THE HOSPITAL PATIENT SERVICE IN TRANSITION: A STUDY OF THE DEVELOPMENT OF TOTALITY OF CARE

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by

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Abstract

The hospital patient service in transition: A study of the development of totality of care

A concept of "total patient care" was developed in Hong Kong to enhance public hospital services. The development of this concept aimed to resolve two major concerns about patient care delivery. First, for historical reasons, there were differences among public hospitals in their emphases on the scientific medicine and social aspects of caring. Secondly, the health care system was under pressure to change due to rising expectations, in particular to an increasing number of patients requiring complex care in the community.

The purposes of this study were (1) to investigate the historical influence on the development of patient services and (2) to examine the determinants affecting the development of new initiatives. The path-finding process to shift care practice from a traditional institutional orientation to a person-centred approach was studied through a focal point of study in all 38 public hospitals, serving a population of 6.3 millions. An analysis of the "successful" examples of the implementation of the concept of total patient care was initially conducted. The subsequent development of a variety of hospital patient care models was traced back to the different origins of patient care orientations through collecting views of hospital stakeholders and the support provided for patients outside the hospitals. A pluralistic approach, which involved site visits, interviews, focus group discussion and survey, was chosen to understand the complexity of historical influence and contemporary determinants in the development of the totality of patient care. A "mapping" method was adopted to analyse the data reflected different levels of concerns.

The findings in this study indicated that, technological and financial factors often identified as the more important determinants in development of health care system, might have ignored the historical development of the hospitals and health traditions in the community in the development of totality of patient care. This study suggested that influences of these informal factors, as experienced in a Chinese community, would likely to continue and diffuse the goal of a planned policy. Formalisation of the informal and community involvement in formal hospital settings, through a concept of total patient care, had resulted in the consolidation of some diversified experience in the support of a diversified range of patient needs. The strengthening of a hospital-community linkage was highlighted as a possible solution to bring a full transformation of patient care into a model of totality.

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This study comprises eight chapters. Chapter 1 is an introduction, which provides backgrounds and health traditions of a complex health care system of this study. Chapter 2 consists of literature review related to orientations and influences leading to the formulation of different health care systems. Chapter 3 describes major events in the development of hospital patient care between the government and the community sectors since 1960s, a time when the local health care system expanded. Chapter 4 discusses the study methodology and pluralistic data collection process, which were selected to understand a complex policy- practice issues in the changes of patient care approach and its influences from various sources. Thirty-eight public hospitals were investigated through a focal point of study; the establishments of new patient care structures (known locally as Patient Resource Centres). Chapter 5 describes successes in the implementation of a total patient care approach, illustrated by the new development of patient care models in hospitals. The expected model of care, as it branched into various formats, was studied. The variation in such development was traced to the possible sources of influences, in particular to the historical differences in health care orientations between the government hospitals and the community hospitals. It was noted that historical factors seemed to be more influential than financial ones on the content of patient care. Chapter 6 reports the views of stakeholders from user level to policy decision level. There were different expectations on the content, extent and location of patient care to be provided by hospitals. Some unresolved issues due to historical and cultural issues were reflected. Chapter 7 summarises survey findings on community support for different patient groups requiring continuity of care outside the hospitals. There were similarity and difference in the priority of serving some specific patient groups selected by hospital and the community. The hospitals, however, specialised in its medical-oriented strategies, continued to develop care for some selected groups. The community supported the age-related or life-stage groups with more specific strategies. There were differences between patient groups in the delivery of patient care due to community factors. Chapter 8 analyses the findings from Chapters 5 to 7. The historical and community factors on pattern of development of public hospitals, from the findings, were more influential than the financial factors commonly regarded as essential for bringing health care changes. Three major policy and practice issues related to the study were discussed. First, the concept of providing totality of care could not resolve current differences fully. Such a concept, as experienced in a diversified health care system, has resulted in a partial transition of patient care. Second, the historical involvement of the community sector in the development of public hospitals has its roots in providing patient care inside a hospital and is likely to continue and responsibility for the diversified approaches in hospital patient care. Third, the potential of the community involvement has its significance to be further developed through guidelines and policy which encourage standardised format of care with joint efforts from different sectors to materialise a new model of total patient care.

Chapter 1 Introduction

This chapter provides an overview of the healthcare system in Hong Kong. The forces of change towards total care will be discussed in terms of the local health traditions and contexts of patient care. The research questions, with particular reference to the introduction of the new patient care initiatives in the 1990s will be included.

1.1 Background

Hong Kong is a city with a highly homogenous cultural background. Ninety-five percent of the total population (6.3 millions at the time of the study) are of Chinese descent (Hong Kong, 1997). It has a history of adopting western medicine, introduced by the British administration over the last 150 years. The western health system has co-existed with traditional Chinese medicine, which has been available as an alternative method of healing and disease prevention. For historical reasons, different orientations towards health and patient care have operated independently (Chao, 1993).

Patients in Hong Kong have enjoyed "a choice of access" to different health care systems - including western, traditional medicine provided by both the private and public sectors for many years (Yuen, 1990). The British administration developed a health care service based on the western model and currently the public hospital services account for 90% of in-patient care. The private sector provides the remaining 10% of western hospital beds. Government clinics located in three geographic areas, namely, Hong Kong Islands, Kowloon and the New Territories provide the majority of non-hospitalised outpatient services. An estimation of 50 - 63% of the population uses Traditional Chinese Medicine (TCM) regularly or on occasional basis (Leong, 1996).

1.2 Public services for patients

The administration of patient care through government clinics and hospitals (by the Medical and Health Department) was reorganised in 1990. The Department of Health (DH) was to become responsible for general medical consultations through its health clinics. A newly established semi-government structure known as the Hospital Authority (HA) was responsible for public hospitals which provide in-patient services and specialist medical outpatient consultations. Out-patient services in the public hospitals mostly serve those who have already seen another doctor and have been referred for specialist consultation, or ex-patients previously discharged from hospitals. The general and specialist consultations provided by the government account for about one-fifth of outpatient services. The private sector provides a low percentage of hospital care. However, it serves over 80% of outpatient consultations, through private hospital outpatient department or general practitioners' clinics. (Fig. 1.1)

Figure 1.1 Public and private patient care in Hong Kong

In-patients care	Western Medicine	Chinese Medicine
Public hospitals	90%	0
Private hospitals	10%	0

Out-patients care	Western Medicine	Chinese Medicine
Public sector	20%	0
Private sector	80%	100%

1.3 Health care practitioners in Hong Kong

The Hospital Authority has its jurisdiction under the Hospital Authority Ordinance (1992) (please also refer to section 3.5 in Chapter 3) to manage and control the delivery of the public hospital service in Hong Kong. In 1993, the public health care system under the HA consisted of 38 hospitals and four other facilities. Employees in public hospitals comprise of health professionals, i.e., 2,500 doctors (6.6%); 16,500 nurses (44%); 2,900 allied health staff (7.7%) and 16,000 administrative or supportive staff (42%) (Hospital Authority, 1993, p.3).

1.4 Utilisation of the public health care system

In 1993, in-patient services in public hospitals were 97% subsidised by the government. The cost of a hospital bed was about HK$2000 per day. The total number of patients admitted into hospital for treatment in 1993 was 761,540. An average of 10 days in each hospital admission was recorded (Hospital Authority, 1993). In the same year, government clinics provided 3 million general and specialist outpatient medical consultations. In addition, there were 1.5 million medical consultations provided through 24-hour Accident and Emergency Departments. These emergency services were free of charge. Statistically speaking, 1 in 2 people attended the government outpatient services. One in four used the emergency services and half of these patients (1 in 8) were admitted. The population had an average of stay of 1.2 days per year.

1.5 Policy to ensure public access in health care

The underlying principle of health policy in Hong Kong is to ensure that no one will be denied healthcare access due to financial problems (Towards better health, 1993). As with most developed countries, which adopt high technology in medicine, annual public expenditure on health care in Hong Kong increased throughout the last two decades. The figure for overall health expenditure in

1993 was HKD $14,500 millions (Towards better health, 1993, p.2), 90% of which went on hospital expenses (around HKD $12,000 million). The non-hospital services accounted for only about 10% of the annual budget (Hong Kong Hospital Authority, 1994, p.178).

1.6 Underlying forces for changes in patient service delivery

There were two issues related to changes required in the patient service delivery system. Historically, when the British introduced the western medicine system, traditional Chinese medicine was largely ignored. However, the use of traditional medicine was commonly practised in the community and the government has adopted a policy of "conditional tolerance" of its existence in society (Ma, 1997). There was no ordinance to govern traditional medical practice in the community. The local community established community hospital, for example, the Tung Wah Group of Hospitals (TWGHs) to develop own mandate in the provision and development of the traditional Chinese herbal medicine. As these services were not regarded as part of the mainstream public hospital services, such provision was continuously supported through community funding and was regarded as a charitable patient service. There has also been a wide range of the traditional medicine services including acupuncture and bone- setting services available in the community. Patients go to herbalist shops distributed throughout the city. The choice of using public or private, western-oriented or Traditional Chinese Medicine lies in the hands of a patient, often involving personal and financial preferences. There was no direct communication between the different sectors. Secondly, public hospitals are often criticised as busy and overcrowded places in Hong Kong (McKay, 1993, p.82) with long waiting time. The utilisation of hospital services, influenced by geographical factors, varied from 43% to full hospital occupancy (Ming Pao, East Coast version, 1998). The transfer of patients between hospitals has always been a problem because of difficulty in administrative procedures, different hospital charges and patient preferences in hospital environment. The

government recognised that a new standard of patient care, which improved service efficiency due to compartmentalisation, would be required. Such thoughts were addressed in various documents including *The further development of medical and health services in Hong Kong* (1974), *The delivery of medical services in Hong Kong* (1982), *Towards better health* (1993) and the *Hong Kong Hospital Authority Annual Report* (1994).

1.7 Total patient care approach in Hong Kong

Hong Kong has built a substantial number of large public hospitals since the 1960s. A new patient care approach, intended to promote continuity of care by changing the compartmentalised health care provision through a seamless collaboration between providers, was appealing to service providers and hospital users. This total patient care approach, emphasised in meeting different needs of individual patients with the collaboration of the community at large, was a vision of the Hospital Authority. The Hospital Authority, a management body established in 1990, has adopted a corporate strategy to invite patient, staff and the community to participate in the development of a new health care system that can "maximise health care benefits and meet community expectations". (*Corporate Vision of Hong Kong Hospital Authority, Hong Kong Hospital Authority Annual Report, 1994, p.6*). The intention to remove existing barriers and differences among sectors was trailed in the early 90s through a number of new patient care initiatives. These initiatives included the development of new management culture and skills, outreach services and assessment teams. Among these initiatives, the newly established patient service structures by hospitals (collectively known as the Patient Resource Centre) had brought more debatable discussion. There were different forms of patient care derived after the pioneer model had built. Controversial questions about the development of different models were (a) whether there was any "best model" to suit all hospitals and (b) if these varied forms of development, reflected any background influences on the system that had not been

considered? No one seemed to have any answer to these questions. A detailed description of these different structures will be provided in Chapter 5.

