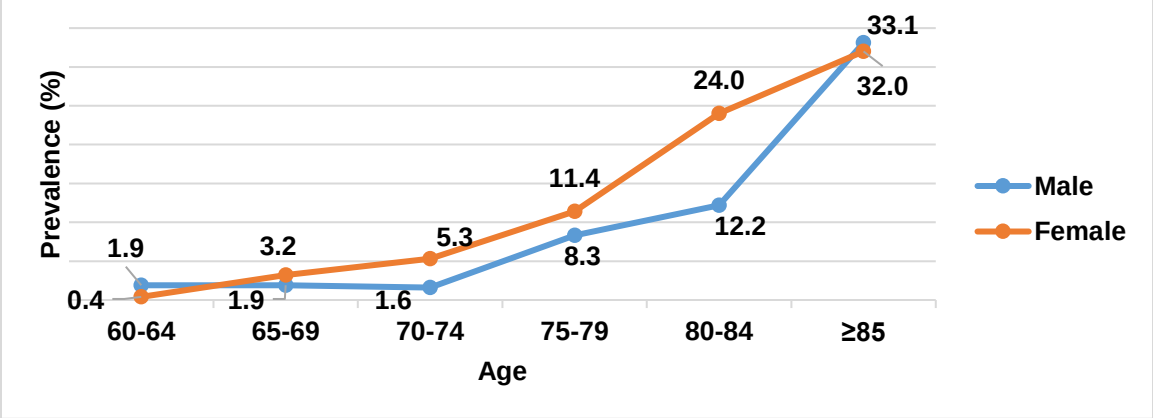
II. Epidemiology of Dementia

a. What is the estimated prevalence and incidence of dementia and the source of these estimates? (GDO 21 & 22)

From the population-based study conducted in 2005-2006, the prevalence of dementia in Hong Kong was 7.2% in people aged 60 or above (9.85% for females and 4.2% for males) and 9.3% in people aged 70 or above (15.3% for females and 8.9% for males). Figure 15 shows the prevalence of dementia by gender and age group. Alzheimer's disease was the most common type of dementia, accounting for 63% of dementia patients. The prevalence of different severities and subtypes of dementia are shown in Table 18 (Elderly Commission, 2006). No data are available for the incidence of dementia in Hong Kong.

Figure 15

Prevalence of dementia by gender and age groups in the population-based study: 2005-2006



(Elderly Commission, 2006).

Table 18

Proportion of different severity and subtypes of dementia in the population-based study: 2005-2006

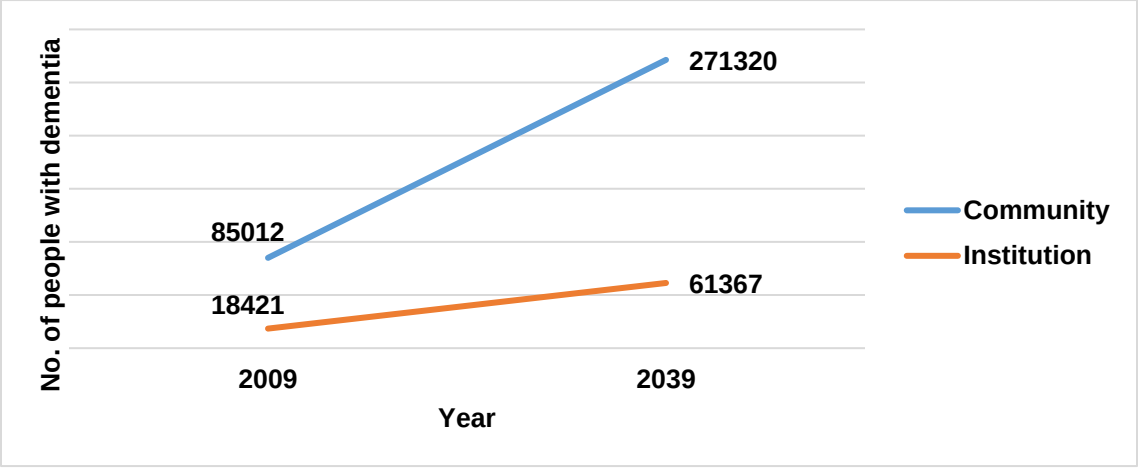
Severity	
Mild	83%
Moderate	10%
Severe	7%
Subtype	
Alzheimer's disease	63%
Vascular dementia	20.3%
AD with cerebrovascular risk factors and Mixed dementia (AD and vascular)	12%
Dementia with Lewy bodies	0.7%
Other dementia	4%

(Elderly Commission, 2006)

Other sources estimate the prevalence of dementia in Hong Kong. A systematic review published in 2013 estimated that the prevalence of dementia among people aged 65 and over in Hong Kong was 6.8% (Wu et al., 2013). Another study used secondary data to predict the prevalence and trends of dementia in Hong Kong and projected that the number of people with dementia aged 60 years or above would increase from 103,433 in 2009 to 332,688 in 2039, more than a three-fold increase. Figure 16 shows the estimated and projected numbers of people living with dementia in the community and institutions (Yu et al., 2012). The population health survey in 2014-2015 estimated the overall population prevalence of self-reported dementia was 0.6% for females and 0.2% for males. The overall population prevalence of dementia by gender and age groups is shown in Figures 3 and 4 in Part 1 (Centre for Health Protection, 2017). The Hospital Authority also estimated that 5-8% of people aged 65 years or above and 20-30% of people aged 80 years or above would have varying levels of dementia (Hospital Authority, 2020, April 20).

Figure 16

Estimated and projected numbers of people aged 60 and above living in the community and institutions with dementia in 2009 and 2039



(Yu et al., 2012)

b. Please outline the total deaths and Years of Life Lost (YLL) due to dementia and the source of these estimates. (GDO 23 &24)

As of July 2018, dementia was the eighth and fifth leading cause of death for males and females, respectively (HealthyHK, 2018, July 19). In 2017, 1,455 people lost their lives due to dementia, accounting for 3.1% of total

deaths. The number of deaths caused by dementia by gender and age groups is shown in Table 19 (Centre for Health Protection, 2019). From 2001-2009, the number of people aged 60 and above dying due to dementia doubled from 1% to 2% of all deaths. The age-standardized mortality rate (per 100,000 population) of dementia increased from 23.3 to 47.3 for males and 45.6 to 62.0 for females. Mortality rates increase exponentially with age (Yu et al., 2012). Between 2001 and 2010, 145 centenarians died due to dementia (Yu et al., 2017).

Table 19

Number of deaths caused by dementia by gender and age group 2017

	Age Group		
	45-64	≥ 65	All
Males	1	556	557
Females	2	896	898
All	3	1452	1455

(Centre for Health Protection, 2019).

The disability-adjusted life years (DALYs) due to dementia for people aged 60 or above was 286,313 in 2006, 83,051 (29%) for males and 203,262 (71%) for females. DALYs consists of years of life lost (YLLs) and years lived with disability (YLDs). The estimate of YLLs due to dementia was 1,987 life years (Yu et al., 2012).

c. Please outline the total Years lived with disability (YLDs) due to dementia and the source of these estimates. (GDO 25)

The YLDs due to dementia for people aged 60 or above in 2006 was 284,326 life years, 82,212 and 202,114 life years for males and females respectively (Yu et al., 2012).

d. Is the prevalence of dementia more pronounced in any specific geographical areas?

There are no estimates of the prevalence of dementia in different geographical areas in Hong Kong.

e. What is the average age of onset?

So far, two local studies have examined the age of onset of dementia in Hong Kong. According to a retrospective case notes review of 454 consecutive people with dementia and mild cognitive impairment at Princess Margaret Hospital in Hong Kong from 1999-2004, the average age of onset of dementia was 76.7 ± 8.7. The median duration from symptom onset to medical consultation was two years (range: four months to ten years) with a mean of 14.8 months (Sheng et al., 2009). An earlier study reported the age of onset of Alzheimer's disease was related to the frequency of Apolipoprotein E epsilon 4 allele (ApoE) among 65 people with dementia. As shown in Table 20, for both genders, the age of onset was lower when ApoE epsilon 4 allele was present (Mak et al., 1996).

Table 20

Age of onset of Alzheimer's disease by frequency of ApoE epsilon 4 allele copies and gender

No. epsilon copies	Age at onset (years)	
	Mean	**Median**
Females		
0	74.0	73.0
1	70.6	70.0
2	69.5	69.5
Males		
0	72.7	73.0
1	73.3	74.5
2	72.3	69.0
All		
0	73.7	73.0
1	72.0	70.3
2	71.2	69.0

(Mak et al., 1996).

f. What is the average number of years people live with dementia?

A study estimated the life expectancy of people with and without dementia using the Hong Kong Life Tables 2006-2036. In 2006, males with dementia at age 60 were expected to live for 16 years and females for 22 years (Yu et al., 2010).

g. Is there evidence for difference in incidence/prevalence by gender and for different ethnic groups?

There is evidence of differences in dementia prevalence by gender (as reported in question a). A study further estimated the difference in the prevalence of very mild and mild dementia by gender for people aged 60 and above and people aged 70 and above. The findings are summarised in Table 21 (Lam et al., 2008). However, there are no data regarding differences in dementia prevalence among different ethnic groups in Hong Kong.

Table 21

Prevalence of very mild and mild dementia by gender and age groups

Age groups	Very mild dementia	Mild dementia
Aged 60 and above		
Females	6.3%	7.6%
Males	5.1%	3.1%
All	5.8%	5.4%
Aged 70 and above		
Females	10.2%	12.3%
Males	6.6%	5.0%
All	8.5%	8.9%

(Lam et al., 2008).

h. What is the average number of years lived by people who have dementia?

In 2006, a study estimated there was a difference of seven years of life expectancy at age 60 between people with and without dementia. Table 22 shows the life expectancy of the general population and the population with and

without dementia by gender (Yu et al., 2010).

Table 22
Life expectancy of the general population and the population with and without dementia by gender: 2006

	General population	**Population without dementia**	**Population with dementia**	*Difference*
		Life expectancies at age 60 (Years)		
Males	22	23	16	7
Females	27	29	22	7

(Yu et al., 2010).

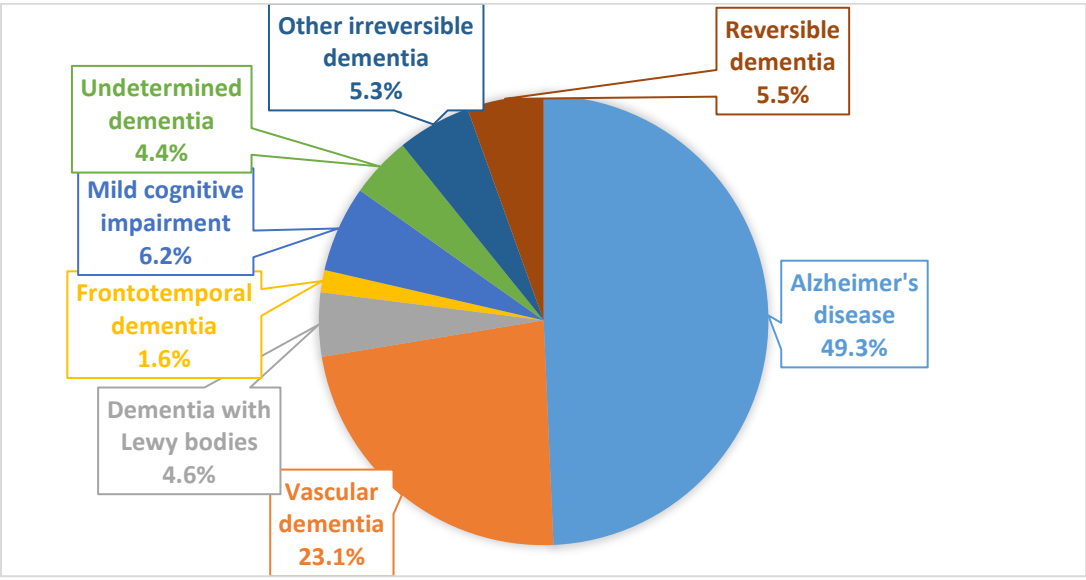
i. Are there relevant sub-groups of specific dementias (e.g. HIV-dementia)? What is their prevalence/ incidence?

The prevalence of different severities and subtypes of dementia are reported in the response to question a in this section.

The prevalence of HIV-associated neurocognitive disorder among 98 participants from Queen Elizabeth Hospital in Hong Kong was measured using the International HIV Dementia Scale (IHDS) and Montreal Cognitive Assessment (MoCA) in 2013-2015. Thirty-eight (39%) and 25 (26%) participants scored below the cut-offs of IHDS (≤10) and MoCA (25/26), respectively (Chan et al., 2019).

Another study investigated the diagnostic profiles of 436 consecutive patients with dementia and mild cognitive impairment at Princess Margaret Hospital in Hong Kong from 1999-2004, as shown in Figure 17. Reversible dementia includes depression, delirium, anxiety disorder, psychosis, hyponatremia, epilepsy, Parkinson's disease, adjustment disorder and vitamin B12 deficiency. Other irreversible dementias include Parkinson's disease dementia, post-concussion dementia, brain tumour, subdural effusion, alcohol dementia, Huntington's disease, anoxic brain insult, uraemia and subarachnoid haemorrhage (Sheng et al., 2009).

Figure 17
Diagnostic profiles of patients with dementia and mild cognitive impairment at Princess Margaret Hospital: 1999-2004



(Sheng et al., 2009).

j. Is there evidence of associations between dementia and poverty in your country?

A study has found a cross-sectional association between neighbourhood economic disadvantage and the prevalence of dementia among 21,008 older adults aged 65 years and above. Data were extracted from 18 Department of Health Elderly Health Centres from 2009-2011. As shown in Table 23, the results suggested a correlation between a higher prevalence of dementia and higher neighbourhood economic disadvantage (Guo et al., 2019).

Table 23

The prevalence of dementia and neighbourhood economic disadvantage among adults aged 65 years and above: 2009-2011

	Dementia (%)	
Neighbourhood economic disadvantage	Large Street Blocks	Small Tertiary Planning Units
Quantile 1 - Minimum	8.5	6.8
Quantile 2 - Lower	10.1	9.9
Quantile 3 - Median	12.2	15.1
Quantile 4 - Upper	14.3	14.9
Quantile 5 - Maximum	18.4	14.8

(Guo et al., 2019).

k. Is there a campaign to reduce the risk of dementia in your country? (GDO 13.3) Please provide details.

The Department of Health Visiting Health Teams organize regular health promotion activities such as health talks and support groups in 18 Elderly Health Centres across the 18 districts in Hong Kong. Reducing the risk of dementia is one of their major goals. Their monthly topics concerning dementia include a healthy lifestyle, exercise and eating, no smoking education, weight management, accident prevention and home safety, mental health check and management of other common age-related diseases, such as hypertension, heart disease, stroke, diabetes mellitus and Parkinson's disease (Elderly Health Service, 2020, March 26).