1.8 A study of the development of totality of care

In 1993, all public hospitals had assumed the role of providing "total care" for patients whose needs are complicated. A new patient-centred approach began to develop and there was no standardised format taken into consideration as each hospital would have to define its own model.

The public hospitals, varying in size and in their philosophy of care, had both internal issues and global pressures to address. In many cases, resource issues, such as an increase in the number of staff employed or additional funding were thought to be the only way to bring about new changes. However, some new patient care initiatives were not given any additional funding from the central management office.

This study began as an attempt to understand the development of health care by capturing the crucial moment of change without additional financial resources from the HA. The importance of such development, without direct financial incentive from the central management office, implied that these hospitals had to find a practical way to implement service improvement and integration.

1.9 Terminology

(a) **Public hospital** refers to the thirty-eight government-funded hospitals at the time of this study.

(b) **Patients** refer to in-patients, out-patients or ex-patients

(c) **Patient service or care** interchangeably used to refer to both medical and non-medical support provided for patients and their families.

(d) **Basic care** refers to technical level of medical care that achieves a standard generally considered to be adequate.

(e) **Quality care** refers to care beyond basic level that emphasises genuine quality provided through positive human interaction, system co-ordination and technical improvement (Joss and Kogan, 1994). A person-centred care includes "concern, empathy, honesty, tact and sensitivity." (Blumenthal, 1995, 1996; Palmer, 1991; Donabedian, 1988)

(f) **Total care or holistic health** interchangeably used to refer to physical, psychological or mental, social, spiritual and emotional aspects of the person. (WHO; 1980; Williams and Knight, 1996).

(g) **Development of totality of patient care** in this study refers to a process of developing "Total Hospital Service Product" through community participation (Hong Kong Hospital Authority, 1994/95). Although some literature refers to total care as institutional care, this study focuses on hospital-community collaboration to serve patients regardless of whether a person is an in-patient, an outpatient or an ex-patient.

(h) **Patient care initiatives** in this study often refer to the newly established Patient Resource Centres in Hong Kong or other initiatives such as hospital out-reach services.

(i) **Hospital-community interfaces**

The interface specifically defined in this study refers to interactions between hospital and its community through partnership in the development of patient care.

(j) **Transition** is used interchangeably with the word "change". A change perspective, to examine the different forces operating on the developing process and their resolution, is adopted in this study.

1.10 The scope of the study

The Hong Kong health care system is highly complex. Although public hospitals are not the only places where healing and treatment occur, they are the

largest core facilities where lives are saved. This study focuses on 38 public hospitals and their in-patient and specialist out-patient services. The general clinics in the Department of Health and the 10% in-patient services provided by the private hospitals are not covered.

1.11 Rationales of the study

There were two rationales to support this study. Demographic change has resulted in an increased number of public hospitals built since the 1960s. The "free access" policy, and the improvements in public hospital image and services, would add to service demands on public hospitals (HKHA Annual Report, 1996). Under a cost-contained atmosphere and no substantial increases to be allocated to individual hospitals, internal pressures on hospitals and practitioners could be expected. In a situation where pressure to change is expected, a policy to develop totality of care and better services for the users might not be carried out whole-heartily.

There was a number of local studies, which attempted to resolve system issues by focusing on the financing and economic aspects of the care delivery system (Yuen, 1991; Hay, 1992). This study took on a different approach to examine the care delivery system, i.e., the latent potential of the health care system when less financial resource could be available. The understanding of background influences on individual hospitals, the choice of different strategies adopted to bring new change in the health care system, could have implications for the further development of the health care system.

The second rationale was based on the fact that hospitals are formal and technical institutions, quite distinct from other social institutions in society. The effort to improve current services that was compartmentalised in practice was not supported by local material due to a lack of empirical study on the interface between hospitals and community sectors in Hong Kong. This could be a disadvantage to the development of a care continuum. The intention of this

study, by re-examining new and old forces, interacting to resolve into new solutions, was to search for knowledge that will be valuable in policy-making when a balance of interests was needed within a particular socio-cultural context. Implications from the study would be made on this basis.

Hong Kong offered a unique experimental site because of the wide variety of factors. It provided a "natural" environment to study on different forces in health care systems in early 1990s when initiatives were started simultaneously by different hospitals.

1.12 Research questions

This study concerns the different patterns of care that have emerged in Hong Kong. The first research question inquires into the historical and background influences that have resulted in these different patterns. The variations in hospital responses to one single patient care policy lead to the second research question which concerns the consistency of these differences with the policy. The third question is based on the first two research questions, and is in fact a policy question aiming to discuss on implications on policy action and choices.

The three core questions for this study are:

(1) Why were there differences in the provision of patient service in hospitals? Where did these differences originate?

(2) Were these differences consistent or inconsistent with the planned policy to implement total or high quality care? In what way?

(3) Should these differences of potential be maintained in the new system or could they be combined into a standardised format?

The specific research objectives will be discussed in Chapter 4 (section 4.1).

1.13 Study outcome

At the end of this study, descriptive analysis of the historical influences and other factors that accounted for the diversity of patient care development will be discussed (Chapter 5). The views of hospital stakeholders, including the users, practitioners, administrators and policy planners on the new changes will be depicted (Chapter 6). Findings from the hospital representatives on their perception towards community resource to be incorporated into the total care system will be analysed (Chapter 7). These findings will be compiled and discussed in Chapter 8 to provide some conclusive remarks on the total caring of patients with specific needs.

1.14 Significance of the study

In the light of major global trends, an increasingly ageing population and more patients surviving serious illness, there is evidently a need for hospitals to review their role in patient care. The existing solutions are predominantly medicine focused, rely heavily on scientific research, and on technological advances in new drugs, surgical procedures and genetic techniques (Lam S, 1996). The length of a patient's stay (LOS) in hospital is generally being shortened. Admission of patients into the hospital through a "revolving door" indicating some unresolved patient problems was recognised (Lam, 1996). In such a context, there are clear advantages in involving a large sector of the community to collaborate in the development of patient support. This community-based perspective, having an emphasis on continuity of support, has been examined in the literature (Davies et al, 1990; Rothman, 1993). However, there was no empirical study about the change of patient care delivery within a Chinese community, this study is expected to adapt earlier work and apply it to the local context in order to build new knowledge that will improve patient service development in Hong Kong.

1.15 Assumptions

This study assumes that variations within a health care system are not random phenomena. As will be seen later, the total patient care policy led to many diverse models, in spite of the parallel attempts to induce new standards on a common basis, was under the influences of many different forces. The diverse health care system in Hong Kong, although unique in its mix of different health care characteristics, is part of a global health system that is going through a transition--a search for pathway to improved system efficiency, quality and comprehensiveness.

Conclusion

This chapter has displayed the multiple health care orientations and structures in Hong Kong, against which the introduction of total patient care can be assessed. The research questions will be pursued in the following chapter.

Chapter 2 Literature Review

This research is grounded on previous studies related to the influences on the development of different health care systems: the impact of medical technology and changes in health concepts; traditional medicine and patient involvement in treatment and hospital movements towards a patient-centred paradigm. Studies from Roemer (1991), Evan and Stoddart (1990) and Wolinsky (1988) were chosen to highlight the historical, contemporary and individual factors acting on a dynamic health care environment. The key arguments generated from the literature in the transition of patient care are provided in this chapter.

2.1 Scientific medicine and medical advances in patient care

Differences in the provision of health care over time can be analysed against changes in the scientific bases of medicine. The advancements in medicine have improved life expectancy and have ensured the survival of an increasing number of patients suffering from previously known as "incurable" diseases (McKay, 1993). Inevitably, a time lag occurs between the moment when the mechanism of a disease is formally understood and the development of a scientific measure to cure. A common result of this gap is that certain groups of patients have improved life expectancy but are still waiting for other advances in drugs and technology in order to achieve complete recovery.

The limitations of biomedicine and the state of patients having to due with a chronic illness on one's own has been discussed in the literature (Chan, 1992; Morgan, Calnan and Manning, 1991). It has been pointed out that unequal attention is given to the "success" and the "incomplete" treatment conditions. Patients benefiting from medical successes are often well attended, while "incomplete" or "unsuccessful" medical treatment conditions are normally left out of the medical system, to be handled by patients, families or the community.

A biochemical medical model involves a medical professional who makes a diagnosis and prescribes a drug to address disease(s) and related symptoms. The specialisation of western medicine, supported by sophisticated tests and microscopic analyses, has its strength of focusing on complicated disease problems in isolation. (Starling, 1993). A patient can be seen as a person with different organs or systems, each having a specialist who can address the part in details. The overall impact on a person is often not attended. The family medicine which developed from a "continuous comprehensive holistic care" perspective (McWhinney, 1989, 1997), does not consider personal discomfort due to different treatment processes that a patient thinks he has but not proved scientifically. A notion of person-centred care, compared to the conventional symptom-focused concept of care, expects more than the "dealing with disease" but an extension to its "dis-ease" to the person (Arnold, Granshaw & Jones, 1997; Lam, 1997).

Disease ----------> A person with illness and Dis-ease

The conventional "disease" paradigm that focuses on sickness and whose solution is professional intervention may have undermined the role of the patient in the holistic spectrum of illness and health. The new "dis-ease" perspective has a wider span, and includes maintenance of a state of well-being that can prevent illness. An integration of care to include the different dimensions of a patient's life has emerged within the last few decades. This global shift of paradigm from laboratory and professional solutions, to attention on the actual daily impacts on a patient within his or her own social context, has been discussed in many recent studies (Lathrop, 1995; World Health Organisation, 1990; World Vision, 1993).

2.2 Complexity and holism in patient care orientation

Traditional medicine has preceded the dominance of modern scientific medicine and developed with its influence from ancient simple materialism The human body is interpreted not only as a system of organs interacting with each other. It is also an entity closely connected with the outside environment, i.e., the natural world and its conditions. (Easthope, 1986). Illness is thus seen as a response to the changes in the natural world as well as other individual emotions. The commonly used Traditional Chinese Medicine (TCM) in Hong Kong, can be traced back to a history of over 3000 years (Roemer, 1991, p.578).