Moreover, the Social Welfare Department launched a three-year "Dementia Friendly Community Campaign" in 2018, which provides a public education programme to increase public awareness, reduce risk and enhance the care of people with dementia and their family members (more details can be found in Part 5). It emphasized the following advice to reduce the risk of dementia (Social Welfare Department, 2018):

- Prevention of cerebrovascular diseases
- Maintain healthy lifestyle
- Maintain active social life and develop personal hobbies
- Regular body check and cognitive assessment
- Keep a positive mind
- Reduce the chance of brain injury
- Develop daily participation in aerobic and mind-body exercises
- Develop Six Arts multi-cognitive domains (i.e., interpersonal and social, musical, visual-spatial, kinesthetic, linguistic and logic-mathematical elements)

l. What risk factors have been associated with dementia in your country?

Various modifiable risk factors for dementia have been identified in Hong Kong, including family history, gender, low educational attainment, physical inactivity, social isolation, depression, head injury, smoking and alcohol consumption. In addition, some non-communicable diseases are also associated with the risk of dementia, such as hypertension, high blood cholesterol, diabetes mellitus, coronary heart disease, stroke, overweight and obesity (Department of Health, 2017).

m. Dementia is associated with a number of preventable risk factors. Please provide information, if available, on: (please include age, sex, ethnicity and other relevant stratifier when available)

i. The proportion of people with primary education?[2]

The education level of most older people in Hong Kong is primary. In 2018, 37.2% of people aged 60 or above had primary education, 39.8% female and 34.4% male. More detailed information related to the proportion of different age groups and gender is shown in Table 5 in Part 1 (Census and Statistics Department, 2019i).

ii. The proportion of people with secondary education?[2]

In 2018, 18.3% of people aged 60 or above had lower secondary education, 15.6% female, and 21.2% male. 21.1% of people aged 60 or above had upper secondary education, 18.4% female, and 24.1% male. More detailed information related to the proportion of different age groups and gender is shown in Table 5 in Part 1 (Census and Statistics Department, 2019i).

iii. The proportion of the population living with high blood pressure (hypertension)? (GDO 33)

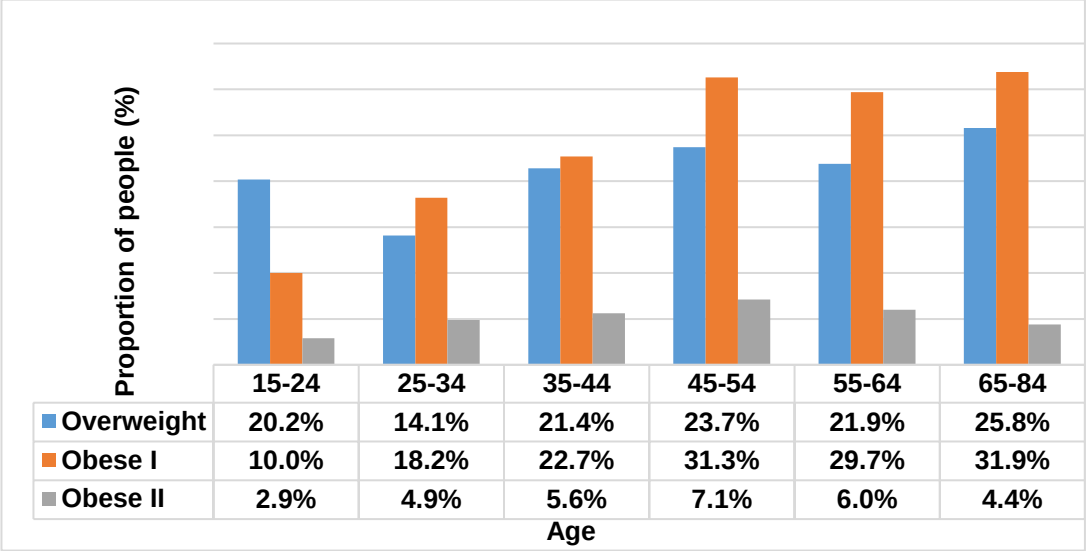
According to the population health survey in 2014/2015, the overall prevalence of self-reported doctor-diagnosed hypertension was 17.8% (17.9% for females and 17.6% for males) for people aged 15 or above. The prevalence of hypertension increased rapidly from 45.8% for people aged 65-74 to 61.2% for people aged 85 or above. More detailed information related to the proportion of different age groups and gender is shown in Figures 6 and 7 in Part 1 (Centre for Health Protection, 2017).

iv. The proportion of the population considered to be obese? (GDO 31)

According to the population health survey in 2014/2015, the overall prevalence of obesity and overweight was 29.9% and 20.1%, respectively, among people aged 15-84. Females aged 65-84 (34.3%) and males aged 45-54 (51.1%) were the most common age groups having obesity. Figure 18 shows the prevalence of overweight and obesity by age group (Centre for Health Protection, 2017).

Figure 18

Prevalence of overweight and obesity by age group: 2014 - 2015



	15-24	25-34	35-44	45-54	55-64	65-84
Overweight	20.2%	14.1%	21.4%	23.7%	21.9%	25.8%
Obese I	10.0%	18.2%	22.7%	31.3%	29.7%	31.9%
Obese II	2.9%	4.9%	5.6%	7.1%	6.0%	4.4%

Notes: Obese I = BMI ≥ 25.0 and < 30.0 kg/m^2; Obese II = BMI ≥ 30.0 kg/m^2

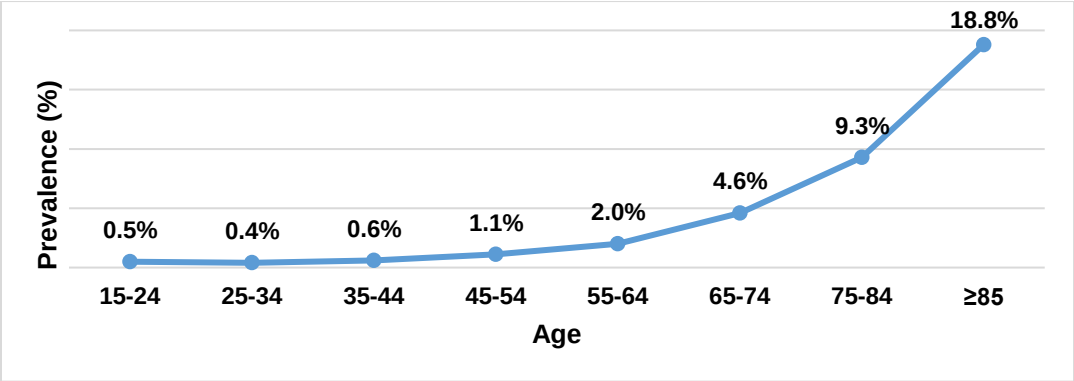
(Centre for Health Protection, 2017)

v. The proportion of the population experiencing hearing loss?

According to the population health survey in 2014/2015, 2.2% of people aged 15 or above (2.1% females and 2.2% males) had self-reported doctor- or audiologist-diagnosed hearing impairment or loss. The prevalence increased rapidly from 4.6% among people aged 65-74 to 18.8% among people aged 85 or above. Figure 19 shows the proportion of self-reported doctor-diagnosed hearing impairment or loss by age groups (Centre for Health Protection, 2017).

Figure 19

Prevalence of self-reported doctor-diagnosed hearing impairment or loss by age group: 2014 - 2015



(Centre for Health Protection, 2017).

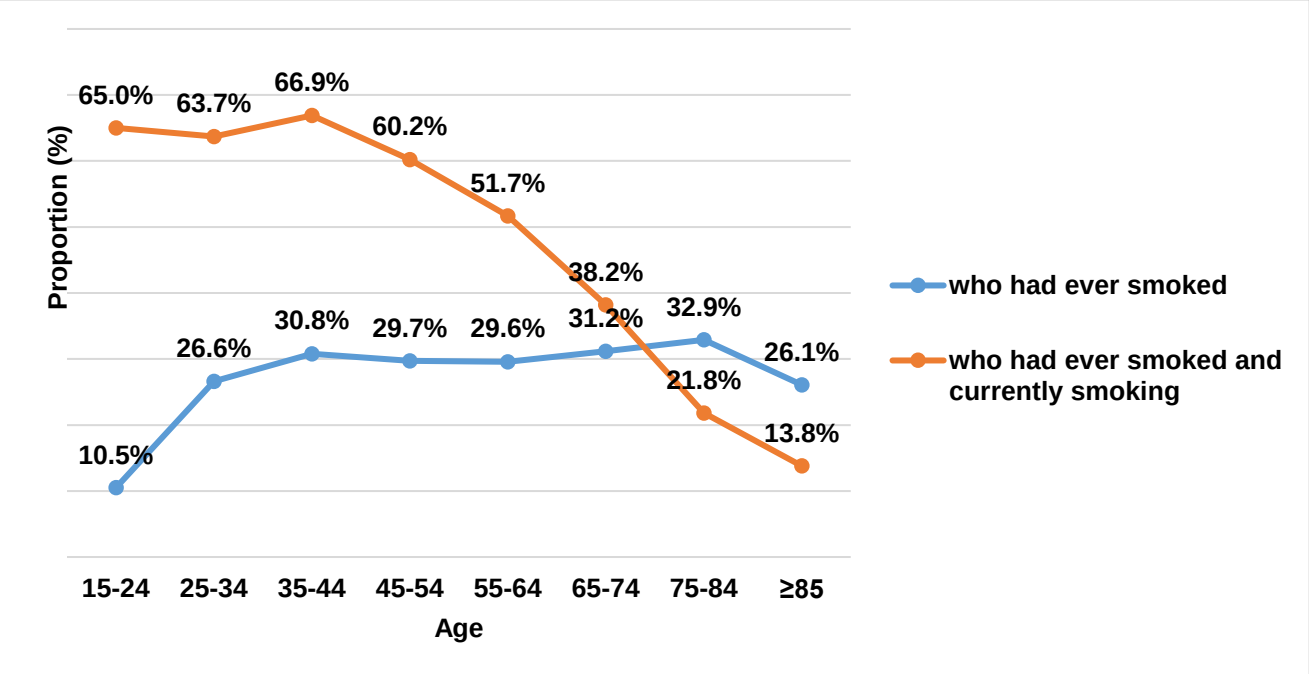
vi. The proportion of the population that smokes? (GDO 29)

According to the population health survey in 2014/2015, 27.1% of people aged 15 or above (10.8% females and 45.0% males) had ever smoked cigarettes. Figure 20 shows the proportion of people who had ever smoked cigarettes by age group (Centre for Health Protection, 2017). Furthermore, among those who had ever smoked cigarettes, 54.6% (49.3% females and 56.0% males) currently smoked. Figure 20 also shows the proportion of

people who had ever smoked cigarettes and currently smoked by age group. The proportion of smokers was highest in the 35 – 44 age group (66.9%) and lowest among those aged 85 or above (13.8%) (Centre for Health Protection, 2017).

Figure 20

Proportion of people i) who had ever smoked cigarettes and ii) who had ever smoked a cigarette and currently smoked by age group: 2014 - 2015



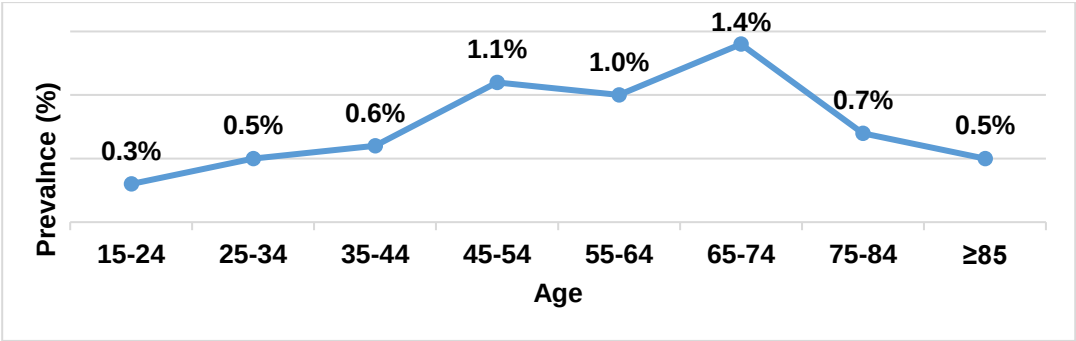
(Centre for Health Protection, 2017).

vii. The proportion of the population living with depression? (GDO 35)

According to the population health survey in 2014/2015, 0.8% of people aged 15 or above (1.1% females and 0.5% males) had self-reported doctor-diagnosed depression. The prevalence was the highest among people aged 65-74 at 1.4%. Figure 21 shows the prevalence of self-reported doctor-diagnosed depression by age group (Centre for Health Protection, 2017).

Figure 21

Prevalence of self-reported doctor-diagnosed depression by age group: 2014 - 2015



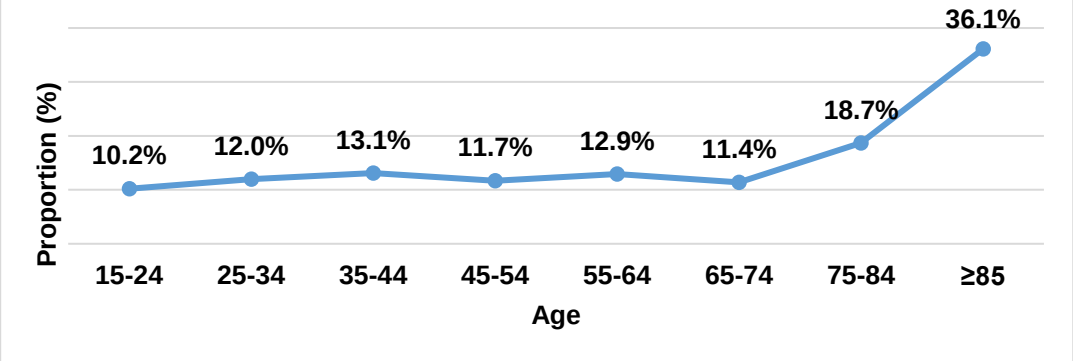
(Centre for Health Protection, 2017).

viii. The proportion of the population that is physically inactive? (GDO 28)

According to the population health survey in 2014/2015, 13.0% of people aged 18 or above (14.2% females and 11.6% males) had insufficient physical activity according to WHO's definition. The prevalence was the highest among people aged 85 or above at 36.1%. Figure 22 shows the proportion of people who had insufficient physical activity by age group (Centre for Health Protection, 2017).

Figure 22

Proportion of people with insufficient physical activity according to WHO's definition by age group: 2014 - 2015



Note. WHO recommendation: at least 150 minutes of moderate-intensity aerobic physical activity, 75 minutes of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity physical activity achieving at least 600 metabolic equivalent minutes per week.