A TCM practitioner analyses illness ("Bian" meaning to differentiate) and identifies symptoms or signs ("Zheng" meaning to diagnose). A diagnosis is made through discussion with the patient ("Lun" meaning to discuss with patient). A prescription is made based on an analysis of the combination of symptoms, the nature of the problem as well as the body resistance to the pathological agents. A TCM practitioner will select treatment according to the stages of problem and personal factors of the patients through a discussion process ("Zhi" meaning to prescribe). This treatment approach sometimes resulted into differential interventions for one similar disease. Conversely, different illnesses may receive the same treatment if there are some common primary causes. For example, both rectum and uterine prolapse are considered to have common problem source in the spleen. Therefore, same intervention to improve the condition of the spleen will be provided. These TCM concepts have become better understood in the later 50 years since they began to be translated into other languages after 1949. (The English-Chinese Encyclopaedia of Practical Traditional Chinese Medicine, pp. 1-4)

2.3 Development of totality of care

2.3.1 Conceptual level

It follows from these different scientific and traditional medical assumptions that there are different perspectives on how health care systems should respond to changes of expectations from society. The rapid development of medical and rehabilitation technology, stimulated by an increasing demands from a large population of injured persons in the two World Wars, had made the case for patient care to extend from physical aspects to include psychological and social support (The Science Museum Document, 1992; World Health Organisation, 1946). The definition of care for those having health problems was further expanded to totality by embracing personal satisfaction, i.e., the emotional and spiritual dimensions in the 1990s (Williams and Knight, 1995).

Figure 2.1 Changing concepts of health

Before 1950s	Health = No disease or injury
From 1950s	Health = physical + psychological + social well-being
In the 1990s	Health = physical + psychological + social + spiritual + emotional well-being

2.3.2 Implementation level

The process of implementing such a concept of totality was recent as compared to other movements in improving physical survivals. It is the researcher's view that both scientific and traditional medical approaches have shared a common intention to provide the best support to a patient. In the traditional medicine, the patient was the centre of treatment. A total or holistic concept of health in the context of western medicine, implied an extension of patient care from technical support to personal aspects needs to be introduced.

2.4 Movement towards a patient-centred paradigm

An online computer search, conducted at the beginning of this study, revealed a trend of increased interest in issues to improve quality of services for patient through changes in the health care environment. The 600 articles searched in *Medline* showed a trend of an accelerated proportion of studies focusing on achieving a higher standard of care. (Figure 2.2)

Figure 2.2 Medline search: articles on changing patient care

Year	No. of articles (a)	Quality in care (b)	% (b/a)
1966-75	16	1	6.25%
1976-85	97	7	7.2%
1986-95	522	80	15.3%
Total	635	88	Average = 14%

2.5 The structures of formal health care and informal social support

The major difficulty to implement a total care concept, described in the literature (Brown 1961, 1991), was the tradition of classifying physical and social aspects as separate needs in the development of patient care in the last few decades. The physical scientists developed medical technology and pharmacology to improve physical conditions related to different diseases. The roles of professional interventions in saving lives, relieving pain and improving the health conditions of individuals are well defined. The non-health care sector provided support to those who required day to day assistance. Most communities have developed traditions to support groups of vulnerable individuals. Rothman (1994) specified the very young, very old, mentally handicapped, and severely physically disabled persons as the four major social groups commonly required community support.

The roles of the formal health care structures and of informal patient support were historically defined in different ways. A new patient-centred (Lathrope, 1997) and care-led approach (Leathard, 2000) was viewed by the researcher as having implications on the practice of a collaborative formal health care and informal community support for patients.

2.5.1 Hospitals as centres for patient care

Public hospitals, being the largest service structures, (covering 90% of health care services in the public sector in Hong Kong), were not originally designed to provide comprehensive support for patients. Resources were allocated to support technical-orientation of the medical structure. For the last two decades, there were many internal resource issues requiring the management to address (Packwood et al, 1991). More recently, it was pointed out that a system change which aimed to search for service excellence required not only internal efforts but also service co-ordination to ensure total service quality mechanism is in place (e.g. Joss and Kogan, 1995).

A patient-centred orientation re-focuses the different efforts in providing patient care. A total care strategy implied that previously compartmentalised patient care delivery would be transformed. Vetter (1996) predicted that many of the old institutions would not continue to exist. New integrative health care structures will be replaced old structures in the next decade.

The following sections trace the literature on the development of different health care structures. In this study, the context of health care and the change process are perceived as both dynamic and complicated, involving many factors across time and place. The literature review described below summarises the classical and contemporary perspectives relating to the formation and development of health care systems.

2.6 Models of health care delivery

2.6.1 National policies

Formal health care systems can be classified according to national policies into major global models. The different patterns of care, according to the earlier literature, (Roemer, 1966) is "a result of complex historical developments...influenced by the nature of disease, the technical developments of medical science and the social, economic and political environment" (p.2). Different national health care policies varied according to the degree of government intervention, constituted five major types of national health care system in the world.

The first type is a private-dominance health care system. An example of this is the United States health care system, which is based on a philosophy of individual choice. The government input of financial resources is the lowest. An individual pays into a medical insurance scheme for health protection.

The second type is a comprehensive health care coverage for the population. This is based on the welfare state model funded by compulsory social insurance. Many European countries, including the United Kingdom, have adopted it. The government assumes a responsibility to ensure free access to health care. Such welfare state concept evolved in response to a growing poverty in cities due to urbanisation and industrialisation.

The third type is a health care model that undergoes economic or social changes. There is an assumption that a transition occurs when resources improve. A transitional model is likely to move towards a modern medical system. Improved financial conditions allow resource allocation in health care development, particularly the purchase of technology and equipment.

Roemer described the fourth type as a developing country model. Developing countries often encounter economic constraints in terms of financial resources and thus the public generally adopt traditional or cultural medicine.

The fifth type is a socialist model, which provides medical coverage organised mostly through the work place or public intervention. The government has a centralised plan, whose main aim is usually to control the limited resources available. A community-based approach that involves fewer professionals is sometimes referred as an alternative method of providing public health protection through a smaller budget. Roemer's study quoted China as an example of this model.

Historical determinant as a source of influence

It was clear from Roemer's early study that historical development of a country could strongly affect the philosophy of patient care and the nation's choice of a health plan. In Roemer's more recent study (1991), the historical influence on

health care system was not seen as a unique source of influence. The degree of government intervention was viewed as largely influenced by economic factors and the amount of public funding available for a particular population. The development of health care plan was viewed differently over time. This earlier approach focused on the pragmatic purpose of health care services, closely relating public health to the productivity and labour capacity of a society (Roemer, 1968). The political influences were described as controlling factors on the use of public funding which resulted in the readiness of adopting a higher level of medical technology. Cultural factors had influences on the utilisation of scientific and traditional medicine in different societies (Roemer, 1968; 1977; 1988; 1991).

Roemer's studies as an illustration: Historical factor in organisational change

The existence of different forces on the health care system, as the researcher sees in Roemer's discussion on the development of national health policy and its relationship to the quality of patient care, was vertical and static in nature. The formation of a health care system was based on a top-level decision-making approach. The transitional state occurs when economic factors change, in particular, increased resources would improve availability of funds for purchase of costly technological equipment, more pharmaceutical research and sophisticated medical training.

Roemer's studies have been chosen for discussion in this study because they provide an overall explanation of why different national health care delivery systems have resulted. He pointed out that a health care system is not a purely medical paradigm. It functioned within a unique social context.

2.6.2 Interactive forces between health care sectors

As the last section outlined, the planning and development of health care systems are strongly affected by different background forces, in particular, the economic and historical factors which shape the formation of a national health care system. Changes to any fundamental or historical structure are difficult.

An interactive perspective by Evan and Stoddart (1990) explains variations from contextual factors within a changing environment. For instance, social and demographic factors interact to constitute a unique demand for health care. Physiology and the age distribution of the population determined health care needs and services required. Socio-demographic factors, including age, sex, marital status, and family size have impact on the service to be required in serving such a population. An infant requires care, which differs from that required by a retired person, who may have one or more types of chronic illnesses. Social factors such as, education level, occupation, ethnic background and personal lifestyle are tied closely to demands on health services.

Evan and Stoddart's study --an illustration

Evan and Stoddart's (1990) study suggested that a range of continuously interactive factors between planners, providers and users largely determine the health care context on day to day basis. They found, in contrast to Roemer's analysis of public intervention and top level decision-making process, personal factors and the health behaviour of individuals, including biological determinants are significant in delivery of health services and patient care. Their comprehensive health care framework is illustrated in Figure 2.4 below.

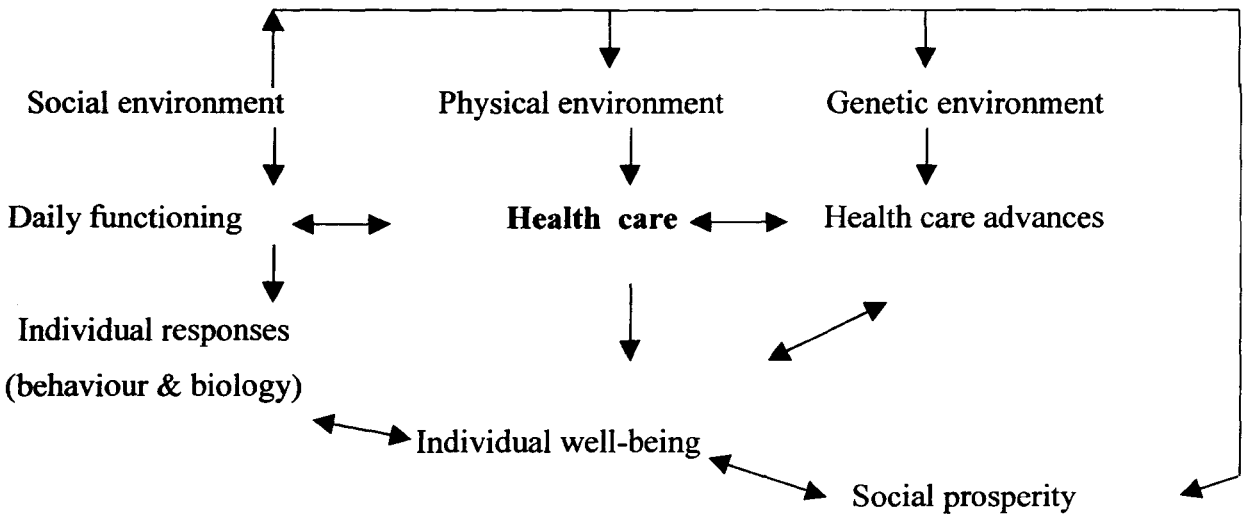


Figure 2.4 A Comprehensive health care framework

Adapted and modified from Evans and Stoddart Producing health, consuming health care. *Social science and medicine.* (1990) 31(12).pp.1347-1363

The limitations of a dynamic perspective

Evan and Stoddart's study (1990) pointed out a disease-focused approach in health care system has an intrinsic problem to separate an individual from its community environment. However, as an inclusive perspective that relates health care to most other social factors, Evan and Stoddart (1990) discussed the limitation as having difficulty to be studied empirically. As recognised by the authors, a health policy is now becoming a social policy.