(Centre for Health Protection, 2017).

ix. The proportion of the population living with diabetes? (GDO 32)

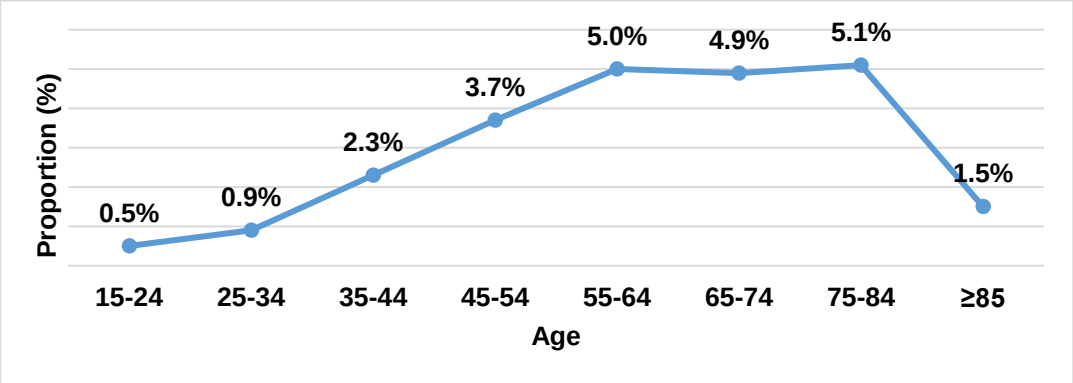
According to the population health survey in 2014/2015, 5.5% of the population aged 15 or above (5.6% females and 5.4% males) had doctor-diagnosed diabetes mellitus. The prevalence increased with age to a peak of 22.7% among people aged 75-84. More detailed information related to the proportion of different age groups and gender is shown in Figures 3 and 4 in Part 1 (Centre for Health Protection, 2017).

x. Amount of alcohol consumed per capita (15+) (GDO 30)

According to the health fact statistics released by the Department of Health in 2016, the prevalence of daily alcohol consumption in Hong Kong was 2.8% for the population aged 18-64 (4.3% males and 1.8% females) (Department of Health, 2019b). For a further breakdown by age groups, according to an earlier population health survey in 2014/2015, the prevalence was the highest at 5.1% for the 75–84 age group. Figure 23 shows the proportion of people who had daily alcohol consumption by age group (Centre for Health Protection, 2017). In 2018, the alcohol consumption per capita was 2.85 litres among people aged 15 or above in Hong Kong. Figure 24 shows alcohol consumption per capita from 2008-2018 in Hong Kong (Department of Health, 2020, March 5).

Figure 23

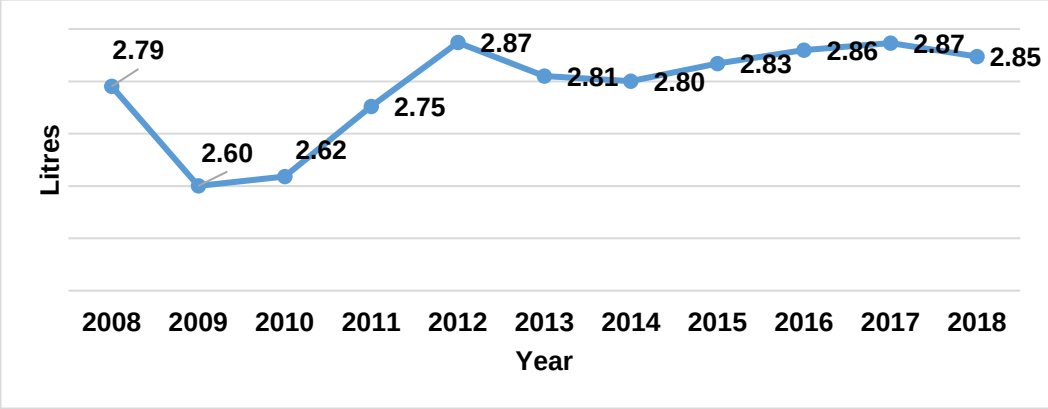
Proportion of people who had a daily alcohol consumption by age group: 2014 - 2015



(Centre for Health Protection, 2017).

Figure 24

Alcohol consumption per capita: 2008 - 2018



(Department of Health, 2020, March 5)

xi. The proportion of the population with high cholesterol (GDO 34)

According to the population health survey in 2014/2015, 14.4% of the population aged 15 or above (14.0% females and 14.8% males) had high blood cholesterol. The prevalence increased with age to a peak of 39.0% for people aged 75-84. More detailed information related to the proportion of different age groups and gender is shown in Figures 3 and 4 in Part 1 (Centre for Health Protection, 2017).

Part 7: The Dementia Care system

I. Overview of the Dementia care system

a. Where and how do people get a diagnostic assessment for dementia? Please describe what would be the "typical" path to access a diagnostic assessment.

Typically, people receive a diagnostic assessment for dementia from specialists (e.g., geriatricians, psychiatrists) in public hospitals.

Primary care physicians (either public or private) are usually the first point of contact, who play an important role in detecting dementia in the community, and referring people with dementia and suspected cases to specialist care in public hospitals or the private sector for further investigation (Food and Health Bureau, 2017a). Older adults may need to undergo several and sometimes repeated tests from different service providers before a formal diagnosis is made. As family doctors may not have relevant expertise and multi-disciplinary support to make a diagnosis, and not all older adults can afford services in the private sector, they usually rely on the services of public hospitals. The major role for formal diagnosis lies in the public sector.

b. What is the % of people with dementia that have received a diagnostic assessment? (GDO 7x1)

According to findings from the prevalence study conducted by the Department of Health and Chinese University of Hong Kong in 2005 (Elderly Commission, 2006), 89% of the 70,000 community-living older people with dementia were not known to any medical services, meaning that only 11% of people with dementia received a diagnostic assessment at that time. No more recent figures on the diagnostic rate are available.

c. Please provide the number of people who received a diagnostic assessment in the most recent year for which data are available (GDO 7x2)

There is no information available regarding the exact number of individuals receiving a diagnosis assessment in each year.

Regarding diagnoses made by public hospitals, a related estimate could be the number of people with dementia receiving a service. In 2015-2016, about 28,000 people with dementia received specialist care provided by the Hospital Authority, mainly provided by the Department of Psychiatry and Department of Medicine (Food and Health Bureau, 2017a). The number of diagnosis assessments provided by private doctors is not known.

An NGO-operated self-financing early detection service could also provide a related estimate for reference. Starting in 2006, Hong Kong Alzheimer's Disease Association has provided an Early Detection Service at its centres to promote timely diagnosis in the community. In the most recent five reporting years (2014/15 – 2018/19), a total of 1,978 people received this early detection service, 802 males (41%) and 1,176 females (59%). Of these, 1264 (64%) were suspected of having dementia and were referred for further investigation (Hong Kong Alzheimer's Disease Association, 2017, 2019).

d. Are there differences in diagnostic assessment according to geographical areas (rural/urban) and also according to other socio-economic factors?

The rural-urban division is not applicable in Hong Kong as, according to the World Bank, the urban population accounts for 100% of its total population since 1993. Local evidence on the impact of socio-economic factors on

receiving diagnostic assessment is relatively limited. In a study (Tang, Wong, et al., 2016) comparing the characteristics of early help seekers (i.e., seeking help within a year since noticing the first symptom) and late help seekers, early help seekers were more likely to live in private housing, suggesting that higher socio-economic status may facilitate earlier help-seeking.

e. Which health or long-term care providers are responsible for coordinating the care of people with dementia?

The Hospital Authority is the main healthcare coordinator for dementia care. The Social Welfare Department and the NGO-operated District Elderly Community Centres are the main long-term care coordinators. Since the implementation of the Dementia Community Support Scheme in 2017, the two sectors have collaborated more closely and frequently to coordinate dementia care (Social Welfare Department, 2020c).

f. Are there dedicated services supporting people with dementia (e.g. mental health, dementia specific) after a diagnostic of dementia?

For public services, the Dementia Community Support Scheme, a publicly-funded programme implemented by the Food and Health Bureau, Hospital Authority, and Social Welfare Department, was designed exclusively for people with dementia. Through medical-social collaboration, people with dementia who receive their diagnosis in a public hospital are referred to a District Elderly Community Centre for interventions and carer training. Services for each individual are provided according to the individualised care plan formulated by professionals from both the healthcare and social care sectors.

For private or self-financing services, at least ten NGOs provide dementia-specific services covering day care services, non-pharmacological interventions, and/or in-home services: 1) Hong Kong Alzheimer's Disease Association; 2) CFSC Mind: Delight Memory and Cognitive Training Centre; 3) ELCHK Smart Club; 4) HKSR Community Rehabilitation Network; 5) Jockey Club Centre for Positive Ageing; 6) Pok Oi Hospital Day Centre for the Elderly (Yuen Long); 7) St James' Settlement Kin Chi Dementia Care Support Service Centre; 8) TWGHs Circle of Care – Community Support Network for Elders with Dementia; 9) Yan Chai Hospital Yim Tsui Yuk Shan Active Mind Centre; 10) Yan Oi Tong Clarea Au Eldergarten (Hong Kong Alzheimer's Disease Association, 2020d).

g. What are the links between primary care services, specialist care services and community/ institutional care services supporting people with dementia?

i. How are these links initiated/ maintained?

These services are all connected by service referrals made by professionals. These links are strongly maintained by the professional training of the various professions involved and the referral guidelines of each party. Primary care, such as a general practitioner's private clinic, is usually the first point of contact for people suspected of having dementia. Depending on the individual's ability to pay and preference, referrals will be made to a specialist clinic in a public hospital or another private clinic for further investigation or diagnosis. After a diagnosis is made, the medical team will formulate individualised treatment plans for the person with dementia, provide them with medication, cognitive training, and rehabilitation services, and refer them to appropriate social service agencies for follow-up in the community according to their needs. As for other older adults, people with dementia needing subsidised community or residential care services, must go through the needs assessments regulated by the Social Welfare Department.

Apart from the aforementioned path, older adults often need care before developing dementia. If an existing community care service user is suspected of having dementia, their service providers would be their first point of contact and refer them directly to a specialist for diagnosis.

More recently, the connections between these services were further strengthened since the implementation of Dementia Community Support Scheme in 2019 (Food and Health Bureau, 2019a), which is designed as a collaboration between specialist care and community care service, with a small component of collaboration between primary care and community care service. Apart from this public service, links across these services may be available under individual partnerships supported by charitable institutions, such as HKADA's Project Sunrise (refer to Appendix in Mental Health Review Report (Food and Health Bureau, 2017a))

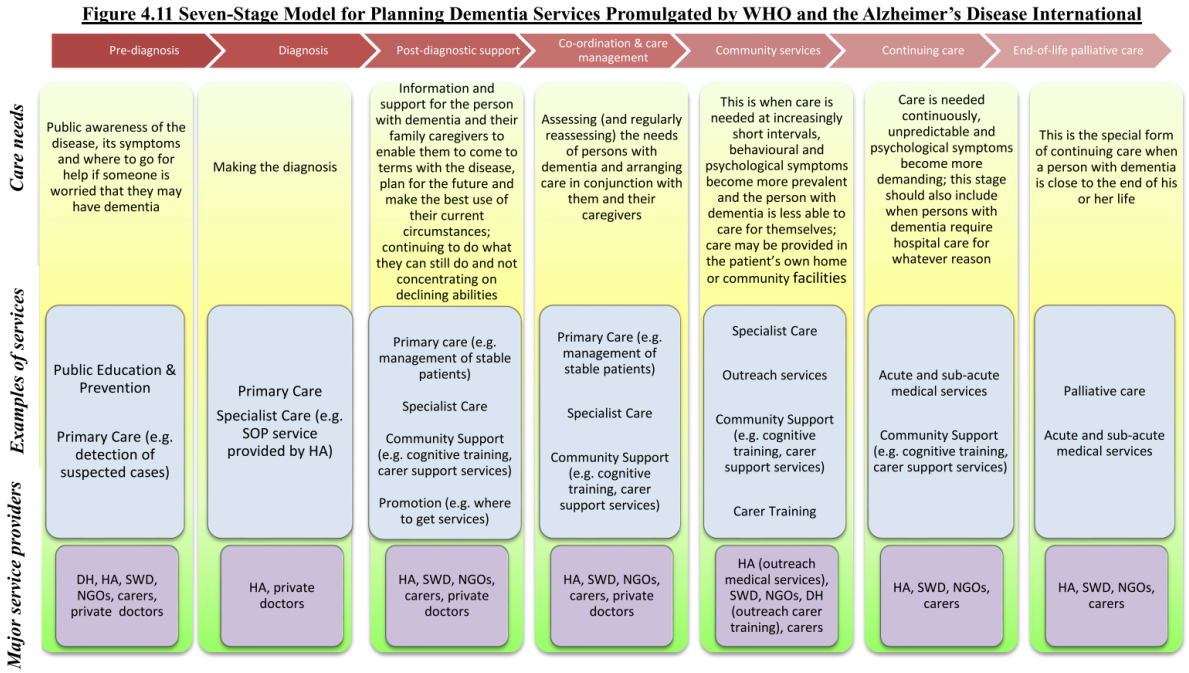
ii. Are there protocols/bills (laws)/ policies that outline who carries responsibility or is this depending on local practice/ individuals?

There are no relevant protocols/bills (laws)/ policies at the macro level, although they exist for individual parties within their organisation. Each organisation, such as the Hospital Authority, Social Welfare Department, and NGOs, has internal protocols or practice guidelines regarding the responsibility of each type and rank of staff and when to refer cases to another department within the organisation or to an external party. However, there is no overarching protocol or policy guiding the development of these practice guidelines.

Mirroring the seven-stage model for planning dementia services suggested by WHO and Alzheimer's Disease International, the Food and Health Bureau's depiction of dementia care services in Hong Kong and the responsibilities of each party are outlined in Figure 25.

Figure 25

Adopting the Seven-stage Model for Planning Dementia Services in Hong Kong



Note. DH = Department of Health, HA= Hospital Authority, SWD = Social Welfare Department (Food and Health Bureau, 2017a).

h. Do people with dementia experience out-of-pocket expense to access diagnosis or care?

For public healthcare services, users have to cover 5% of the cost and the remaining 95% is subsidised by the government (Food and Health Bureau, 2010). Individuals experiencing more financial difficulties may apply for a

waiver of the medical fee so they will have no out-of-pocket expenses when using public healthcare services (Hospital Authority, 2019d). The service fees for public services offered by the Hospital Authority are listed in Table 24. Specialist outpatient, general outpatient, geriatric day hospital and rehabilitation day hospital services are commonly used by people with dementia.

Table 24

Service fee by type of service provided by the Hospital Authority

Service	Fee / HK Dollar
Accident & Emergency	$180 per attendance
Inpatient (acute general beds)	$75 admission fee, $120 per day
Inpatient (convalescent / rehabilitation, infirmary and psychiatric beds)	$100 per day
Specialist outpatient (including allied health clinic)	$135 for the 1st attendance, $80 per subsequent attendance, $15 per drug item
General outpatient	$50 per attendance
Dressing or injection	$19 per attendance
Psychiatric day hospital	$60 per attendance
Geriatric day hospital	$60 per attendance
Rehabilitation day hospital	$55 per attendance
Day procedure and treatment at Clinical Oncology Clinic or Renal Clinic	$96 per attendance
Day procedure and treatment in ambulatory facility	$195 per attendance
Community nursing service (general)	$80 per visit
Community nursing service (psychiatric)	Free
Community allied health service	$80 per visit

(Hospital Authority, 2020c).

In the private healthcare sector, the Hong Kong Medical Association has conducted surveys on doctors' fees every four years since 1991 to gather information on the prevailing charges of medical services in the private sector. According to the latest survey conducted in 2018 (Hong Kong Medical Association, 2019), the median service charge (inclusive of medication) of specialists for regular clinic consultation and psychiatry consultation (half-hour) were $800 and $900, respectively. Under the government's Health Care Voucher Scheme, adults aged over 65 may make use of the annual voucher amount of $2000 to cover their medical expenses in the private sector.

For public social care services, under the Dementia Community Support Scheme, people with dementia can receive care and support services, training and carer support services provided by NGO-operated District Elderly Community Centres. Recipients of Comprehensive Social Security Assistance or the Old Age Living Allowance and holders of medical fee waivers can receive services free of charge. Other users have to pay $150 per month to receive support under this scheme (Food and Health Bureau, 2019a). Most other care services provided by NGOs under governmental subvention are entirely free or subject to a very small fee.

People with dementia will experience higher out-of-pocket expenses for care services provided by dementia-specific service centres operated by self-financing NGOs. For instance, the service fee of daycare services provided by Hong Kong Alzheimer's Disease Association is $340–420 per day (meals inclusive) (Hong Kong Alzheimer's Disease Association, 2020e); the service fee for daycare services provided by for Jockey Club Centre for Positive Ageing is $435–565 per day (meals inclusive) (Jockey Club Centre for Positive Ageing, 2020b).

i. How do people with dementia access long-term care?

In Hong Kong, older adults, including people with dementia, have to undergo the Standardised Care Need Assessment Mechanism for Elderly Services to access subsidised long-term care service, which has been in operation since November 2000 by the Social Welfare Department (Social Welfare Department, 2020h). Under the mechanism, an internationally-recognised assessment tool, Minimum Data Set-Home Care is used to ascertain the care needs of older people and match them with appropriate services. People in need can contact the Social Welfare Department or their social services provider for an assessment of their eligibility for subsidised long-term care services. Individuals opting for long-term care provided by the private sector, for instance, residential care service, may contact the service provider directly.

j. What is the estimated cost of dementia in your country? Please report all the studies available, reporting whether they include costs from a societal perspective (that is, including medical care, long-term care (or social care), and unpaid care), or just from the formal care or public sector perspective. (GDO 27)

Three studies have estimated the cost of dementia in Hong Kong, all including costs from a societal perspective. These estimates are summarised and presented in Table 25. The estimates in the studies conducted by Wimo et al. (2007); Wimo et al. (2010) consisted of the direct cost and three options of informal care, (i) 1.6 hours per day for basic activities of daily living (ADLs), ii) 3.7 hours per day for ADLs and instrumental activities of daily living (IADLs), and iii) 7.4 hours per day for ADLs, IADLs, and supervision. Yu et al. (2010) estimated the cost of dementia in 2010 and the projected cost in 2036, covering hospitalisation, institutional (i.e., residential) care, and informal care costs.

Table 25
Estimated cost of dementia in Hong Kong

	HK$ million	
Studies 1 & 2: Wimo et al. (2007; 2010)[1]	**2005**	**2009**
Direct cost	6,779	9,263
(i) Informal care cost (1.6 hours per day)	2,033	2,777
(ii) Informal care cost (3.7 hours per day)	4,700	6,422
(iii) Informal care cost (7.4 hours per day)	9,401	N/A
Total cost if (i)	**8,812**	**12,039**
Total cost if (ii)	**11,479**	**15,684**
Total cost if (iii)	**16,180**	N/A
Study 3: Yu et al. (2010)	**2010**	**2036**
Hospitalisation cost	228	594
Institutional care cost	1,624	4,212
Informal care cost	10,368	27,004
Total cost	**12,220**	**31,810**

[1]Costs in the original study were reported in US dollars. Conversion is calculated based on the exchange rate of 1 USD = 7.8 HKD.

II. Dementia Care System Organisation

1) Community-based Services for Dementia

a. Does your country provide health and long-term care services to support people with dementia in community-based settings? (GDO 8x1)

For healthcare services, the Hospital Authority provides out-patient services, day rehabilitation training and community support services to people with dementia. Community support services, including the Community Nursing Service and Community Psychiatric Nursing Service, are delivered by qualified community nurses to provide nursing care during home visits and equip people with dementia and their families with self-care ability and carer skills to cope with their needs.

For social care and long-term care services, the Social Welfare Department and a wide range of NGOs under government subvention provide daycare, home care, centre-based services, respite services and carer support services to people with dementia and their carers. There are currently 41 District Elderly Community Centres, 76 Day Care Centres/Units for the Elderly, 34 Enhanced Home and Community Care Services and 60 Integrated Home Care Services Teams providing services for older people and families in need. All these services cover people with dementia.

A cross-sectoral collaborative Dementia Care Support Scheme has been implemented by the Hospital Authority and Social Welfare Department to provide community support services dedicated to people with dementia and their carers to enhance/improve cognitive functions, knowledge of home safety, self-care ability, physical functioning, social skills, and alleviate the burden on carers.

b. Do you have any of the following (if yes, please provide details) (GDO 8x2)

i. Diagnostic services (in primary care)

The main providers of dementia diagnostic services in Hong Kong are specialists (i.e., in secondary care). However, primary care physicians with specialist qualifications can diagnose. By the end of 2017, there were 124 registered neurology specialists, 160 registered under geriatric medicine, and 376 registered under psychiatry in Hong Kong (Medical Council of Hong Kong, 2017). Some of these specialists work in primary care settings, although the exact number is unknown.

In addition, some primary care physicians have received dementia-specific training. In 2016/2017, 132 and 51 physicians completed the basic and advanced courses for doctors in dementia, respectively, provided by the Hong Kong Alzheimer's Disease Association. (Hong Kong Alzheimer's Disease Association, 2017). Since 2006, Hong Kong Alzheimer's Disease Association has provided an Early Detection Service at its centres in the community. In the five recent reporting years (2014/15 – 2018/19), a total of 1978 people received this early detection service (802 males (41%) and 1176 females (59%)) (Hong Kong Alzheimer's Disease Association, 2017, 2019). Some of these service users were later referred to primary care physicians for further investigation and diagnosis.

ii. Assessment & management of behavioural and psychological symptoms of dementia

Healthcare professionals in out-patient clinics assess behavioural and psychological symptoms of dementia and prescribe the appropriate management.

Daycare units and dementia-specific centres in the social care sector provide appropriate management of behavioural and psychological symptoms of dementia while providing care and intervention. The Social Welfare Department allocates resources to subsidised Day Care Units to enable their staff to provide dementia-specific assessment and services, including cognitive training, memory training, reality orientation, reminiscence therapy, etc., to ensure better care and safety for older people with dementia (Legislative Council, 2017).

Moreover, the Dementia Community Support Scheme has enabled District Elderly Community Centres to provide support services for people with mild or moderate dementia and their carers. The scheme incorporates interventions targeting behavioural and psychological symptoms of dementia as an additional module depending on service users' needs.

iii. Psychosocial services and rehabilitation

Multi-disciplinary teams in the healthcare sector, led by doctors in public hospitals, provide day rehabilitation services according to the needs of people with dementia (Legislative Council, 2017).

Similar to the assessment and management of behavioural and psychological symptoms of dementia mentioned above, Day Care Units and District Elderly Community Centres in the social care sector provide psychosocial and rehabilitation services to people with dementia.

iv. Activities of daily living (ADLs) support services

Day Care Units and Home Care Teams are integral parts of the long-term care service that provide ADLs support services to older adults in need of care, including people with dementia.

Further, in the Dementia Community Support Scheme, an independent community living skill training programme is a major theme of training under functional training, which mainly focuses on enhancing the instrumental activities of daily living of people living with dementia (Food and Health Bureau, 2019a).

v. Palliative and end-of-life care services

Hong Kong has a publicly-funded palliative care service coordinated by the government under the auspices of the Hospital Authority. There were 17 palliative care service units in 2019 (Lam, 2019), and about 400 beds for palliative care provided by public hospitals and NGOs (Ng, 2018). The healthcare and social care sectors provide an end-of-life care service through hospitals and NGOs. However, public awareness and professional readiness for end-of-life care are questionable. In a population survey of 1,067 adults in Hong Kong, 85.7% had not heard of Advance Directive, although 60.9% would prefer to make an Advanced Directive if formally legislated (Chung et al., 2017). Stakeholders, including philanthropists, researchers and service providers have promoted end-of-life care though strengthening collaboration between the healthcare and social care sectors, providing professional training to hospital and care home staff, volunteer training, and raising public awareness. The "Jockey Club End-of-Life Community Care Project' is a 10-year project (2016 -2026) and the key driver of end-of-life care in Hong Kong. For details, please visit: http://foss.hku.hk/jcecc/en/. These services include people with dementia.

vi. Social & financial protection and benefit

Please refer to 'Part 9: Social Protection for People with Dementia'.

c. Are these community-based services available in certain areas only? e.g. capital city only; capital and main cities; capital, main cities and rural areas (GDO 8x3)

These community-based services are territory-wide.

d. Are these services provided by the public sector, the private sector or both? (GDO 8x4)

These services are provided in both the public and private sectors.

e. If available, the number of people who received community-based care (most recent estimate). If these estimates are not available, please state this. (GDO 8x5)

Estimates in relation to dementia are not available.

f. Is there a mechanism to co-ordinate care, treatment and support for people with dementia such as a care manager or dementia advisor, particularly across health and long-term care? (GDO 5x1)

There is currently no designated unit or recognised mechanism of care management for co-ordinating care and support for people with dementia.

However, there is a newly-developed collaboration between the health and social care sectors the Dementia Community Support Scheme providing territory-wide support services to people with mild or moderate dementia and their carers through a medical-social collaboration model (Social Welfare Department, 2020c). Advanced care nurses from the Hospital Authority, nurses, social workers, occupational therapists and/or physiotherapists in District Elderly Community Centres work together to plan for inter-disciplinary care for people with dementia. Although this scheme is not designated to provide care management, the multidisciplinary team with professionals from both the healthcare and social care sectors improved care co-ordination across sectors for people with dementia when they enrolled in the scheme.

Moreover, although currently there is no formal care co-ordination mechanism, some NGOs provide professional training for dementia-specific care managers. For instance, Hong Kong Alzheimer's Disease Association Institute of Alzheimer's Education offers professional care planners the Certified Dementia Care Planner Course to equip them with comprehensive skills and knowledge about dementia care and enable them to provide continuity of care for families living with dementia, and coordinating with different dementia care teams in community, residential and hospital settings (Hong Kong Alzheimer's Disease Association, 2020a).

g. Are family and other unpaid carers recognised/registered as part of dementia diagnostic services?

As the information provided by carers and family members is considered an important source for identifying symptoms and functional impairment, the diagnostic process usually involves family carers' participation. The Department of Health has recommended that input from families and caregivers is needed in dementia diagnostic services (Department of Health, 2017).

h. In question b(ii) you provided information on assessment and management of behavioural and psychological symptoms. What kind of interventions are available to people with dementia or their informal carers? (e.g. pharmaceutical, behavioural)

Both pharmacological and non-pharmacological interventions are available. For pharmacological interventions, please refer to section V in this chapter.

For non-pharmacological interventions, rehabilitation day hospitals and NGO-operated community care service units provide a wide range of interventions, including, but not limited to, cognitive training, occupational therapy, reality orientation therapy, reminiscence therapy, validation therapy, multisensory stimulation intervention, physical exercise programmes, cognitive stimulation therapy, music therapy, aromatherapy, carer educational programmes, and carer stress-reduction intervention. However, owing to the diversity of service providers' practices, there are no comprehensive statistics on the provision of different types of non-pharmacological intervention available.

i. Are there any other social interventions available for people with dementia in community-based settings? What kind of interventions are available?

Cognitive stimulation therapy, for instance, is a group-based therapy emphasising social interaction among participants.

j. In questions c you provided information on the provision of community-based services. Could you provide some information on potential regional diversity?

Fewer community-based services are available for residents of Islands Districts than in other Districts. Islands residents rely on in-home services from providers in another District.

k. Are home care services available? Are the difference in availability by location? What kind of services are provided in people's homes?

60 integrated home care services teams provide a range of home-based community support services to older people, people with disabilities and families in need living in the community. Services provided include personal care, escorting, household cleaning, sitting with older people, environment risk assessment and home modifications, purchasing and delivering daily necessities, meal service, simple nursing care, and carer support. 34 enhanced home and community care services teams provide more specialised services (e.g., special nursing care, rehabilitation exercise) for older people with more care needs (Social Welfare Department, 2020a).

In terms of availability, although home care services cover all Districts in Hong Kong, some services in remote Island Districts are more limited than in the other Districts. For example, while all previous Home Help Teams have been upgraded to Integrated Home Care Services Teams since 2003, one service unit in Tung Chung, Lantau Island still functions as a Home Help Team.

l. Is access to care restricted through eligibility criteria? What are these criteria?

For healthcare specialist services, a referral from a general practitioner or another specialist is required. For subsidised long-term care services, older adults must be assessed as moderately or severely impaired via the Standardised Care Need Assessment Mechanism for Elderly Services (Legislative Council, 2017).

2) Non-governmental Organizations (NGOs)

a. Is there at least one national nongovernmental dementia association such as an Alzheimer Association/Society? (GDO 11x1)

Hong Kong Alzheimer's Disease Association is the only Hong Kong organisational member of Alzheimer's Disease International.

b. If so, please indicate if they have (1) a national office; (2) sub-national offices or (3) both. (GDO 11x2)

The head office of Hong Kong Alzheimer's Disease Association is located in Kowloon. The Association provides the Institute of Alzheimer's Education and four regional day centres: Brain Health Centre (Lok Fu, Kowloon), Jean Wei Centre (Wan Chai, Hong Kong Island), Tseung Kwan O Integrated Service Centre (Tseung Kwan O, NT), and Gene Hwa Lee Centre (Tsuen Wan, NT) (Hong Kong Alzheimer's Disease Association, 2020c).

c. Are the majority of staff (>50%) volunteers or salaried? (GDO 11x2x3)

No available information is available, although most staff are likely to be salaried.

d. What dementia-specific activities and/or services does the association provide? (GDO 11x2x4)

Hong Kong Alzheimer's Disease Association mainly provides four types of service (Hong Kong Alzheimer's Disease Association, 2020c):
1) Early Detection Service, which provides comprehensive assessments to speed up the diagnostic process;
2) Day Centres, aiming to maintain clients' existing function, delay further cognitive deterioration and alleviate caregivers' stress by using non-pharmacological therapies and different structured and suitable training.
3) Home Service, which designs comprehensive care plans and implements home-based training by prescribing different therapeutic interventions and providing professional advice to caregivers on home care management and behavioural management techniques to maintain clients' abilities in daily functioning and minimise the effects of dementia.
4) The Institute of Alzheimer's Education provides training and educational courses for medical and social service practitioners, carers, and the general public to raise understanding of dementia and help build capacity for quality dementia care. Hong Kong Alzheimer's Disease Association also plays a role in dementia education; since 2017, it has replicated the United Kingdom Alzheimer's Society *Dementia Friends* initiative to encourage people in all walks of life in Hong Kong to become a Dementia Friend and motivate the public to translate care and acceptance of people with dementia into action.