Other literature was in support of the importance of developing a relevant health care framework. Their accounts of many other models were not exhausted in this study (Allred, Hoffman et. Al, 1994; Dale, Rae et. Al, 1995; Johnston, H. & Klandermans, B. 1995; Sherer, J, 1994).

2.7 A patient-oriented approach

A total care policy is patient-oriented. A patient-focused care is transformational in nature. Its ultimate goal is to create "healthier communities" through resolving compartmentalisation and discontents related to high cost and poor health care services (Lethrop, 1993). This approach challenges the health care delivery system because individuals are also highly complex. What makes different people feel healthy and happy can be very different. Social, cultural and religious factors all acted on an individual's subjective feeling of healthiness. The different perception towards one's own health will affect the person's behaviour in the health care system. In turns, it may affect the development of patient care delivery.

2.7.1 Implementation issues of a patient-centred approach

Wolinsky's study (1988) focused individuals' responses as social influences in the health care contexts. An individual's perception of own state of illness or wellness changes within a particular socio-cultural context. A wide range of psychological and social conditions could be resulted from similar physical conditions. (Figure 2.7.1)

Figure 2.7.1 Variations in perceiving individual wellness with similar physical conditions

Physical	Social	Psychological	Individual sense of healthiness
Well	Well	Well	Normal and wellness
Well	Well	Not well	Pessimistic
Well	Not well	Well	Socially ill
Well	Not well	Not well	Hypochondriac
Not well	Well	Well	Physically ill
Not well	Well	Not well	Martyr
Not well	Not well	Well	Optimistic
Not well	Not well	Not well	Seriously ill

Source: adapted from Wolinsky, F. (1980*). The Sociology of Health, p.89*

The study elaborated on individual factors that influenced the perception of healthiness and the use of health resources. Other factors such as family stages, the demographic and community resources also had impacts on extent of the health care services that would be required. Organisational and systemic factors in health care systems would also intrinsically lead to demands of new changes in the patient care delivery. Wolinsky (1980) suggested seven resource factors and these factors were grouped into internal, external and integrative levels of influences to bring changes to an existing health care system. (Figure 2.7.2)

Figure 2.7.2 Variables affecting changes in health care system

Types of resource factors	Key variables
(a) Internal factors	
Life-stage or structural variables	Structural variables of the population such as education, occupation, ethnicity and lifestyle which affect the use of information or certain medical procedures
Psychological variables	Individual perception related to susceptibility or seriousness of illness; the expected benefits of taking action or using health services
Organisation	Health service utilisation is related to the different forms of health care delivery adopted by different organisations. Common different modes include (a) partnership or contractual style of practice, (b) financial nature of delivery (service fee, free, pre-paid); (c) site of service delivery (hospital, clinic, private office); (d) patient's contact person to patient in the system (e.g. physicians, nurses, or assistants).
(b) External factors	
Family resource variables	Family income, health insurance coverage and other regular sources of health care such as a private health plan
Community and demographic resource	The variables typically referred to the resource of a given population, including the supply of health services and resources in a given geographically defined community. Community resource models are sometimes criticised for being no more than a cost saving approach -- calling on informal support and volunteer services in order to save formal funding
(c) Integrative factors	
Health system	These include all variables described above. Such incorporation provides a greater understanding of health service system, within the economic structure of the wider society. It also has the advantage of estimating health outcomes more accurately by taking into consideration service availability & accessibility.

2.7.2 The professional intervention and internal factors

The probability of a patient with infectious disease leaving hospital alive was less than 50% before antibiotics were discovered (The British Medical Museum publication, 1992). The use of drugs and medical technology has been changing the health care environment. More people survived and pharmaceutical development shortened the treatment time. Patient stayed shorter in hospitals comparing to the last decade (Freund & McGurie, 1999; Vetter, 1996). The success of health care, often associated with the number of trained doctors in the public hospitals. (MacKay, 1993). The specialist and their high salary, in addition to the medical cost for technological had brought other issues for the health care managers. The sustainability of health care system in the future has begun to be questioned (Hiaso et al, 1998).

Tripp and Reimer (1984) re-conceptualised on professional intervention and their effectiveness in patient care. The effectiveness of achieving high standard and individualised patient care was based on physician's ability to understand the patient's subjective feeling and the use of different health care strategies required for different individuals. (Figure 2.7.3)

Figure 2.7.3 Patient compliance in the treatment process

Use of different health care strategies to improve compliance		Subjective perception of patient	
		Well	**Not-well**
Objective Assessment By professional	**Well**	(I) *Compliance Promotion*	(II) Non-compliance self-healing
	Not-well	(IV) Non-compliance Education	(III) *Compliance* Treatment

Source: adapted from Tripp-Reimer's health grid (1984) in Reconceptualising the construct of health: Integration of emic and etic perspectives. *Research in nursing and heath (7), pp. 101-9.*

Tripp-Reimer's study highlighted inconsistencies occurred during professional intervention. As we can see from the grid, when a person feels he or she has a different opinion during the treatment process, non-compliance is likely to occur either in the form of seeking an alternative (in quadrant II) or ignoring the treatment altogether (in quadrant IV). Professional intervention becomes ineffective if the patient is not complying. For instance, if a patient decides not to go to a professional for medical advice and uses a self-healing method, then the medical staff will find it difficult to make any changes to the patient's medical condition and peer counselling might be more effective. Such practice might not be regarded as important enough to be taught in medical school.

2.8 The argument: community involvement in health care changes

Among different forces selected above for discussion, this study has based on an argument that the role of the most long-standing social forces, which withstood changes in the past, will continue. The health tradition and cultural influences from the community that have shaped the provision of personal support in the past, are therefore most influential in the direction of the healthcare development. This argument will be discussed in Chapter 5.

2.8.1 Complementary roles in formal and informal sectors

Historically, the roles of health care structure and informal patient support seemed to complement each other in different ways. Rosenthal & Frenkel (1992) have approached new patient and health care issues by examining the use of para-professionals in developing economy. The experience of Mainland China in the 1960s was an illustration. It was observed that such initiative of training para-professionals has its significant impact on the formal health care system. The Barefoot Doctor (BFD) programme in China encouraged the development of community-based health care programmes. With 80% of people living in the rural area, the medical development in China was described

as a mixture of historical and cultural influences. Such national practice of using "grass-root" approach and traditional medicine has met the needs of the majority rural population.

Studies on the development of community-based health support conducted by Rothman since the 1960s suggested that a shift of paradigm to community-based support was necessary as the number of persons with functional issues increased in the community. The social and physical disadvantaged groups, whose needs are complex were those who were too young to look after themselves, the older persons who were physically frail, adults with severe physical or mental disabilities (Rothman, 1994). The support for these people outside the hospitals (e.g. McClelland et al., 1985) required some planning when they were hospitalised.

There were six major dimensions discussed by Rothman (1994) to assess the continuity of support for these disadvantaged groups in informal sector. These dimensions, adapted with some modifications in this study, will be discussed in the methodology section (Chapter 4). A survey was conducted to collect data on community support for the different target groups and the findings will be compiled for discussion in Chapter 7.

2.8.2 Other health studies in local context

Patient feedback and their satisfaction level towards patient care provision were studied in Hong Kong in the early 1990s. These studies covered similar ground to those in other countries. Many recent local studied, concerned with health care financing and patient satisfaction in service delivery, focused on one specific aspect of the system. For instance, the financial aspects were studied at a policy level to review existing trends and propose new direction in future health financing (Hisao et al, 1998; Ho, 1995; Hay, 1992;Yuen, 1991). Patient feedback was collected to reflect on service delivery from user point of view

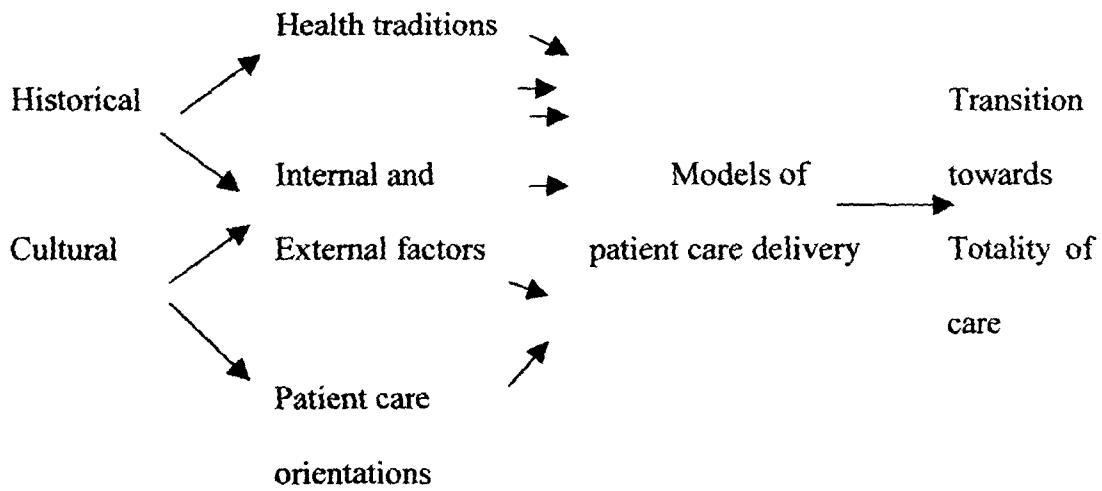
(Lui & Lam et al., 1994;). Different departments conducted internal professional service evaluation. There was also study compiling complaint and appreciation feedback on the practice of care (QEH, 1996). Comparative studies between health service systems could only be found overseas (Rosenthal, & Frenkel, 1992; Powell & Wessen, 1999; Packwood & Buxton 1991).

Two previous studies conducted by researcher of this study had attempted to investigate impact on patients (Lam, 1994) from changes in the delivery systems in the 1990s (Lam, 1996) with special focus in the implementation of new service policy. In this study, the researcher attempted to broaden the scope of investigation on the forces which affects implementation of new changes in local health care system.

2.8.3 A study about transition into a patient-centred approach

As discussed in this chapter, the literature has provided a wide range of theories, which complement each other in the construction of a multiple source of influence framework for a dynamic health care system undergoing changes. The health care system of Hong Kong, with a long standing influence of the British health system and being different from the that in the mainland China (due to), has its flexibility in seeking new solutions when a new management system was introduced in the 1990s.

Figure 2.8 A study framework on multiple influences from historical and cultural factors



2.9 Development of transitional patient care structures

Roemer (1977) described the reality as "a great laboratory in which many experiments are being conducted on different methods or organising and providing health services." As the world has experienced great changes in the health care systems since the 1960s, many new patient care structures have been developed since then.

The development of resource centres in hospitals started in the 1990s. The need of cancer patients was perceived as requiring different strategies by encouraging timely information and early access to research material. The Cancer Patient Resource Centre was the first type of patient resource centre established in hospitals (California Cancer Patient Resource Centres, 1998 and Patient and Family Resource Centre, 1997). Other resource centres were established according to specialty (Greater Baltimore Medical Centre, 1998). Examples of different types of hospital initiatives to meet different needs of patients included Women's resource centres, fertility centres and comprehensive breast care centre have been set up in many university-affiliated health facilities. The Resource Centre of the Illinois Institute of Developmental Disabilities, part of the University of Illinois at Chicago, was established "to develop and publish the Centre's promotional materials, compile an inventory of Latino health-related data bases, and provide library services"(University of Illinois at Chicago, 1998). The American Hospital Association established a resource centre designed for those staff encountering difficulty in getting updated about community support programmes, which might benefit their work (AHA Resource Centre, 1998).

The researcher has visited the Patient Resource Clinic in the Richmond Hospital in Vancouver, Canada in 1993 to prepare for the study. This Clinic

mainly served doctors and nurses by providing updated community resource information for patient care. Other example of technological support provided by hospitals and health care facilities is the Technology Resource Centre. This offers individuals, their families and professionals a place to learn about the assistive communication devices for children and adults who are unable to speak, read or write (Technology Resource Centre, 1996).

The role of the family members is recognised in the Family Resource Centres, in particular, for parents with hospitalised children. This illustrates a hospital's recognition of the parents' important role as a member in their child's health care team. "The resource centre's staff help families find the information they need in order to understand their child's medical condition and to take part in their child's care. Pamphlets, booklets, contact information, and other relevant materials are available or can be found with the help of the Centre's staff. (Children's Hospital Boston, 1998)

The McLean Hospital, affiliated to the Jonathan O. Cole Centre, established the Mental Health Consumer Resource Centre which was "a first-of-its kind" operation that offers a wealth of information on psychiatric disorders and related topics. It is a joint initiative with the hospital, which is one of the pre-eminent psychiatric hospitals in the country to house mental health resources from a variety or origins. Consumers are regarded as "people who have dealt successfully with mental health problems first hand and understand the questions that come up when someone needs psychiatric help" (Jonathan O. Cole Mental health Consumer Resource Centre, 1998).

The Pullman Memorial Hospital Community Resource Centre which provides "access to health and wellness information to all members of the community, contains leaflets, booklets and videos on a wide variety of health related topics; from Alzheimer's to ulcers."(Pullman Memorial Hospital, 1998) The Health Care Ethics Resource Centre established in 1996 was a response to growing

need for information, guidance, and networking among health care professionals. The purpose of the centre is to assist its members in developing institutional policies, resolving difficult patient care and organisational dilemmas, and monitoring state, regional and national trends in health care." (The CHA Health Care Ethics Resource, 1998)

2.9.1 Patient Resource Centre as a focal point of study

While most new resource centres in health care facilities developed in the North America in early 1990s, the first Patient Resource Centre was established in 1993. The Patient Resource Centre was an early initiative to implement total patient care concept. The development of Patient Resource Centre models by different hospitals in Hong Kong will be studied as a pivot point to reflect on the implementation of a new policy encouraged by the Hospital Authority to improve current services for patients.

Conclusion

This chapter has considered different sources of influence on a health care system. The literature discussed historical forces (Roemer's study), which affect the development of a national health care policy, interacting social (Evan and Stoddarts' study) and individual (Wolinsky's study) factors that influences on the development of new delivery models. The literature, however, does not directly address the central issue of this study, namely, how these forces affected the current health care system in Hong Kong. The following chapter will provide background on the major events in the development of the health care system in Hong Kong in the last few decades.

Chapter 3 Major events in public hospital development

This chapter describes the major changes in the hospital system, in particular, after 1960s when Hong Kong experienced a series of demographic and social changes. Major health care development within the last few decades included four different policy periods that aimed to address different aspects of health care delivery. The information was collected from hospital reports, interview with museum in-charge and reviews on policy papers (listed in the bibliography). Some background on community involvement in the hospital system and its influences on new patient service development will be provided in this chapter.

3.1 Four major health care policy periods

3.1.1 Separation in health care development

The building of public hospitals in Hong Kong marked the history of the formal health care system in Hong Kong, around 100 years ago. In 1890, both government and community hospitals were built to serve different patient groups. The government hospitals, modelled on the British medical system, served as offshore medical services for British officials, military men and their families. The first community hospital was set up in response to the needs of local Chinese. Other community hospitals were built after the influx of refugees arriving in Hong Kong in the late 1940s and early 1950s. In response to requests from new-comers who could not find the Chinese medicine in the public hospitals, local residents requested government permission to donate a sum of money for the supply of traditional medicine in a community hospital for those who needed it.

All hospitals by law had to be monitored by the government. An informal request from the community to provide Traditional Chinese Medicine was

accepted under a "tolerance" policy. That is, the service could be provided as long as no complaints were received and there were no financial implications for the government. The Kwong Wah Hospital, a community hospital belonging to the Tung Wah Group of Hospitals, took the initiative to provide Chinese medicine for local people. (Tung Wah Group of Hospitals, 1971). The Tung Wah group has remained to the only community group that had built a Chinese community and an outpatient Chinese clinic until the early 90s (Chao, 1993).

3.1.2 Action to reduce sub-standard service

There was a drastic increase in population in the 1950s. The sudden increase in population was caused by the large number of refugees from Mainland China who had arrived in Hong Kong after the Communist Revolution in 1949. This was first perceived to be a temporary increase in population. Temporary medical services were set up by various organisations to serve this temporary need. The consequent overcrowding in hospitals resulted in a "below-standard" service, including use of camp beds, unattended care and so forth.

The government had undertaken a pro-active approach in this period. The first formal health care policy paper, known as the *White Paper on Medical and Health Services*, published in 1964, was published to address two major issues relating to the service standard in public hospitals. This was at first regarded as tolerable. However, when it became clear that the population would settle down permanently in Hong Kong, the whole issue of the delivery of care had to be reconsidered.

The White Paper focused on the building of large public hospitals to replace the below-standard services. The building of more hospitals was expected to help relieve the over-crowding in the public hospitals. An international standard of

5.5 hospital beds per 1000 people was adopted. This action was taken gradually. Some poor existing services continued for many years.

There was a difference in hospital fees between the government and the community hospitals. It was considered as a major barrier to the integration of the two hospital groups into one system. (Hong Kong Legislative Council, 1974) There were difficulties to transfer patients between hospitals. Such difficulties were resolved through the introduction of a standardised hospital charge implemented for all public hospital beds.

While the fees were standardised, the community sector initiated new service approach to the public hospital system by introducing community nursing services in late 1970s (The United Christian Community Health Project proposal, 1979).

3.1.3 Collaboration between government and community sectors

The population in Hong Kong continued to grow between 1960s to 1990s (*Census and Statistic, 1961, 1971, 1981, 1991, 1996)*. There were people moving outside the original urban centres of Hong Kong Island and Kowloon to reside in the newly developed areas, known as the New Territories. New hospitals were built in these new areas, where the population grew fast. Even distribution of health services was regarded as a priority in policy discussion. (*The Further Development of Medical and Health Service in Hong Kong, 1974*)

The 1970s was described as a time of prosperity in Hong Kong by the medical advisory committee, the Medical Development Advisory Committee (MDAC), established in March 1973. This committee provided recommendations to the government with particular interests in major financial and staffing issues. The MDAC had narrow membership that consisted of mainly appointed personnel. (Hong Kong Government, 1974).

The1970 policy paper, known as the *Further Development of Medical and Health Services in Hong Kong,* had made recommended on resource and service co-ordination within each geographical district. Four regional acute hospitals, with Accident and Emergency Departments, had the highest level of medical expertise. These were the Queen Mary Hospital (QMH), Queen Elizabeth Hospital (QEH) in East Kowloon, Kwong Wah Hospital (KWH) in West Kowloon and the Princess Margaret Hospital (PMH) in the New Territories. Each major regional hospital had its network of district rehabilitation hospitals and other smaller hospitals for patient convalescent purposes.

3.1.4 Attempts to standardise differences

As Hong Kong health statistics became comparable to other developed countries by the late 1970s (World Health Statistics), the policy focus shifted towards reducing the expense of the hospital services, which had continued to grow. Constantly, rising medical expenses had outpaced other public services. Expenditure on medical and health services had been maintained at around 8% of total public expenditure each year. Improvement in the overall use of resources, through the introduction of more technology and a review of management systems was stated as the aim of a 1985 policy paper. This paper, "*Report on the Delivery of Medical Services in Hospitals*" underlined major government concerns over health care costs, in particular the expense of the larger hospitals.

The co-ordination between the government and community hospitals through the subvention system, whereby the government could use beds in the community hospitals, continued to strengthen the complementary relationship between government and the community health care systems. However, systemic issues, such as differences in staff employment conditions and

working environments were still outstanding. Hospital service integration was finally to be achieved only through a new management structure, the Hong Kong Hospital Authority (HKHA).

3.1.5 Establishment of a new management body --the Hospital Authority

The Hong Kong Hospital Authority (HKHA) was established in 1991 as an independent or quasi-government structure. As a quasi-government structure, it has autonomy to resolve various historical issues relating to differences between government and non-government hospitals. From its establishment, the HKHA became responsible for managing and developing the public hospital system. It has powers to establish and maintain hospital services as the Authority considers necessary or desirable *(Hospital Authority Ordinance, 1992, p.6)*.

The HKHA advocated the provision of continuous, holistic total care to patients through close collaboration between all carers in the primary, secondary and tertiary health sectors, including welfare agencies, family members and community carers. Instead of a "hospital as centre" perspective, the HKHA now considered the public and the service users; hospital staff, service providers, government or non-government as hospital stakeholders.

A corporate approach was adopted to implement its mission through its service units. There were five corporate strategies listed in the Business Plan (1994). These strategies intended to enhance collaboration with other health care providers and carers in the community. This was the first time in the medical and health history of Hong Kong that a seamless health care environment had been designed to maximise health care benefits and to meet generic community expectations.

These strategies are:

(1) Re-focus on health benefits and community expectations instead of government or institutional objectives;
(2) Re-structure and organise medical services in collaboration with other providers and carers in the community;
(3) Involve the community as partners in the health care decision-making process;
(4) Cultivate a multi-disciplinary instead of a medical-lead team to enhance holistic care; and
(5) Promote an innovative infrastructure to solve unresolved problems and to develop new support services

3.2 Diversity within the health care systems

The diversity of experience within the health care system was expressed in terms of two hospital groupings, the government hospitals (Schedule I) and and community hospitals (Schedule II). The establishment of a new management body was aimed to focus on hospital issues that could achieve a standardised quality of care to all hospital patients (The Hospital Authority Annual Report, 1993).

3.2.1 Types of public hospitals

The 38 public hospitals in this study are listed in Appendices I and II. There are two groups of public hospitals in Hong Kong, namely, the government group and the community group. The following sections provide a brief description of the two types of hospitals.