Currently, Hong Kong Alzheimer's Disease Association implements two special projects:
1) Project e+: Dementia Community Support Service
Project e+ is a collaborative activity with Kwai Tsing District Office, aiming to raise community awareness of dementia through sustained publicity campaigns, enhance early detection of dementia to ensure timely intervention, and provide concrete support to people with dementia and their families.
2) 4E's Action for Dementia: Early detection, Early diagnosis, Early intervention, and Early planning.
Sponsored by the Ronald and Rita McAulay Foundation, this project aims for early detection, diagnosis, intervention, and planning by providing Early Detection Service, Community Memory Clinic, day centre services, Care planning consultation and Emotional support.

e. Are any of their activities funded by the government? (GDO 11x2x5)

The regular services are not funded by the government. Government funding may be provided for the collaborative special project - Project e+ - involving Kwai Tsing District Office, although the details are not clear.

f. Has the association been involved in any policy development related to dementia? (GDO 11x2x6)

There is no evidence that Hong Kong Alzheimer's Disease Association has been involved in any policy development related to dementia in Hong Kong.

g. Where are services provided by NGOs available? (nationally, regionally, locally). Please describe the variability in availability and accessibility (across regions, rural/urban)

Overall, NGOs provide territory-wide community centres, day care centres, and home care services for older people. There is no urban/rural distinction in Hong Kong.

h. Are there any costs associated with accessing services provided by NGOs for PLwD and their carers/families?

Details of costs are provided in the response to question 'I. item h' in this chapter.

i. How many people with dementia and their carers are served by NGOs? Please provide information on their profile e.g. do they tend to be more educated, living in urban areas, etc.

No information on their profiles is available.
For publicly funded NGO services, no information is available in relation to dementia (similar to question e in the previous section).
For self-financing NGO services, , Hong Kong Alzheimer's Disease Association provided day services to 512 people, early detection services to 356 people, family caregiver support and public education activities to 16,020 people, and professional training to 535 professionals or frontline workers in the year 2018/2019 (Hong Kong Alzheimer's Disease Association, 2019).

III. Dementia Care System Workforce

a. For each type of LTC workforce category, please specify the total number (absolute) in your country, please specify the year these estimates were updated (GDO 6x1)

i. Neurologists

124 specialists were registered under neurology of 7012 registered medical practitioners in the Specialist Register in 2017 (Medical Council of Hong Kong, 2017).

ii. Geriatricians/Psychogeriatricians

160 specialists were registered under geriatric medicine, and 376 under psychiatry of 7012 registered medical practitioners in the Specialist Register in 2017 (Medical Council of Hong Kong, 2017).

b. For each type of health and social workforce category, please indicate whether basic competencies on dementia are included in either undergraduate or graduate curricula training, residency programmes, continuing education programmes, specialist certification or clinical practice training (GDO 6x2)

i. Physicians/medical doctors

Yes.

ii. Specialist medical doctors

Yes.

iii. Psychologists

Yes.

iv. Rehabilitation professionals/workers

Yes depending on profession (e.g., occupational therapists).

v. Nurses

Yes

vi. Pharmaceutical personnel

Uncertain.

vii. Social workers

Yes

viii. Personal support workers

Several organisations/institutions provide training for personal support workers. Some training bodies have covered dementia in their curriculum, but some may not.

c. How are education and training programmes for members of the long-term care workforce delivered and assessed?

The Social Welfare Department regularly organises training for professionals (including social work staff and allied health professionals) and non-professional staff (including care workers and health workers) in service units for older people to enhance their knowledge of dementia and strengthen their skills in caring for older people with dementia. In 2016-17, 484 staff, including 290 non-professional staff and 194 professional staff, attended these training programmes.

d. Is training/education available for 'untrained' paid workers (e.g. live-in carers)? Who provides that training?

The Department of Health provides such training. For details, please refer to 'Part 8 – I. item a)'.

e. For question b you provided information on the training for members of the health and long-term care workforce. Are there other professionals that receive dementia training? (e.g. Clinical psychologists, occupational therapists, physiotherapists, receptionists)

Dementia information sessions and short-term workshops are provided to other professionals, such as receptionists and security guards, under the auspices of the Dementia-friendly City campaign. For more detail, please refer to Part 5. This training is not comparable to the professional training received by the long-term care workforce.

IV. Health and Long-term Care Facilities

a. Are the following types of health and long-term care facilities available in your country? (GDO 9)

i. Residential long-term care facilities

Residential long-term care facilities are commonly known as Residential Care Homes for the Elderly in Hong Kong and are generally classified into four types according to their operation and financing mode: subvented homes that are publicly funded, contract homes that obtain their service contract through bidding, non-profit-making self-financing homes, and private homes (Social Welfare Department, 2020f).

ii. Hospice centres

In the public sector, 17 palliative care services operated under the auspices of the Hospital Authority in 2019 (Lam, 2019). In the private sector, The Jockey Club Home for Hospice started services in 2017, providing quality hospice and palliative care to patients with life-limiting illnesses and their families (Society for the Promotion of Hospice Care, 2020).

iii. Adult day centres

There were 87 government-subsidized daycare centres and 80 self-financing day care centres in March 2020 (Social Welfare Department, 2020b). People aged 60 or above assessed by the Care Need Assessment Mechanism for Elderly Services as having moderate or severe impairment are suitable for day care service provided by the Social Welfare Department; otherwise, they can select self-financed services.

iv. Outpatient (community) social centres

41 District Elderly Community Centres and 169 Neighbourhood Elderly Centres provide the following services: collaboration with and provision of support to other service units for older people in the District, community education, case management, outreaching and networking, support team for older people, health education, educational and developmental activities, provision of information on community resources and referral services, volunteer development, carer support services, counselling services, educational and supportive programmes on dementia, social and recreational activities, meal and laundry services, and drop-in services.

b. Please specify the total number of residential long-term care facilities in your country i.e. long-term nursing care facilities and other residential long-term care facilities. If available, please also specify the total number of beds across all long-term residential facilities in your country.

953 residential care homes for older people provide 76,343 beds (Social Welfare Department, 2020f).

c. How many people with dementia are living in residential long-term facilities in your country (ideally for a one year period)?

In 2009, it was estimated that 18,421 people aged 60 and above were living with dementia in residential care facilities. This was projected to reach 61,367 people by 2039 (Yu et al., 2012).

d. Do hospitals in your country have any dementia-specific beds? If yes, please try to find the number of beds available either at national or sub-national levels

No.

e. Do hospitals in your country have any geriatric-specific beds? If yes, please try to find the number of beds available either at national or sub-national levels.

There are acute geriatric beds in public hospitals. But the exact number is not clear.
Geriatric (together with Internal Medicine, Respiratory Medicine, Medical Infectious Diseases and Coronary Care Unit) is grouped under the specialty of Medicine in the Hospital Authority. The specialty of Medicine had 9657 beds In 2019 (Hospital Authority, 2019b).

f. Do hospitals in your country track dementia-related admissions? If so, please indicate the total number of dementia-related admissions and specify the date this was reported.

Not sure. For public hospitals under the Hospital Authority, 28,000 people with dementia received care by the end of 2016 (Food and Health Bureau, 2017a), but it is not clear how many have been hospitalized.

g. Of the different types of health and long-term care facilities listed above, where such facilities are available, how many such facilities are available?

These facilities are available in each District in Hong Kong and provide territory-wide service. For details, please refer to the answer for item a).

h. What services are provided in (community) social centres?

Listed above in item a) iv.

i. Do these facilities offer dementia specific programmes/interventions? What kind of interventions are provided?

Following the regular implementation of the Dementia Community Support Scheme in 2020, all 41 District Elderly Community Centres provide dementia-specific programmes (Food and Health Bureau, 2019a) targeting cognitive performance, functional ability, carer burden, psychosocial wellbeing, behavioural and psychological symptoms of dementia and physical co-morbidities are provided.

j. Question c above investigated the number of residential long-term facilities. Do mental health hospitals/institutions play a role in the provision of residential dementia care?

No, or probably a very limited role. People with dementia aged under 60 but who need hospital or residential care may be referred to the psychiatric inpatient service or a long-stay care home. However, there is no information about this group of people with dementia.

V. Antidementia Medication and Care Products

a. Are any antidementia medications approved by your National Medicines Regulatory Authority? Please specify. (GDO 10)

Four major types of antidementia medication are approved by the Hospital Authority Drug Formulary in Hong Kong, as shown in Table 26 (Hospital Authority Drug Formulary, 2020, April 10; Institute of Mental Health Castle Peak Hospital, 2020). They are commonly used in treating dementia to slow disease progression, maintain functioning, defer decline, and alleviate behavioural and emotional problems. Apart from that, other drugs may be also used to ease distressing symptoms relating to dementia at different stages, such as depression, anxiety, sleeping disorder and antipsychotics (Social Welfare Department, 2018).

Table 26

Antidementia medications approved by the Hospital Authority Drug Formulary in Hong Kong

Drug Name	Brand Name	Drug Type
Donepezil	Aricept	Cholinesterase inhibitor (ChEI)
Rivastigmine	Exelon	Cholinesterase inhibitor (ChEI)
Galantamine	Reminyl	Cholinesterase inhibitor (ChEI)
Memantine	Ebixa	N-methyl-D-aspartate (NMDA) receptor antagonist

(Hospital Authority Drug Formulary, 2020, April 10; Institute of Mental Health Castle Peak Hospital, 2020).

b. Are any of these medications available as generics?

The four major types of antidementia medications are special drugs that are available as generics in Hong Kong through the Hospital Authority. They are prescribed by specialists for people with dementia who have been assessed as having the specified clinical conditions and therapeutic needs. People with dementia who do not have the specified clinical conditions can only purchase these drugs with a prescription in Hospital Authority or community pharmacies as self-financed items (Government of the Hong Kong Special Administrative Region, 2015, February 25; Hospital Authority Drug Formulary, 2020, February 8)

c. Are any of the following care products, equipment and technologies available for free or partially subsidised for those with dementia in your country?

i. Adult hygiene products (e.g. diapers, disposable cloths, underpads)

Adult hygiene products are not subsidised for people with dementia in Hong Kong.

ii. Assistive technology (e.g. walking frames, wheelchairs, spectacles, hearing aids)

Assistive technology products are not subsidised for people with dementia in Hong Kong.

iii. Housing adjustments (e.g. ramps, grab bars, smoke detectors)

In most cases, housing adjustments are not subsidised. The government launched the "Building Maintenance Grant Scheme for Elderly Owners" in 2008 to provide financial assistance up to HK$40,000 for each eligible older owner-occupier to repair and ensure the safety of their accommodation and/or common areas in residential buildings, including structural aspects, the safety of external elevations, defective windows, fire safety, sanitary services, waterproofing membranes, cubicles, slopes and retaining walls (Hong Kong Housing Society, 2020a).

d. Are any of the aforementioned medications available for free or partially subsidised?

All medications, including special antidementia drugs, are partially subsidised and provided at standard fees and charges for Hospital Authority patients. Non-Hospital Authority patients may purchase these drugs with a prescription from community pharmacies as self-financed items (Government of the Hong Kong Special Administrative Region, 2015, February 25). Comprehensive Social Security Assistance and Old Age Living Allowance recipients, medical fee waiver holders, or Level 0 Voucher holders of the Pilot Scheme on Residential Care Service Voucher for the Elderly are exempted from paying for these drugs and other public healthcare expenses (Hospital Authority, 2018).

e. Are non-pharmacological interventions, such as Cognitive Stimulation Therapy available for people with dementia? Are such interventions evidence based?

Yes, including Cognitive Stimulation Therapy. A local study (Wong et al., 2018) provides preliminary evidence supporting its effectiveness for cognitive improvement. For the types of non-pharmacological intervention, please refer to 'section II – 1) item h' in this chapter.

f. Does technology play a role in dementia care? (e.g. GPS tracking)

The rapid development of innovative technologies in recent years has played a role in enhancing care services for older people and dementia care in Hong Kong. The use of a GPS-watch or smart phone app is common practice among some older people and family members to track a person's location or provide a reminder to take medication. In addition, many community and residential care service units for older people have installed systems or devices to ensure the safety of service users, such as anti-wandering, fall prevention and out-of-bed detection systems.

In recent years, the government has introduced more information technology and gerontech products with reference to other countries to enhance the quality of life of service users and reduce pressure among care staff and family carers. The government and Hong Kong Council of Social Service jointly initiated the "Gerontech and Innovation Expo cum Summit (GIES)" in 2017, providing an international platform for stakeholders to engage in the development of gerontechnology for the ageing population in Hong Kong (Gerontech and Innovation Expo cum Summit, 2020). The government also earmarked HK$1 billion for the "Innovation and Technology Fund for Application in Elderly and Rehabilitation Care" in 2018 (Social Welfare Department, 2020d). The first round has been approved to provide more than HK$37 million to 210 rehabilitation service units and service units for older people to purchase or rent a total of 870 technology products, such as electric nursing beds, the lifting and transfer machine "SASUKE Robohelper", the rehab training manipulator "HandyRehab", the interactive robot "UNAZUKI KABOCHAN", the multi-sensory emotion comforting pillow "inmuRELAX", the VR bicycle machine, and a face recognition technology app for pain assessment (HKET, 2020, January 8; Hong Kong Council of Social Service, 2019; Job Market, 2020, February 28). More examples of technology use in dementia care in Hong Kong are listed below:

Care-on-Call services
The Senior Citizen Home Safety Association provides 24-hour care-on-call service to older people, including those with dementia. It uses mobile positioning technology to locate users, and family members can check their locations easily via the "e-See Find" smartphone app. Users can also seek help from passers-by using a remote control ringer that helps users to forward phone calls to families and friends and provide regular reminders of outpatient appointments and useful information when needed (Senior Citizen Home Safety Association, 2019).

Anti-wandering vests
One large NGO, Tung Wah Group of Hospitals, has developed anti-wandering vests incorporating a GPS positioning device for older people with dementia at risk of wandering. The organisation has provided the vests to Day Care Centres, District Elderly Community Centres and Specialised Services Units for Dementia Care to reduce wandering by older people with dementia (Tung Wah Group of Hospitals, 2017).

Smart shoes
The Electrical and Mechanical Services Department and Hong Kong Productivity Council have produced 100 smart shoes using an RFID tag for indoors use, and a GPS tracking system for outdoors use, distributed for trialling to centres for older people. The trials successfully allowed family members to easily check the location of older people and ensure their safety via an online platform (Electrical and Mechanical Services Department, 2018).

Caring Communities for Dementia Campaign
The Jockey Club Centre for Positive Ageing initiated the Jockey Club Caring Communities for Dementia Campaign to increase public awareness on wandering behaviour of older people with dementia. It has developed a smartphone app incorporating a GPS tracking device to shorten the search time for older people who have wandered by involving people in the community to assist (Jockey Club Centre for Positive Ageing, 2020a).

Information Sharing
The Electronic Health Record Sharing System (eHRSS) in Hong Kong is a territory-wide, patient-oriented electronic sharing platform which enables authorised healthcare providers to access and share participating patients' electronic health records for healthcare purposes (Government of the Hong Kong Special Administrative Region, 2019, October). In Dementia Community Support Scheme, which is a dementia-specific community service jointly provided by the healthcare and social care sector, the eHRSS enables timely information sharing among multiple service providers and thus facilitate better care tailored to the healthcare needs of the people living with dementia.

g. What are the costs of the main antidementia medications in Hong Kong: donepezil, galantamine, rivastigmine and memantine?

The following prices of three main antidementia medications were extracted from a pharmacy service of a local NGO for reference (Lok Sin Tong Benevolent Society Kowloon, 2022):

Donepezil 5mg Generic price: $150/box (30's)
Memantine 10mg Generic price: $49/strip (14's)
Exelon (Rivastigmine) 4.6mg/24 hours patch: $30/patch

For galantamine, there is no information publicly available.

Part 8: Unpaid Care and Other Informal Care for Dementia

I. Informal Care Workers

Two types of informal care workers provide care for older people in Hong Kong, foreign domestic helpers and local domestic helpers. They enjoy fundamentally different employment conditions and identities in Hong Kong.

Foreign domestic helpers have comprised the main type of informal care workers in Hong Kong since the policy regulating their admission in 1973. They are full-time workers and must live in their employers' households. Up to the end of 2018, there were 386,075 foreign domestic helpers in Hong Kong, comprising 5.2% of the population and 9.7% of labour force (Census and Statistics Department, 2019i). In 2016, 9% of households including an adult aged 60 or over hired a foreign domestic helper (Legislative Council Secretariat, 2017). Only 13.2% of households including adults aged 65 and over hired a foreign domestic helper (39,609 out of 300,906 households) (Census and Statistics Department, 2018a).

Local domestic helpers are far less common than foreign domestic workers, and their involvement in caring for older adults is believed to be relatively small. They are usually local citizens, mainly female, who wish to have a part-time job and are hired on an hourly basis. Statistics about the number of local domestic helpers and their characteristics are very limited. According to a household survey conducted by the Census in 2000, 87.9% of households that hired domestic helper(s) hired foreign workers, and only 12.1% hired local helpers, constituting 1.2% of the total number of households only. (Census and Statistics Department, 2001; Legislative Council Secretariat, 2017). No further information or more updated statistics regarding the number of local domestic helpers are available.

a. To what extent are informal care workers used to care for people with dementia in your country?

Local studies on dementia care have usually collected information about the role of domestic helpers (informal care workers) in the households of people with dementia. Findings from several local studies are identified and summarised in Table 27. The proportion of people with dementia receiving care from informal care workers ranges from 26–54%.

Table 27

Proportion of people living with dementia receiving care from informal care workers in Hong Kong.

Author	Sample	Source of participants	% hiring an informal care worker
Yan and Kwok (2011)	122 family carers of people with dementia.	District community centres	38%
Chau et al. (2012)	300 older adults with both functional and cognitive impairments	Public hospitals, District Community Centres and Day Care Centres	48%
Kwok et al. (2013)	37 family carers of people with dementia	Memory clinic and hotline services of dementia service centre	54%
Cheng, Lam, Kwok, et al. (2013)	142 family carers of people with dementia	Clinics, social service agencies, and community-dwelling older adults with diagnosis but not known to services	26%
Shi et al. (2020)	1385 dyads of people with dementia and family carers	Dementia Community Support Scheme	32%

In view of the significant role of foreign domestic helpers in providing informal care for older adults, the Social Welfare Department implemented the 'Pilot Scheme on Training for Foreign Domestic Helpers in Elderly Care' to strengthen their caregiving skills. The training began in September 2019 and was delivered by nurses, dieticians, physiotherapists, and occupational therapists from the Department of Health. It comprises 12 core modules on common topics in the care of older people and care skills, and four elective modules on dementia and stroke. The topics relating to dementia are 'meal arrangements for older people with dementia', 'communicating with older people with dementia', and 'managing behavioural and psychological symptoms of dementia'. The course is fully subsidised and aims to train 950 foreign domestic helpers (Social Welfare Department, 2020g).

b. Please describe the employment conditions and any safeguarding concerns related to informal care workers for dementia in your country.

All employees in Hong Kong, including informal care workers, are regulated by the Employment Ordinance (Department of Justice, 2019a). Protection of employment, such as wages, paid leave, medical attention, maternity protection, and termination of contract are all covered in the Ordinance. The Labour Department is responsible for monitoring compliance with the Employment Ordinance.

Foreign domestic helpers comprise a special type of employee in Hong Kong regulated by both the Immigration Department and the Labour Department. Foreign domestic helpers must work in a full-time live-in mode and only perform domestic duties for the employer in relation to their household (Imigration Department, 2019). If the employment contract is terminated or expires without renewal, the worker must return to her home country. The duration of this employment is not recognized for the purpose of applying for permanent residence in Hong Kong. The Statutory Minimum Allowable Wage prescribes the wages payable to foreign domestic helpers; effective from 29 September 2018 these are HK$4,520 per month if the employer provides food for the helper; an extra HK$1,075 per month is payable if the employer does not provide food (Government of the Hong Kong Special Administrative Region, 2019c).

The wages of local domestic helpers are regulated by the Minimum Wage Ordinance in addition to the protection under the Employment Ordinance. With effect from 1 May 2019, the Statutory Minimum Wage rate for local domestic workers is HK$37.5 per hour (Labour Department, 2020).

c. Please describe the socio-demographic characteristics of informal carers in your country

Nearly all foreign domestic helpers are female (98.5%) (Census and Statistics Department, 2019i). In 2016, their median age was 35, with 41% aged 25-34 and 39% aged 35-44. The majority had attained secondary school education (82%), and some completed tertiary education (10%) (Legislative Council Secretariat, 2017). According to a local study of 152 foreign domestic helpers caring for people with dementia (Bai et al., 2013), 53% were married, 34% single, 7% widowed and 5% divorced/separated.

No socio-demographic information about local domestic helpers is available, although it is also believed that most are female.

d. Does migration (within and between countries) play a role in the availability of informal care workers? What are the migration patterns?

As previously mentioned, foreign domestic helpers are the major source of informal care. In 2018, they comprised 5.2% of the Hong Kong population and 9.7% of the workforce (Census and Statistics Department, 2019i). Nevertheless, it is important to note that the admission policy for foreign domestic helpers into Hong Kong does not allow them to permanently migrate to Hong Kong even if they continuously reside in Hong Kong for more than seven years (i.e., the major eligibility criterion for determining the right of abode in Hong Kong). The length of their stay is always subject to the employment contract. Regarding the home countries of foreign domestic helpers, the major countries of origin have been Philippines (54%) and Indonesia (44%), with 2% from India, Thailand, Sri Lanka, and Bangladesh combined (Legislative Council Secretariat, 2017).

e. Do you have information on the socio-economic status of informal care workers?

All foreign domestic helpers work full-time on a live-in basis in their employer's household. The Statutory Minimum Allowable Wage (effective from 29 September 2018) is HK$4,520 per month if the employer provides the helper's food and HK$5,275 per month if the employer does not provide food (Government of the Hong Kong Special Administrative Region, 2019c).

Little is known about the socio-economic status of local domestic helpers. The Employee Retraining Board, a statutory body in Hong Kong, has issued guidelines and suggested wages for hiring local domestic helpers: HK$85-105 per hour for 'Escort for Out-patient visit' and 'Elderly Care for Elderly with self-care ability', and HK$90 or above 'for Elderly without self-care ability'. The suggested minimum duration of each service session is three hours (Employee Retraining Board, 2019).

f. What is the average income of an informal care worker?

Please refer to the information provided in 'question e'. No further information is available.

II. Family/Unpaid Care

a. What support is available for family/unpaid carers in your country? (GDO 12x2)

i. Social protection (i.e. care support grants; paid/unpaid leave; tax credits)

A Carer Allowance has been available for low-income family carers taking care of older adults in Hong Kong since 2014 (Social Welfare Department, 2019, January 28). Carers of people with dementia can apply for the allowance if they meet the following three major eligibility criteria: i) the older adult who needs long-term care (i.e., previously assessed as moderately or severely impaired), ii) the carer is from a household whose income does not exceed 75% of the Median Monthly Domestic Household Income, and iii) the carer provides at least 80 hours of caregiving per month (Social Welfare Department, 2019, January 28). For more details, please refer to 'Part 9 item iii'.

All employment in Hong Kong is regulated by the Employment Ordinance (Cap 57). However, there is no policy or guideline regarding paid or unpaid leaves for personal or family matters. For more details, please refer to 'Part 9 item iv'.

Family carers of people with dementia can benefit from a wide range of tax reduction measures, although these measures are not designed specifically for dementia. For more details, please refer to 'Part 9 item vi'.

ii. Payments (cash transfers)

Under the Carer Allowance scheme, low-income family carers in Hong Kong receive HK$2,400 per month to supplement their living expenses. For more details, please refer to 'Part 9 item iii'.

iii. Training and education
iv. Psychosocial support for carers

Carer training programmes and support services, such as counselling services, mutual support groups and group-based psychosocial intervention, are widely available in Hong Kong and are provided by all publicly-funded community care service units operated by NGOs, including community centres for older people, day care centres and home care teams. Home Care teams even provide on-site training in the carer's home when necessary. Furthermore, since implementation of the Carer Allowance scheme, the coverage of carer training programmes and support services has been further broadened as social workers at community centres for older people (i.e., District Elderly Community Centres) can reach more carers in need. Although these training programmes are not necessarily dementia-specific, dementia is a common and recurrent training topic.

In addition, dementia-specific carer training is delivered under the territory-wide Dementia Community Support Scheme. One of the core services of the scheme is the "provision of training and support services to the carers on stress management and counselling services, knowledge of taking care of elderly persons with dementia, formation of carer support groups, etc. to alleviate carers' burden" (Food and Health Bureau, 2019a). For more details about Dementia Community Support Scheme, please refer to 'Part 7 – I & II'.

Apart from the social care service units, the healthcare sector also provides carer training and support. The Department of Health's Visit Health Teams provide territory-wide outreach services in the community to provide health promotion activities for older people and their carers to increase health awareness, older people's self-care ability, and enhance the quality of caregiving (Department of Health, 2019a). The Hospital Authority

established a website, "SmartElders" (https://www21.ha.org.hk/smartpatient/SmartElders/zh-HK/Welcome/), to provide useful online resources for both older adults and their carers.

v. Respite services for carers where they can take time away from their caring role to engage in other activities of choice.

Three types of publicly-funded respite services are available in Hong Kong: (1) day respite, (2) residential respite and (3) home respite / sitting with older people. Subsidised daycare units for older people provideday respite services are provided by (Social Welfare Department, 2020, May 21), and residential respite services are provided by residential care homes (Social Welfare Department, 2020, May 21). These respite services are subsidised and provided at an affordable price (summarised in Table 28). Up to the end of May 2020, there were 189 subsidised day respite and 283 residential respite places. Home respite/sitting with older people services are provided by home care teams. Information about their availability and usage are not available.

Table 28

Fees for respite services

Type	Service Providers	Fee (HK$/day)
Day Respite	Day care units	$41.5
Residential Respite	Care-And-Attention Home and Contract Home	$62
	Nursing Home	$72
Home Respite / Sitting with older people	Enhanced Home and Community Care / Integrated Home Care service teams	Information not available

(Social Welfare Department, 2020, May 21)

vi. Information on legal rights

Carers requesting information about legal matters such as applying for guardianship, drafting a will or advance directive, can seek support and service referrals from a long-term care or healthcare service unit (e.g., District Elderly Community Centre, Specialist Outpatient Clinic).

Resources for carers are also available on a local website designed for caregivers of people with dementia (https://www.adcarer.com/eng/course1_future.php) set up by the Jockey Club for Positive Ageing.

b. What are the social norms and traditions of family care in your country? Are there gender roles associated with family care in your country

Taking care of aged parents remains a social norm of family care in Hong Kong. In general, the traditional Confucian notion of filial piety as a cultural norm still runs deep even in this modern and highly-developed city. It motivates adult children to embark on the caregiving journey. However, two local studies (Lee, 2004; Wong & Chau, 2006) have described and articulated that the filial values in the context of care of older people in Hong Kong are different and evolving from traditional values. Other than filial values, the provision of care for an aged parent by an adult child is also determined by their living arrangements, geographical proximity, and quality of relationship. It turns out that daughters usually become the carer instead of the eldest son, who was supposed to have the largest responsibility to take care of parents according to traditional filial values (Lee, 2004). Moreover, carers have adopted some, but not all, aspects of filial norms to suit their own experiences and circumstances in their everyday caregiving practices. For instance, instead of blindly following their parents' wishes, carers challenged their parents and had their own considerations and decisions during care provision (Wong & Chau, 2006).

In Hong Kong, when an older adult needs care, either their spouse or at least one of their adult children, if any, would take up the role of primary carer. Owing to the limited size of family homes, adult children often live in another household nearby instead of living with their parents. Moreover, live-in foreign domestic helpers and formal community care services are often utilised to assist in household chores and daily care. Regarding gender roles, females are more likely to be family carers. A recent study conducted by the authors in 2018 to evaluate the Dementia Community Support Scheme (Shi et al., 2020) provides some demographic information about family carers of people with dementia in the community. Of 1385 primary carers, 66% were females; 27% were a spouse of the person with dementia, 65% were children, and 4% were children-in-law. In line with other local studies on family care, daughters were the most likely family member to provide family care.

Despite the family values and beliefs that maintain the provision of family care, it is important to note that the family structure in Hong Kong is changing. Due to decreasing marriage and fertility rates, Hong Kong will inevitably face the challenge of families' reduced capacity to care for older people. In other words, the number of older adults without support from younger family members is expected to increase. Recent statistics on living arrangements provided by the Census provide evidence that such a trend is already emerging (Census and Statistics Department, 2018a). From 2006 to 2016, the proportion of older adults living alone increased from 11.6% to 13.1%, and those living with their spouse only increased from 21.2% to 25.2% (Table 29).