3.2.1.1 Government hospitals

The government group receive full funding from the government and the community group received partial funding from the government. There are 18 government hospitals, comprising 13063 beds. Eight of these hospitals are large hospitals having more than 1000 hospital beds. The smallest one is the Eye Hospital that has only 14 beds. The government group consisted of teaching, psychiatric and other acute and other acute hospitals.

Teaching hospitals

There are two teaching hospitals in the government group. The Queen Mary Hospital is affiliated with the University of Hong Kong. The Prince of Wales Hospital is affiliated with the Chinese University of Hong Kong.

Psychiatric hospitals

The government group includes large psychiatric hospitals. There is no psychiatric service provided in the community group.

3.2.1.2 Community hospitals

The community groups composed of different charity bodies and religious organisations that provided health care services. There were 20 community hospitals providing a total of 9706 hospital beds. Although as part of the public hospital system, the community hospitals had their own management boards. The status of a community hospital was also different from that of a government hospital.

For instance, the Kwong Wah Hospital, one of the four regional hospitals, did not have the same status as the other regional hospitals in that it was not involved in regional co-ordination. The community hospitals were also given autonomy to provide traditional and herbal medicine.

Cultural hospitals

In practice, the QEH took over the administrative responsibility and co-ordination in two districts. Most community hospitals had a tradition to provide free-of-charge services for some patients. Examples of the community hospitals included Wong Chuk Hang Hospital (WCHH), Fung Yiu King Hospital (FYKH), Yan Chai Hospital (YCH), Pok Oi Hospital (POH). The cultural hospitals emphasised, within the understanding of Chinese culture, support to fellow people who need help in times of difficulty.

Specialty or rehabilitation hospitals

The development of specialist hospitals was marked by the opening of the Grantham Hospital in 1957. The specialist hospitals which offered comprehensive treatment to specific patient groups, such as patients with heart and lung diseases. The specialist hospitals had stronger professional teamwork in their support to a specific patient group. The Margaret Trench Medical Rehabilitation Centre was built for patients with the spinal injuries in 1962. In 1982, Grantham Hospital was transferred from its original operation by the Hong Kong Tuberculosis, Chest and Heart Diseases Association and developed into a full cardiothoracic centre, to "upgrade and achieve excellence, cardiothoracic patient-centred care, staff, research and education" (Hospital Mission, HA annual report, 1993). Grantham Hospital became affiliated to the medical teaching University which introduced laser techniques and other new technology into the territory so that the hospital "successfully performed the first heart transplant and lung transplants" in 1992 and 1995 respectively. (Grantham Hospital report, 1999) GH has expanded from a small hillside hospital with 625 hospital beds and now provides 24-hour service for emergency heart operations.

Some smaller hospitals serving particular patient groups with specialist support. The Margaret Trench Medical Rehabilitation Centre, being one of the

small hospitals, had made its service vision to the "highest attainable self sufficiency and employment skills in the shortest possible time" for spinally injured and orthopaedic patients. There were other small hospitals with similar background of stronger professional teamwork. The MMRC, a sister-unit of MTMRC was built in a different district in 1982. The Duchess of Kent Children's Hospital was built in 1953 with the support of a separate professional body, and aimed to provide "free service for disabled orthopaedic children".

Religious hospitals

The religious groups had also contributed in the development of public hospitals. These included three religious efforts involved in developing major acute services between the 60s and the 70s after when an increasing influx of immigrants from the Mainland China arrived in Hong Kong. Overseas Christian missionaries developed the Caritas Medical Centre (CMC) and the United Christian Hospital (UCH) in 1964 and 1973 respectively. A chaplaincy office or a chapel and religious activities are available. The local religious group built the Buddhist Hospital (BH) in 1970. Special vegetarian meals for patients with Buddhist belief were served. A chronology of public hospitals developed by different initiatives in the last four decades is shown in Table 3.2

3.3 Periods of major public hospital service expansion

The number of public hospitals increased with the growth of the population. There were two periods of major development in public hospitals through the building of more hospitals in the 1960s and 1990s. Seven large hospitals were built in the sixties and nine were built to the 1990s. (Table 3.2)

Table 3.2 Chronology of public hospital development (1859 - 1998)

Year	Hospital	Founders
1859	Naval Hospital	Government
1872	Tung Wah Hospital	Local community group-- the Tung Wah Group
1887	Alice Ho Miu Ling Nethersole	London Missionary Society from overseas
1911	Kwong Wah Hospital	Tung Wah Group
1919	Pok Oi Hospital	Residents in native villages-- Yuen Long
1938	Lai Chi Kok Hospital	Government
1949	Ruttonjee Sanatorium	Joint community and professional efforts
1953	Duchess of Kent Children Hospital	Professional group
1957	Grantham Hospital	Professional group
1961	Castle Peak Hospital	Government
1962	Margaret Trench Medical Rehab Centre	Professional group
1963	Queen Mary Hospital	Government
1963	Queen Elizabeth Hospital	Government
1964	Caritas Medical Centre	Overseas missionary
1965	Wong Tai Sin Hospital	Local community
1967	Nam Long Hospital	Religious
1970	Hong Kong Buddhist	Local religious
1972	Siu Lam Hospital	Government
1973	United Christian Hospital	Overseas missionary
1973	Yan Chai Hospital	Local community
1975	Princess Margaret Hospital	Government
1981	Kwai Chung Hospital	Government
1982	McLehose Medical Rehab Centre	Local foundation
1985	Prince of Wales Hospital	Government
1990	Tun Mun Hospital	Government
1991	Ruttonjee Hospital	Government
1991	Shatin Hospital	Government
1992	Hong Kong Eye Hospital	Government
1992	Fung Yiu King Hospital	Local Community
1993	Pamela Youde Nethersole Eastern	Government/ community and religious groups
1997	Alice Ho Miu Ling Nethersole	Joint local and missionary efforts
1997	Tai Po Hospital	Government
1998	North District	Government

3.4 Hospital traditions and missions

The two groups of hospitals had expressed their ideological traditions differently in their hospital mission statements. These differences indicated that there was a wide range of perspectives on how hospitals would provide their services for their patients. Illustrations are extracted from the hospital annual reports in 1993 (Table 3.3). The hospital traditions will be discussed in Ch.8.

Table 3.3 Examples of the mission statements in public hospitals in 1993

Government hospitals	Community hospitals
"Provides out-patient and in-patient care as well as accident and emergency service" (FH)	"To provide holistic, high quality and professional health service" (FYKH)
"To provide adequate, appropriate and acceptable community-oriented psychiatric service for people disabled by serious mental health problems."(KCH)	"To rehabilitate patients to the maximum of their residual capacity and to reintegrate them back into the community."(WTSH)
"To provide comprehensive emergency and clinical services as well as tertiary services"(PMH)	"To provide holistic care for the physical, mental, social and spiritual well being of people with disabilities" (CH)
"To provide quality services to improve the quality of life of our clients". (SH)	" To serve the community through the application of Christian faith and the teaching of Jesus..." (UCH"
"To provide high-quality total patient care" (QMH)	With kindness of heart and concerns for others' sickness and distress..." (YCH)
"To provide the highest possible standard." (QEH)	"To provide a home for the disabled to live an active and dignified life" (CH)
To provide highest quality service in total patient care." (PWH)	"To provide free treatment, rehabilitation and schooling services" (DKCH)
"To excel in the provision of holistic patient-centred quality health care." (PYNEH)	

3.5 Issues of variation and standardisation

The health context in Hong Kong was observed, in this research, as varied and complex in its structures and missions between systems. Contrary to the differences inside the system, individual expectations on health care outcomes was quite uniform, that is, to be able to return to the previous health condition or to receive the best of care the system could provide.

3.5.1 The establishment of a new management body

In 1990, the Hong Kong Hospital Authority was set up as an independent or quasi-government structure to re-structure public hospitals. The establishment of a single management body was to focus on hospital issues in order to ensure the care practice is standardised in all hospitals.

3.5.2 New health care vision : No additional cost in implementation

Subsequent to the establishment of the HA, a government consultation paper on this topic was issued, *Towards Better Health*, in 1993. This paper recommended that an improved environment for patients and their carers in all hospitals was necessary. There were indications that the people of Hong Kong were not contented with some of the existing public hospitals. The original thought of these improvements were to be implemented while the patients have to prepare to pay for increase in their contribution from 3% to 5% of the total cost of a public hospital bed. The public did not accept the increase in cost contribution and such recommendation was not implemented by 1998, the time this study was completed.

3.5.3 A period of innovation

The physical structures of the government and government-aided hospitals were merged under the management of HKHA. The total number of hospital beds had increased to 25,500. The two basic principles of the Government policy specified in the White Paper of the 1960s, namely, (1) to safeguard and promote the general public health, and (2) to ensure the provision of medical and personal health facilities, continue to be the guidelines for health care policy in Hong Kong. As there was no substantial increase to the health care expenditures, the involvement of outside party such as the community in the provision of new services has become important.

3.6 A model of totality of care

The Hospital Authority had initially identified some priority target groups to implement total patient care. Patients suffering from diseases that were of critical nature and related to the top death rates were selected. These patients included those suffering from cancer, stroke, heart, renal, lung and diabetics. The emphases of attention for disease-related groups ranged from prevention, treatment and end-of-life stage management. These patients were expected to require more attention because of social vulnerability and frailty. The hospitals were expected to provide support in their adjustment to illnesses. These patients included the infant, adolescent, older persons and mental patients. (Figure 3.6)

Figure 3.6 Patient-focused strategies defined for totality of care

	Hospital initiatives in patient service improvement			
Strategies:	Prevention	Treatment	Management	Support
(a) High risk disease groups				
Cancer	√	√		√
Stroke	√	√		
Heart	√	√		
Renal			√	
Lung	√	√		
Diabetics				√
(b) Socially vulnerable groups				
Geriatric				√
Adolescent				√
Infant				√
Mental				√

Total care product

The new innovation period which involved community participation was encouraged by the new HA. The Hospital Authority Corporate Plan 2000 was designed to invite the community as partners in order to formulate new solutions to current service provision. A total care policy was expected to produce an end-product for the hospital. Such "Total Care Product" was to be achieved through a process jointly determined defined by the hospital and the community. The community was then invited to participate in the search for new patient care solutions in regional board, hospital governing committee, hospital groups and or community panel.

This model involves different stakeholders in working out the gaps between demands and benefits through workable solutions. (Hospital Corporate Plan 2000)

Conclusion

In this chapter, the historical development of Hong Kong's health care system has been described. It shows how a system was constructed which was more comprehensive over time. The new system in the 1990s attempted to develop new approach in order to incorporate some of the senses from the traditional and community-based health care that were developed outside the public system. The following chapter will discuss the methodology of the study.