Table 29
Living arrangements of older adults and the use of domestic helpers among domestic households with older adults only: 2006, 2011 and 2016

	2006	2011	2016
Living arrangements of 65+ population	N (%)		
Living in domestic household			
Alone	98,829 (11.6)	119,376 (12.7)	152,536 (13.1)
With spouse only	181,139 (21.2)	221,766 (23.6)	293,308 (25.2)
With spouse and child(ren)	259,154 (30.4)	279,786 (29.7)	337,623 (29.0)
With child(ren) only	196,581 (23.1)	201,906 (21.4)	226,801 (19.5)
With others	31,522 (3.7)	37,849 (4.0)	58,657 (5.0)
Living in residential care homes, hospitals, or other non-domestic households	85,571 (10.0)	80,629 (8.6)	94,228 (8.1)
Total	852,796 (100.0)	941,912 (100.0)	1,163,153 (100.0)
Use of domestic helper among domestic households with older adults only[1]	12,807 (7.1)	24,246 (10.9)	39,609 (13.2)

[1] In 2016, 300,906 households comprised older adults only, including 176,295 households with one older adult, 122,166 with two older adults, and 2,445 with three or more older adults.
(Census and Statistics Department, 2018a)

c. Please describe the documented impacts on the caregiver of provision of unpaid care to people with dementia

i. Health impact

Local studies on family caregivers found in 'Part 10: Dementia Research' are reviewed and discussed here.

Among 33 local studies identified, a wide range of caregiver mental health domains have been studied, including care burden (16 studies), depression/ depressive symptoms (14 studies), distress caused by behavioural and psychological symptoms of dementia (four studies), role overload (three studies), caregiving strain (one study), burnout (one study), anticipatory grief (two studies), positive aspects of caregiving (four studies), quality of life (three studies), life satisfaction (two studies), meaning in life (one study), psychological wellbeing (one study), and overall wellbeing (one study). However, only one study reported on caregivers' physical health. Descriptive statistics of care burden, depression/depressive symptoms, positive aspects of caregiving, quality of life and caregivers' physical health reported by some local studies have been extracted and summarised in Table 30. The mean of the care burden measured by the 22-item Zarit Burden Interview ranged from 24.4 to 43.6, indicating a mild to moderate level of burden; the mean score for depression/depressive symptoms measured by the 20-item Center for Epidemiologic Studies Depression Scale ranged from 12.9 to 19.6, with a score of 16 or above suggesting significant or mild depressive symptomatology.

Table 30

Care burden, depression/depressive symptoms, positive aspects of caregiving, quality of life and physical health of family carers of people with dementia

Author (Year)	Sample size	Dementia severity / cognitive performance	Mean (SD)
Care Burden			
Family Caregiving Burden Inventory (FCBI) (24-item) (0-96)			
Chien and Lee (2008)	44 (Exp) 44 (Control)	Early (ambulatory): 80% Late: 20%	68.1 (14.9) 67.8 (15.7)
Chien and Lee (2011)	46 (Exp) 46 (Control)	DSM-IV Mild to moderate; MMSE: Exp: 17.5 (4.7) Control: 17.3 (3.9)	68.0 (14.6) 66.9 (13.7)
Zarit Burden Interview (ZBI) (22-item) (0-88)			
Yan and Kwok (2011)	122	Not specified	36.8 (14.4)
Cheng, Lam and Kwok (2013)	99	Clinical Dementia Rating: 3% Very mild, 24% Mild, 53% Moderate, 20% Severe MMSE: 12.16 (8.26)	24.4 (15.6)
Cheng, Lam and Kwok (2013)	142	MMSE 15.18 (5.57)	24.5 (14.8)
(Kwok et al., 2013)	18 (Exp) 20 (Control)	Global Deterioration Scale – Median (range): 5 (4–6) Abbreviated Mental Test (AMT) – Median (range): Exp: 4.00 (2–8) Control: 4.00 (0–7)	37.0 (17-54) 34.0 (15-57)
Cheng et al. (2016)	45 (Gp 1) 42 (Gp 2) 42 (Gp 3)	Clinical Dementia Rating: 1 or 2; mild to moderate dementia	35.0 (16.7) 35.1 (14.2) 33.7 (16.6)
Yu et al. (2016)	123	34%: early, 53%: moderate, 13%: severe dementia	26.8 (15.1)
Wong (2018)	89	Not specified	37.1 (12.4)
Cheung et al. (2018)	108	Functional Assessment Staging Test (Stage 4-7): 73 (68%) score 4 or 5; 35 (32%) score 6 or 7	43.6 (18.2)
Zarit Burden Interview (ZBI) (12-item) (0-48)			
Cheng, Ip, et al. (2013)	76	Not specified	19.5 (8.71)
Cheung et al. (2015)	201	Not specified	20.3 (9.30)
Lou, Kwan, et al. (2015)	374	MMSE: 15.6 (6.2)	15.5 (9.41)
Tang, Ho, et al. (2016)	500	Not specified	19.1 (8.8)
Lau et al. (2018)	397	Not specified	19.7 (8.84)
Depression / Depressive symptoms			
Center for Epidemiologic Studies Depression (CES-D) scale (20-item) (0-60)			
Wong et al. (2008)	120	MMSE: 14.68 (5.53) Mild (MMSE > 19): 16 Mild – moderate (MMSE 15 – 19): 38 Moderate (MMSE 10 – 14): 46 Severe (MMSE < 10): 18	13.1 (9.50)

Author (Year)	Sample size	Dementia severity / cognitive performance	Mean (SD)
Au et al. (2009)	134	MMSE: 14.84 (5.46)	12.9 (9.25)
Au et al. (2014)	30 (Exp); 30 (Control)	MMSE: Exp: 15.5 (6.3); Control: 12.9 (5.5)	16.1 (10.9) 12.1 (8.90)
(Au, 2015)	49 (Exp); 44 (Control)	MMSE: Exp: 15.12 (5.68), Control 16.40 (5.58)	13.5 (7.28) 13.6 (8.77)
Cheung et al. (2015)	201	Not specified	15.8 (9.48)
Lou, Lau, et al. (2015)	374	MMSE: 15.6 (6.2)	19.6 (8.87)
Wong (2018)	89	Not specified	15.1 (9.0)
Lau et al. (2018)	397	Not specified	15.3 (9.20)
Center for Epidemiologic Studies Depression (CES-D) scale (10-item) (0-30)			
Chan et al. (2017)	120	Functional Assessment Staging Test: 6.8 (2.81)	9.00 (6.49)
Center for Epidemiologic Studies - Depression Scale (CESD) (7-item) (1-4)			
Lau and Cheng (2017)	101	Not specified	2.07 (0.85)
Hamilton Depression Rating Scale (HDRS) (17-item) (0-52)			
Cheng, Lam and Kwok (2013)	99	Clinical Dementia Rating: 3% Very mild, 24% Mild, 53% Moderate, 20% Severe MMSE: 12.16 (8.26)	4.4 (4.87)
Cheng, Lam and Kwok (2013)	142	MMSE: 15.18 (5.57)	3.9 (4.03)
Cheng et al. (2016)	45 (Gp 1) 42 (Gp 2) 42 (Gp 3)	Clinical Dementia Rating: 1 or 2; mild to moderate dementia	6.36 (4.22) 6.14 (3.36) 6.98 (4.12)
Mental Health Inventory (MHI-5) (5-item) from SF-36 (0-100)			
Yu et al. (2016)	123	34% early, 53% moderate, 13%: severe	69.0 (16.8)
Positive Aspects of Caregiving			
Positive Aspects of Caregiving (PAC) Scale (9-item) (9-45)			
Cheng, Lam and Kwok (2013)	99	Clinical Dementia Rating: 3% Very mild, 24% Mild, 53% Moderate, 20% Severe MMSE: 12.16 (8.26)	25.0 (6.19)
Positive Aspects of Caregiving (PAC) Scale (11-item) (0-44)			
Lou, Lau, et al. (2015)	374	MMSE: 15.6 (6.2)	27.8 (9.45)
Cheung et al. (2015)	201	Not specified	27.7 (9.93)
Lau et al. (2018)	397	Not specified	27.0 (9.94)
Quality of Life			
World Health Organisation Quality of Life Measure-Brief Version (WHOQoL-BREF) (28-item) (28-140)			
Fung and Chien (2002)	26 (Exp); 26 (Control)	Not specified	96.9 (14.1) 103.8 (0.68)
Chien and Lee (2011)	46 (Exp); 46 (Control)	Mild to moderate; MMSE: Exp: 17.5 (4.7), Control: 17.3 (3.9)	64.8 (13.0) 67.1 (15.5)
Physical Health			
Self-rated health (single item) (0 – 4)			
Lou, Lau, et al. (2015)	374	MMSE: 15.6 (6.2)	2.84 (0.91)

Note: 1. For each measure, the name of the instrument, number of items and possible range are presented.
2. For clinical trials, baseline scores of each group are presented.

ii. Employment, education and other impacts

No information is available. We do not know how, if any, the provision of care to people with dementia impacts the employment and education opportunities of family carers.

iii. Impact on social protection

No information is available.

d. Does your country have any employment policies for unpaid/family carers?

No.

e. In question c(i) you described the health impact of unpaid carers. Is there evidence for aspects of both physical and mental health?

The evidence is mostly on mental health. For details, please refer back to item c(i).

f. In question a) you provided information on support for family/unpaid carers. Who are the key providers?

The key providers of family carer support are the Social Welfare Department, NGO- operated community care service units, Department of Health and Hospital Authority.

g. Does social media or other technologies (e.g. GPS tracking) play a role in caring for a person with dementia?

Yes, but no local study has yet explored carers' use of social media or other technologies in their provision or care.

Social media acts as a channel for disseminating dementia-related information and articles to caregivers. Four dementia-related Facebook pages established by local parties have been identified:
1. Hong Kong Alzheimer's Disease Association
https://www.facebook.com/%E8%AA%8D%E7%9F%A5%E9%9A%9C%E7%A4%99%E7%97%87%E7%85%A7%E9%A1%A7%E8%80%85%E7%B6%B2%E7%B5%A1-1743136225713466/
2. St. James' Settlement
https://www.facebook.com/SJSDementiaCaringCommunity/
3. Big Silver
https://www.facebook.com/pg/bigsilver.org/photos/?tab=album&album_id=3101252460100149
4. Community self-initiated
https://www.facebook.com/pg/HKDementiaSupport/about/?ref=page_internal

Technology also allows caregivers to form virtual groups easily to provide mutual support. It has been observed that caregivers may form a chat group via an instant messaging tool (e.g., WhatsApp) (Christian Family Service Centre, 2016). Two dementia caregiver groups have been identified on Facebook:
https://www.facebook.com/groups/BigSilver.Dementia.cafe/
https://www.facebook.com/groups/carers.voice/

Moreover, a local NGO, Hong Kong Sheng Kung Hui Welfare Council Limited, developed a mobile app 'Act of Love. Trace Me' for both iOS and Android systems to search for missing people with dementia and support their families. This app can be used to post information about the missing person on a Facebook page:
https://apps.apple.com/hk/app/act-of-love-trace-me/id1059654173?l=en

https://play.google.com/store/apps/details?id=com.cherrypicks.laf&hl=en

For more information on the use of GPS tracking and other technologies in dementia care, please refer to 'Part 7-V: item f'.

Part 9: Social Protection for People with Dementia

No social protection policy has been designed specifically for people with dementia in Hong Kong. People with dementia and their carers are mostly covered, to varying extents, by the current social protection system that aims to protect older people, the poor and those with a disability.

a. Please describe whether any of the following social protection mechanisms are available for those living with dementia in your country:

i. Disability Grant(s); Pensions; Old Age Grants; any other form of cash benefits

Grants for older people and people with a disability, the Old Age Allowance and Disability Allowance, respectively, are available in Hong Kong and cover people with dementia. Every adult aged 70 or over in Hong Kong is eligible for the Old Age Allowance. Those experiencing more difficult financial circumstances may apply for the means-tested Old Age Living Allowance or the Comprehensive Social Security Allowance Scheme (Social Welfare Department, 2019, July 30, 2019, September 6). People with dementia who are severely disabled, regardless of their age and financial situation, are eligible for Disability Allowance. Please refer to 'Part 1: IV Social Protection' for further information on the eligibility and cash amount of various social protection schemes in Hong Kong.

In 2000, the government implemented the Mandatory Provident Fund scheme to provide retirement protection. It is a mandatory, privately managed, and fully funded contribution system. Under the scheme, employers and employees must make regular mandatory contributions calculated at 5% of the employee's income, subject to relevant income levels (Mandatory Provident Fund Schemes Authority, 2019, April 1). Table 31 shows the relevant monthly income and the amount of Mandatory Contributions (Mandatory Provident Fund Schemes Authority, 2019, April 1). Besides mandatory contributions, employees are encouraged to make voluntary contributions and enjoy tax deductions. As all employees, people with dementia and their carers are covered by the Mandatory Provident Fund scheme. However, there are no additional benefits in relation to dementia.

Table 31

Mandatory Provident Fund: Relevant monthly income and mandatory contributions

Monthly Income	Amount of Mandatory Contributions Payable by Employer	Amount of Mandatory Contributions Payable by Employee
≤ HK$7,100	Relevant income x 5%	HK$0
HK$7,100 - HK$30,000	Relevant income x 5%	Relevant income x 5%
≥ HK$30,000	HK$1,500	HK$1,500

(Mandatory Provident Fund Schemes Authority, 2019, April 1)

ii. Employment protection

There is no dementia-specific policy to provide employment protection for people with dementia. However, if a person with dementia is in employment, they will be protected in the same way as all employees in Hong Kong by the Employment Ordinance (Cap 57) (Department of Justice, 2019a) and the Disability Discrimination Ordinance (Cap 487) (Department of Justice, 2015). It is unlawful for an employer to discriminate against a job applicant or an employee with any disabilities or illness (Equal Opportunities Commission, n.d.).

iii. Carers' benefit (including in-kind and financial benefits)

The Carer's Allowance is available for family carers taking care of older adults in Hong Kong since the Government launched "Pilot Scheme on Living Allowance for Carers of Elderly persons for Low-income Families" in 2014 (Social Welfare Department, 2019, January 28). The three major eligibility criteria for the scheme are: (i) the older adult needs long-term care (i.e., previously assessed as moderately or severely impaired), ii) the carer lives in a household whose income does not exceed 75% of the Median Monthly Domestic Household Income, and (iii) the carer provides at least 80 hours of caregiving per month. Up to September 2020, three phases of the pilot scheme have been rolled out, benefitting approximately 6,000 family carers. Eligible carers receive a monthly cash allowance of HK$2,400, regular carer support provided by a social worker, and recommendations for a carer training programme according to their caregiving needs (Social Welfare Department, 2019, January 28).

iv. Paid or unpaid leave

As mentioned in item (ii), people with dementia are protected by the Employment Ordinance (Cap 57) as all employees to enjoy rest days, holidays with paid and paid leave, including sick leave and annual leave (Department of Justice, 2019a). Although the Employment Ordinance (Cap 57) does not include any provisions regarding unpaid leave, employees can negotiate with their employers to take unpaid leave due to illness. No special arrangements regarding leave have been found that apply to dementia or other illnesses.

There is no legal obligation for employers to make special leave arrangements for carers of people with dementia, due to illness of family members or other family reasons. In most cases, carers must apply for annual leave (i.e., paid leave) if they have to accompany the person with dementia or handle other urgent family matters. If carers have used up their annual leave entitlement, they may need to apply for unpaid leave after discussion with their employer. Some enterprises in Hong Kong offer paid personal, caretaking and/or compassionate leave to their employees. There are no statistics about the prevalence of such leave arrangements and their coverage.

v. Credited social contributions

There is no social insurance in Hong Kong. Hong Kong people rely on public services and voluntary purchase of health insurance products offered by private companies for medical expenses. In recent years, the Government has provided incentives to encourage voluntary purchase of health insurance products. For more details, please refer to "Part 2: II. Health System Financing". Nevertheless, no benefits/discounts are specifically offered to people with dementia.

vi. Tax allowances

Salaries Tax and various types of allowance and deductions are discussed here. Again, there are no dementia-specific tax reduction measures in Hong Kong. People with dementia and their carers benefit from these measures, but they do not enjoy extra benefits.

People with dementia who are employed and whose income is taxable can claim the Personal Disability Allowance if they are eligible for the Disability Allowance under the Social Security Allowance Scheme (Government of the Hong Kong Special Administrative Region, 2020, February).

Carers or family members of people with dementia can claim Dependent Parent and Dependent Grandparent Allowances if their dependent parent and/or grandparent is over 55 or eligible for Disability Allowance (Government of the Hong Kong Special Administrative Region, 2020, February). If the dependent is younger than 55 and is eligible for Disability Allowance, for instance, with very early onset dementia, carers can claim Disabled

Dependant Allowance (Government of the Hong Kong Special Administrative Region, 2020, February). Carers of people with dementia living in residential care homes can apply for Deduction for Elderly Residential Care Expenses if they pay for the care home expenses (Government of the Hong Kong Special Administrative Region, 2019, May-a). Table 32 summarises the amount of Tax Allowances and Deductions in relation to care of older people (Inland Revenue Department, 2020, April).

Table 32

Tax Allowances and Deductions in relation to elderly care in 2020/21 and onwards

Allowances	**Amount (HK$)**
Basic Allowance	132,000
Dependent Parent and Dependent Grandparent Allowance (For each dependant) :	
i) Parent / grandparent aged 60 or above or is eligible to claim an allowance under the Government's Disability Allowance Scheme	50,000
ii) Parent / grandparent aged 55 or above but below 60	25,000
Personal Disability Allowance	75,000
Disabled Dependant Allowance (For each dependant)	75,000
Deductions – Maximum Limits	
Elderly Residential Care Expenses	100,000

(Government of the Hong Kong Special Administrative Region, 2020, February; Inland Revenue Department, 2020, April)

vii. Duty rebates

Not applicable as there is no valued-added tax or other type of consumption tax in Hong Kong.

viii. Discount transportation fares

In Hong Kong, most people with dementia benefit from the Government Public Transport Fare Concession Scheme for the Elderly and Eligible Persons with Disabilities. Under this scheme, 1) adults aged 65 or above, 2) Comprehensive Social Security Assistance Scheme recipients under 65 with 100% disabilities, and 3) Disability Allowance recipients under 65 can travel on designated public transport such as train, bus and minibus at a concessionary fare HK$2 per trip (Labour and Welfare Bureau, 2020, March 31).

ix. Free companion fares

No free or discounted companion fares are available in Hong Kong. Carers have to pay the standard fare when they accompany someone with dementia on public transport.

x. Others

Not applicable.

Part 10. Dementia research

a. Is there a published government policy, statement or document detailing the government's plan or programme for dementia research? If yes, is it national or sub-national, and when was it published? (GDO 17x1)

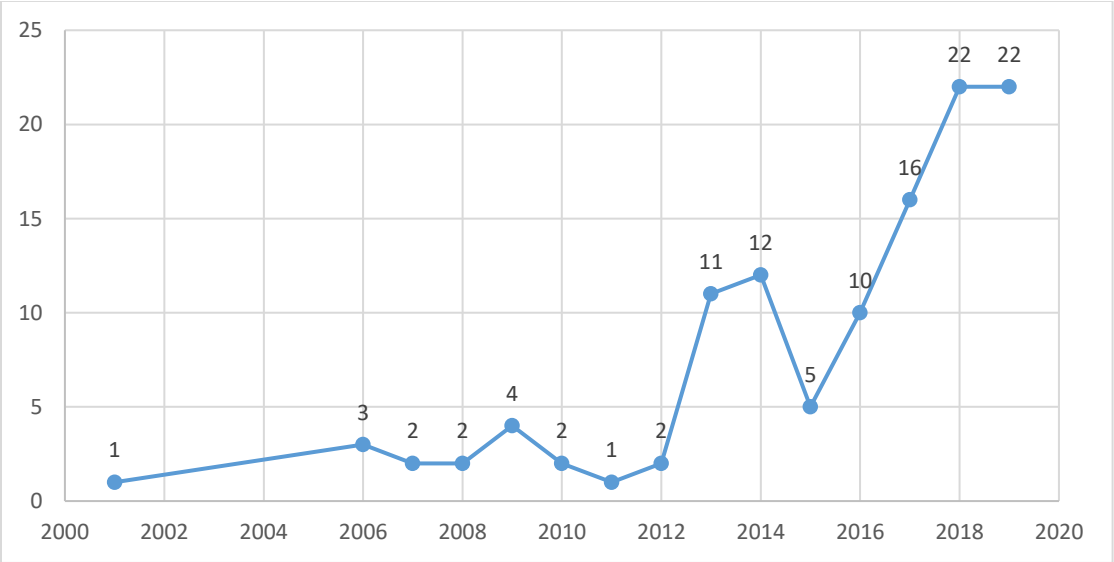
No. The most relevant document was the Mental Health Review Report published by the Food and Health Bureau (2017b)Food and Health Bureau (2017a) in 2017 which made recommendations for mental health policy. In one of the main chapters about dementia, the report highlighted the need to invest in research to assess the effectiveness of prevention programmes, strategies for dementia care, interventions and knowledge transfer. The need for regular territory-wide prevalence studies of dementia to inform service planning was emphasized and listed as one of the ten recommendations for dementia. However, there is still no detailed government plan or programme for dementia-specific research.

b. Has your government been allocating money specifically for dementia research in the last fiscal year? If so, how much was allocated to basic, clinical/translational and implementation, social and economic research? (GDO 18x2)

No governmental funding is allocated specifically for dementia research in Hong Kong. However, the Government has funded dementia research through various schemes to support researchers in different disciplines. The TIP-CARD research team conducted a quick online scan to search for research projects related to dementia funded by the government to date. We looked into the funding records of the major governmental funding bodies with the following inclusion criteria: dementia, Alzheimer's disease and/or mild cognitive impairment in the project title. Up to the end of 2019, a total amount of HKD 201,105,938 had been offered to 163 research projects in relation to dementia, Alzheimer's disease and/or mild cognitive impairment through 20 different schemes under four governmental funding bodies (Table 33). The number of dementia projects funded annually shows an overall increase from one project in 2001 to 23 projects in 2019 (Figure 26).

Figure 26

Number of projects funded by RGC, PICO and ITF in Hong Kong during 2001 – 2019



Remarks: The funding award year of some projects was unidentified during data extraction. These projects are not included in this figure.

Table 33

Government funded projects in relation to dementia, Alzheimer's disease and/or MCI in Hong Kong at year end 2019

Funding Body	Funding Scheme	No of Projects	Amount of funding (HKD)
Research Grants Council	General Research Fund	43	36,498,917
	Early Career Scheme	4	3,009,833
	Collaborative Research Fund	3	19,001,351
	Research Impact Fund	1	3,006,710
	Strategic Public Policy Research	1	4,992,639
Food and Health Bureau	HMRF - Advanced Medical Research	14	14,840,048
	HMRF - Health and Health Services (former HHSRF)	20	14,016,496
	HMRF - Health Promotion	3	1,504,177
	Health Promotion (former HCPF- Health Promotion)	8	1,776,240
	HCPS - Research (former HCPF - Research)	1	80,000
	Health Services Research Fund (HSRF)	1	56,100
	Seed Funding Scheme (former HCPF - Seed Funding Scheme)	1	498,000
Policy Innovation and Co-ordination Office	Public Policy Research	1	332,427
Innovation and Technology Fund	Postdoctoral Hub	10	7,849,000
	Midstream Research Programme for Universities	11	52,320,000
	Innovation and Technology Support Programme	10	23,792,000
	Researcher Programme	26	8,054,000
	University-Industry Collaboration Programme	3	5,225,000
	General Support Programme	1	1,559,000
	Guangdong-Hong Kong Technology Cooperation Funding Scheme	1	2,694,000
Total		**163**	**201,105,938**

The number of funded projects and funding amounts in relation to dementia are categorised by their field of study in Table 34. Two-thirds of the funded projects were in biology and medicine, accounting for 77.4% of the total funding, indicating that basic sciences and medicine continue to be the dominant subject areas for funding allocation. While nearly one-third of the funded projects were in humanities and social sciences, only 16.6% of funds were offered to these projects. Twenty of the 46 funded projects in humanities in social sciences focused on caregivers or both caregivers and people living with dementia, while the project title of only one study in biology and medicine mentioned caregivers. It is also observed that these projects seldom addressed the economic aspect of dementia.

Table 34
Number of funded projects and amount of funding by field of study in Hong Kong

Field of study	Number of Projects (% of total)	Amount of funding (HKD) (% of total)
Biology and Medicine	108 (66.3%)	155,734,959 (77.4%)
Humanities and Social Sciences	46 (28.2%)	33,420,558 (16.6%)
Engineering	9 (5.5%)	11,950,421 (5.9%)
Total	**163**	**201,105,938**

c. Are people with dementia involved in the research development process? (GDO 19x1)

Research development in Hong Kong is mainly directed by the government, funders, care professionals and research professionals. There is no information showing that people with dementia are involved in the dementia research development process.

d. Are there any other sources of funding for dementia research in Hong Kong (even if these are from other countries?)

Besides government funding, a few philanthropic organisations routinely fund dementia research in Hong Kong: The Elderly Fund under the Simon KY Lee Foundation, the Hong Kong Jockey Club Charities Trust, Lee Hysan Foundation, and the Charles K. Kao Foundation.

e. Are there any capacity building initiatives for dementia research? For example: fellowships/scholarships or networks for building early career researchers in dementia?

The HKU COA JMK Dementia Care Scholarships have supported younger researchers interested in dementia since 2013 (Sau Po Centre on Ageing, 2022). The establishment of the scholarships scheme is to support dementia research conducted by postgraduate research students in the Faculty of Social Sciences of The University of Hong Kong. Recipients receive HK$10,000 to support their studies.

Therese Pei Fong Chow Research Centre for Prevention of Dementia of the Chinese University of Hong Kong is a dementia-specific research centre that aims to delay the impact of dementia on the ageing society through innovations, educations, and promotion of prevention and intervention of dementia (Therese Pei Fong Chow Research Centre for Prevention of Dementia, 2022). The centre has been organising seminars that gathered researchers interested in dementia and enabled academic collaborations.

f. Have there been any scoping reviews of dementia research in your country in order to identify research gaps? If so, please highlight the key findings.

No published scoping review of dementia research has been undertaken in Hong Kong up to the present time. However, the TIP-CARD research team conducted a scoping review of the non-medical literature by systematically searching "Hong Kong" and "dementia/Alzheimer's Disease/cognitive impairment" in three databases: Medline, PsycInfo and PubMed, with no restriction on the year of publication. Initially, 1656 non-duplicated articles were identified, published between 1991 and June 2019. After two independent researchers in the team reviewed the article abstracts, 285 empirical studies were included in this review, categorized into the following eight themes:

1. **Interventions for people living with dementia or cognitive impairment: 68 studies**
   - More than half of the intervention studies aimed to improve participants' cognitive functioning and memory. Ten studies focused on behavioural and psychological symptoms of dementia (mainly agitation).
   - Improvement in IADL, falling, mood, social interaction, pain management, diabetic control, sleep quality, psychomotor speed has also gained some attention.
   - The influence of Chinese culture has been widely observed in the application of interventions: nine Tai-Chi, seven acupuncture, four mahjong, three calligraphy, two Chinese Chan, and one Six Arts intervention studies. The effectiveness of music-with-movement intervention, Cognitive Stimulation Therapy, and various cognitive training interventions have also been examined.
2. **Instruments for screening/assessing patient and caregiver: 56 studies**
   - Nine studies developed instruments to measure caregivers' burden, management strategy, expressed emotion, grief, and positive aspects of caregiving.
   - 47 studies are validating instruments for older adults with cognitive impairment. Most of these are screening tools for dementia/cognitive impairment, and assessment for memory and cognitive decline. A few examine behavioural and psychological symptoms of dementia , awareness of memory deficits, dementia psychosocial care quality, executive function and testing new means of assessment.
3. **Caregiver status and caregiving experience: 49 studies**
   - Thirty quantitative studies and 19 qualitative studies, including 14 intervention studies have focused on improving caregiver outcomes.
   - A wide range of topics are observed, including: caregiver well-being, caregiver burden, education and training, coping and management strategy, attitudes towards people with dementia and decision-making, social support, abuse, positive meaning finding, self-efficacy, gratitude, anticipatory grief, expressed emotion and life satisfaction.
4. **Health and functional performance: 48 studies**
   - These 48 studies describe: 1) the clinical profile of the population with neuropsychiatric symptoms, 2) physical status such as eye movement, oral health, hearing impairment, late-life body mass index; 3) activity status like physical activities, sedentary behaviour, getting lost; 4) psychosocial status including emotional reactions, loneliness, subjective complaints, 5) capacity to make decisions on treatment, financial issues; and 6) care needs and service use.
5. **Associated factors for cognitive health: 37 studies**
   - Four groups of factors for cognitive health have been examined in the Hong Kong population: 1) physiological factors: frailty, widened pulse pressure, poor balance, diabetes; 2) neurocognitive

and psychosocial factors: semantic fluency, neuropsychiatric symptoms, depression, distress, self-esteem, anxiety, quality of life; 3) demographic factors: education, gender, subjective social status; and 4) lifestyle: nutrition, diet, spiritual activity, physical exercise, leisure activity.

6. **Service providers' attitudes and capacity: 12 studies**
    - There are studies examining service providers' knowledge, attitudes towards disease and people with dementia, and how they practice and manage care services.
    - The job and life satisfaction of paid carers have also been discussed.
    - Physicians, nurses, nursing assistants and other healthcare workers in both the healthcare and long-term care systems have been mentioned.
    - Two educational interventions for service providers have been evaluated.
7. **Prevalence of dementia: eight studies**
    - Five studies report estimates on the prevalence of dementia in Hong Kong.
    - Regarding different types or stages of dementia, one study reported on the prevalence of very mild and mild dementia, one on cognitive impairment and one on dementia with Lewy Bodies.
8. **Awareness and attitudes towards dementia: seven studies**
    - Seven studies described and investigated the attitudes, awareness and experience of dementia and care of the person with dementia, and public attitudes and awareness.

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