Chapter 4 Methodology

The idea of this study was first implanted when senior hospital management has shared with the researcher in 1993 that the "historical reason" was expected to be "the hardest problem in the system" and likely "not be resolved". The concerns on observed differences in the hospital system was directed to frontline staff and community providers, they did not seem to know the answer either. This study intended to explore the influences from different forces that shaped the patterns of care, which have emerged in Hong Kong. This chapter will discuss the methodology adopted to understand such influences. In addition to the core research questions discussed in Chapter 1 (section 1.11), the specific research objectives of the study are listed below.

4.1 **The specific research objectives** of this study to understand the development of hospital patient service in transition are:

(1) To understand the background forces behind a total care policy aimed at achieving a higher standard of patient care delivery through service standardisation and comprehensive patient services, in particular

- To investigate how historical factors have interacted with other social forces to produce a range of different approaches in the implementation of a theoretical concept of total patient care in Hong Kong.

(2) To identify the strategies adopted by local public hospitals with different service traditions (government dominance and community dominance) in response to a new policy defined by the Hospital Authority, and

- To focus specifically on the development of different Patient Resource Centre models, which provide an illustration of approaches adopted by the hospitals in the implementation of the intended policy.

(3) To investigate feedback from the hospital stakeholders-- patients, frontline staff, administrators and policy planners –in the process of policy implementation by:

- collecting opinions from stakeholders,
- comparing and contrasting differences between the stakeholders in their perceptions of the difficulties and possible solutions to be addressed in resolving the difference in-patient care delivery.

(4) To examine potential community capacity to support an extension of patient care outside the hospital environment by

- focusing on the discussion of the ten priority service areas as illustrative examples,
- defining a point of balance in collaborating efforts between hospital and community to achieve a totality model in patient service delivery.

(5) To document the process in the development of a total patient care model by

- summarising the factors affecting choices in the determination of an appropriate level of care for patients within a patient care delivery context which attempts to move away from historical influence.

4.2 Research design

This study investigates the different attempts adopted by hospitals to re-define their roles in patient care through restructuring their existing patient service approaches. The newly established patient service structures, known collectively as Patient Resource Centres (PRCs), were selected as the focal point of study. The PRCs were developed as new initiatives to provide new pattern of care through hospital partnership with patients and the community

4.3 Patient Resource Centres (PRCs) as the focal point of study

The Patient Resource Centres provided a good basis for comparison between hospitals in a period of transition. The evolution of a total patient care concept was experimented through a pioneer hospital-based PRC project. The development of such a concept provided reflections on a trend of consolidating a pool of new ideas and different implementation strategies to address patient service needs within a local context of resource and historical factors.

4.4 Methods

4.4.1 A Pluralistic study approach

This study has adopted a pluralistic approach in data collection. A pluralistic approach was described as one of the best methods to understand complex organisations such as health care organisations (Smith and Cantley,1985). Such an approach makes an inquiry into the internal functioning of an organisation and the process of policy development, by considering the interests of the various different stakeholders. The different views and expectation due to different positions and activity involvement will be collected. The "top" ideological perspectives to "bottom" daily operational strategies will be identified from these different major constituent groups. Data collection emphasised "successful" implementation. The study assesses the extent to which "success" has achieved the goal set by the organisation. The explanation of process, particular in a complex and dynamic of organisational interaction has implications on future policy action, will be attempted through a mapping process. The processes are depicted in Figure 4.4.1

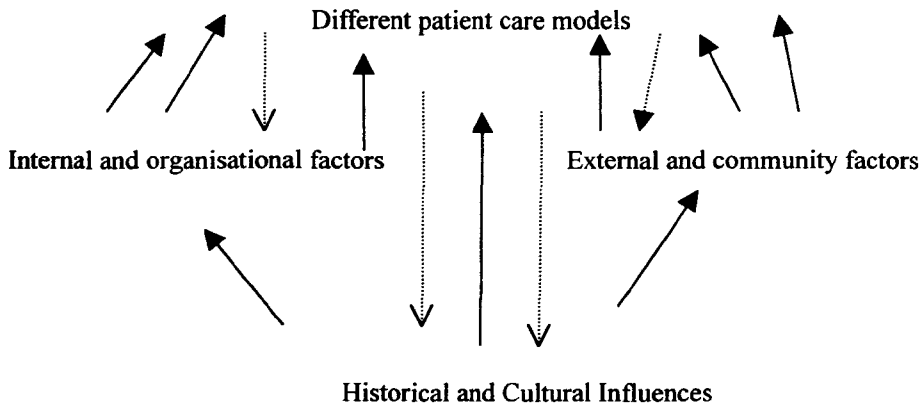
The development of different patterns in local context in the literature was discussed in Chapter 2. Thomas and Rothman (1994) and Davis (1991) further

highlighted the differences in implementation as a choice of selection to ensure successful outcomes.

In this study, the differences in the implementation of a single policy, which cannot be standardised into one single format, will be regarded as a partial achievement or a transitional stage that has not attained a full implementation of a policy or transformation.

As there was no similar study in local context for reference on the development of totality of care for patient, this study attempts to examine the background sources of influences and how these forces interact with the dynamic of the contemporary development of a totality of care model.

Figure 4.4.1 Mapping forces in the development process of totality of care model



The arrows denote the forces suggested in the literature and dotted lines denote the local forces to be mapped to those influences

4.4.2 Three phases

Phase A

This phase was intended to explore the sources of influences and main issues related to the choice of different forms of structural development in hospitals. In this phase, site visits and staff interviews were conducted. The researcher made arrangements to meet the staff in the Patient Resource Centre. In some hospitals, such as the QEH, QMH, the researcher was invited to attend their staff meeting. The background information and historical issues relating to patient care through review on internal reports, non-published articles and newspaper clips from all thirty-eight public hospitals were then analysed. These data were used as a basis for developing focus group theme. Focus group meetings were arranged through a poster placing in the Patient Resource Centre. The focus group discussion was intended to collect a wider range of feedback from hospital stakeholders, and to go beyond official statements of purpose. Focus groups also enabled researcher to explore the main issues, and to identify choices between different forms of institutional development in ways not so possible in more structured methods of research.

Phase B

The second phase, based on the focused groups, was to collect views on the changes occurred in the new health care environment from the four major groups of hospital stakeholders. The stakeholders involved were patients and their families; frontline staff and service providers in the community (referred as practitioners in this study); administrators and policy planners. The focus group discussion method was adopted to collect different views from the four major stakeholders. The advantage of using focus group discussion was that it was described as an effective method in the literature (Morgan, 1997). The strength of focus groups was its efficiency, compared to individual interviews, allowed

the researcher to explore issues and collect data under different topics of interest.

A series of five focus group sessions was conducted. A total number of 77 participants were involved in this phase. Each discussion session lasted about 2 hours. The average size of these groups was 15. Key informant interviews were conducted subsequent to discussion to clarify any query and to substantiate the findings from focus groups. The discussions had themes cored at the changes and development of patient service delivery in health care system. All participation was voluntary. Consent was sought prior to tape-recording of the focus group discussions and some of the interviews. Guideline for focus group discussion is attached in Appendix 5.

In this study, with the awareness of the sample bias, the focus group method only served as one of the data collection tools. To eliminate the possible bias due to sampling effect, collecting data from focus group discussions was compared with other methods as suggested in the literature (Greenbaum, 1998; Rubin and Babbie, 1997). A survey was designed to overcome the disadvantage of a small sampling size. In addition, the views of the hospital staff in the community support for different patient groups was collected in Phase C.

Phase C

The third phase of the study was a survey, conducted to collect views from the hospital staff on the external factor that would affect the continuity of patient care. The significance of a survey to solicit feedback from administrators and practitioners in the implementation process was discussed by Politt et al (1994). A questionnaire was conducted to collect views from hospital staff who was responsible for planning patient discharge and community partnership and was participated actively in hospital-community collaboration at the time of this study. All thirty-eight hospitals were invited. These hospital representatives were selected through nomination from the Hospital Chief Executives. Each hospital

could nominate a maximum of four representatives. A total of 152 copies were distributed and 74 copies were returned. Subjects were allowed to stay anonymous (Appendix 6). Description of the survey can be found in Chapter 6.

4.4.3 The questionnaire

The use of quantitative data to substantiate the qualitative data analysis was designed to improve objectivity of this study. The questionnaire construction was based on an instrument discussed in the literature as a tool used to estimate the potential of community support for clients with complex needs (Rothman, 1994). The original instrument has six dimensions. The five dimensions used by Rothman to understand the capacity of patient support in the community were "durability", "willing to help", and "frequency of contact", "accessibility to support" and "proximity of care". The last dimension, i.e., a "reciprocity expectation" was excluded, as it was considered not relevant for this study.

As this study referred to a larger community than individual support, the headings of the five dimensions were modified slightly in order to provide a better content-specific questionnaire. For instance, "durability" was replaced by "historical involvement", "willing to help" by "attitude in the community. Instead of having two items assessing similar areas of accessibility and proximity, this study replaced "proximity" by "alternative healing methods" which were commonly adopted by patients in their neighbourhood. Ten health care practitioners initially validated the instrument. It was agreed that the essence of the assessment remained the same.

4.4.4 Measurement

A 5-point Likert scaling was used in each area. The values rated in each areas of the survey, with respects to the ten priority disease-related and patient service areas selected by the Hospital Authority, were compiled and analysed

using the standard program, the social science statistical package (SPSS). Mean scores of each item would be compared with the overall average of all respondents to set a norm for comparison (Mark, 1996, p.274 - 277). The ten disease and patient groups, determined by the public hospitals to be given priority patient service (Chapter 3), based on the practitioner's perception on the existing support from the community, would be computed. Such findings were intended to provide some directions on the hospital and community collaboration, taking into consideration of the different initiatives for the disease and patient groups since the early 1990s. The scope of patient service integration by the hospital and the community would be discussed.

4.4.5 The data collection process

The study process is summarised in the diagram below. (Figure 4.4.5)

Preparation Phase and Core research questions:

Why were there differences and where did these differences originate?

Were these differences consistent to the planned policy and if they have potential to be incorporated into the new system of patient care ? (Chapter 1 section 1.12)

↓

Study Design -- 3 Phases in Data Collection

Phase A (1994 - 1998) To identify background forces behind a total care policy and hospital strategies in response to such policy	**Phase B (1997) To investigate feedback from hospital stakeholders in the process of policy implementation**	**Phase C (1997) To examine potential community capacity to support an extension of patient care**
↓	↓	↓
Site visits and Interviews:	***Focus Group Discussion:***	***Survey :***
Development of Patient Resource Centres in 38 public hospitals (Chapter 5)	Compare and contrast differences between stakeholders (Chapter 6)	Illustrative examples on the ten priority service areas defined by hospital planners (Chapter 7)

Data analyses on factors affecting choices of development

↓

Discussions and Conclusions (Chapter 8)

Figure 4.4.5 Time frame and the study process

4.4.6 Data collection and sampling

All public hospitals were involved in the study. The number of hospitals studied was 38. These 38 hospitals located in all 3 geographical districts in Hong Kong. The size of these hospitals varied from 14 beds to 1923 beds. The number of doctors and non-medical staff in the hospitals varied from 1 to 418 and 41 to 4421 respectively. (Appendices 1 and 2)

In 1993, when the new patient care initiative was implemented, there were 18 government hospitals and 20 community hospitals. The 18 government hospitals consisted of eight large regional acute hospitals. The large acute hospitals had 1000 - 1900 hospital beds. Most of the large hospitals were built in the 1960s and two of these large hospitals (TMH and PYNEH) were built in the 1990s. The newest hospital, the Tai Po Hospital, a smaller district-based was the only hospital completely designed and built by the HKHA. Ten out of the eighteen government hospitals were located in new town areas.

The 20 community hospitals consisted of 3 large hospitals. The United Christian Hospital was under expansion to become another large hospital. Most of these community hospitals located in the city and four were built in new town areas.

The sources of data are summarised in Figures 4.4.6

Figure 4.4.6 Data collection from the 38 hospitals

Data Collection from hospitals		Phase A	Phase B		Phase C
Group	Name of Hospital	PRC Site visits & staff interviews	Patients, Staff & Administrators' views	Policy-makers and planners' views	Survey
G1	Castle Peak	X			
G2	Fanling	X			
G3	Hong Kong Eye	X			
G4	Kowloon	X		X	X
G5	Kwai Chung	X	X	X	X
G6	Lai Chi Kok	X			
G7	Pamela Y Nethersole Eastern	X		X	X
G8	Prince of Wales	X			X
G9	Princess Margaret	X	X	X	X
G10	Queen Elizabeth	X	X	X	X
G11	Queen Mary	X		X	X
G12	Shatin	X		X	X
G13	Siu Lam	X			
G14	St. John	X			
G15	Tang Siu Kin	X			X
G16	Tsan Yuk	X			X
G17	Tuen Mun	X			X
G18	Tai Po			X	X
C1	Caritas Medical Centre	X	X		X
C2	Cheshire Home (CHK)	X	X		X
C3	Cheshire Home (Shatin)	X			X
C4	Duchess of Kent Children's	X			X
C5	Fung Yiu King	X			X
C6	Grantham	X	X		X
C7	Haven of Hope	X	X	X	X
C8	Hong Kong Buddhist	X			
C9	Kwong Wah	X	X	X	X
C10	MacLehose Medical Rehab	X			X
C11	Margaret Trench Medical Re	X		X	X
C12	Nam Long	X			X
C13	Our lady of Maryknoll	X			X
C14	Pok Oi	X	X		X
C15	Ruttonjee	X			X
C16	Tung Wah Eastern	X			X
C17	Tung Wah	X	X		X
C18	United Christian	X		X	X
C19	Wong Tai Sin	X	X		X
C20	Yan Chai	X	X		X
No. of hospitals involved		37	12	12	32

4.5 Data analyses

The different forces observed from Phase A will be compiled and reported in Chapter 5. The different perspectives of the hospital stakeholders will be summarised and listed to contrast the similarity in the new service provided (Chapter 6). The survey findings on community support for the hospital targeted patient groups would be summarised in Chapter 7.

4.5.1 Mapping techniques

Forward and backward mapping techniques were applied in the data analyses on different views between stakeholders. The backward mapping, according to Elmore, "turns things upside down by centering on the point of service delivery"(p.2). Forward mapping refers to the traditional top-down view of an implementation process while backward mapping focuses on the point of service delivery. Joss and Kogan (1994) pointed out that a backward mapping approach has its advantage of refocusing on user level. This study collected data from different levels of involvement in the health care delivery, i.e., from top to bottom levels. Mapping method was applied in Chapter 6 to sort out consistencies and inconsistencies between users, practitioners, administrators and policy planners on current and historical issues.

4.5.2 Policy analysis

For the analysis on policy choices and action, a framework discussed by Palmer and Short (1989) was adopted in this study.

4.6 Researcher Bias

The researcher had worked in different hospitals for over 20 years and has been part of the changing system. The subjective experience of the researcher was

considered during the study preparation stage. The personal experience of a researcher was also recognised in the literature (Kirst and Yung, 1982) as strength, particularly in a study involving complexity in policy development and its implications. The professional experience of this researcher offered a longitudinal perspective, which could contribute to a better understanding of the implementation process. An inexperienced researcher, as Kirst and Yung pointed out, might take as long as 13 years to familiarise with a complex social context. Nevertheless, the survey study, however, introduced as a key measure to eliminate some of the possible subjective influence from the researcher on the study outcome.

4.7 Research outcome

The empirical study is expected to provide knowledge on the implementation of a total care concept within a specific context through three major groups of data:

(a) findings on influences that were accounted for the diversity of patient care development (Chapter 5)
(b) findings on views from different hospital stakeholders, including the users, practitioners, administrators and policy planners, participating at different levels of implementing new changes (Chapter 6)
(c) findings on community support serving the same hospital target patient groups (Chapter 7)
(d) Implications for policy choices and action in the implementation of a total care approach (Chapter 8).

Chapter 5 Finding I: Hospital Models of Patient Care

Total patient services in public hospitals implied the hospital system intended to include other non-medical but also essential and tangible service and psychosocial support required by patients and their families (*Towards Better Health*, 1993). This chapter describes the different hospital models of patient care that emerged in Hong Kong, after a total patient care policy was proposed in the 1990s. The researcher collected information on these new hospital-based Patient Resource Centres through site visits and interviews with the Centre-in-charge. The following sections will describe the different models of patient care emerged between 1993 - 1998. The influences that led to emergence of different models of hospital patient care will be summarised, discussed and analysed at the end of this chapter.

5.1 Changing modes of hospital patient services

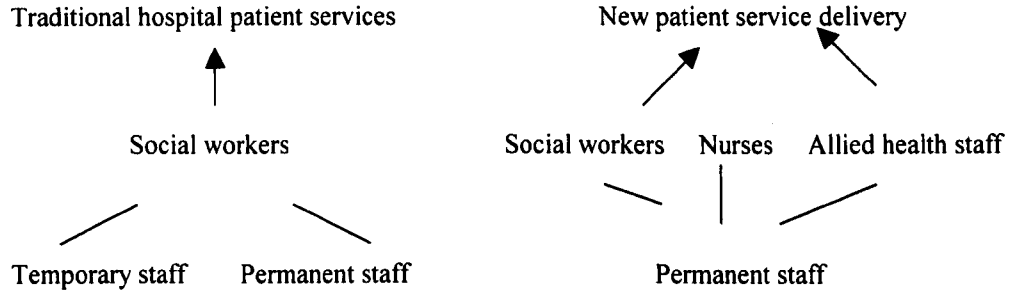
5.5.1 Extending traditional hospital social service to patient resource centres

From as early as 1920, the public hospitals in Hong Kong had considered social needs of patient. (Liu, 1991; *Kwong Wah Hospital Report*, 1996). However, the Social Welfare Department (SWD) managed the Medical Social Service (MSS) in the government hospitals. Medical social workers were SWD staff, who worked on a temporarily basis through a 2-year rotation schedule in hospitals. The community hospitals established their own Medical Social Services and their social workers staff identified themselves as hospital employees.

The PRC employed mostly social workers, but also nurses and allied health staff in the provision of patient services. These PRC staff reported directly to the Hospital Chief Executive (HCE) or another member of the senior

administrative team. The changing role of hospital in its delivery of patient service is shown in Figure 5.1.

Figure 5.1 Comparison on traditional and new hospital patient service delivery



5.1.2 The establishment of new patient care structures

Between 1993 to 1998, all thirty-eight public hospitals in Hong Kong reviewed the scope of patient services. Twenty-two public hospitals adopted new approaches, through the development of new patient service structures, to address a wider scope of care. Among these hospitals, some developed more than one structure in meeting the needs of their patients. Sixteen hospitals, however, did not develop any new patient service structure. The development of these new structures, collectively known as Patient Resource Centres (PRCs) and covered over 70% of the total number of hospital beds, will be described in the following sections. Table 5.2 provides a summary of Patient Resource Centres established by the public hospitals in Hong Kong.

Figure 5.2 Establishment of new patient structures in public hospitals (1993-1998)

Group	Name of Hospital	Name of new patient service structures
G1	Castle Peak	Patient Resource and Social Centre
G2	Fanling	/
G3	Hong Kong Eye	Patient Resource Centre
G4	Kowloon	Health Resource Centre
G5	Kwai Chung	Patient & Social Resource Centre
G6	Lai Chi Kok	/
G7	Pamela Youde Nethersole Eastern*	Community & Patient Resource Department
G8	Prince of Wales*	Health Support Centre
G9	Princess Margaret	Patient Service Centre
G10	Queen Elizabeth*	Patient Resource Centre
G11	Queen Mary*	Cancer Patient Resource Centre
G12	Shatin	/
G13	Siu Lam	/
G14	St. John	/
G15	Tang Siu Kin	/
G16	Tsan Yuk	Patient Resource Centre
G17	Tuen Mun*	Community Service Department
G18	Tai Po Hospital	Patient Resource Centre
C1	Caritas Medical Centre	Patient Resource Centre
C2	Cheshire Home (CHK)	/
C3	Cheshire Home (Shatin)	/
C4	Duchess of Kent Children's	/
C5	Fung Yiu King	/
C6	Grantham	Patient Resource Centre
C7	Haven of Hope	Health Resource Centre
C8	Hong Kong Buddhist	Health Resource Centre
C9	Kwong Wah	/
C10	MacLehose Medical Rehabilitation	Patient Resource Centre
C11	Margaret Trench Medical Rehabilitation	Patient Resource Centre
C12	Nam Long	/
C13	Our Lady of Maryknoll	/
C14	Pok Oi	Patient Resource Centre
C15	Ruttonjee	Health Resource Centre
C16	Tung Wah Eastern	/
C17	Tung Wah	Patient Resource Centre
C18	United Christian	Health Resource Centre
C19	Wong Tai Sin	/
C20	Yan Chai	Patient Resource Centre

G1-G18 government hospitals, C1-C20 community hospitals

*hospitals with more than one new patient care structures

5.2 A pioneer Patient Resource Centre (PRC) model

The Queen Elizabeth Hospital (QEH), the largest major acute regional hospital that has a size of 1900 beds, established the first Patient Resource Centre (PRC) in Hong Kong in 1993. QEH is an old hospital that was built in the sixties. As a response to the growing concerns of the nurses about their patients who have chronic illness, this PRC was an initiative to resolve some existing patient care issues in hospital.

5.2.1 Implementing a concept of total patient care

The paediatric nurses in QEH acknowledged the needs of many adolescent patients who spent their weekends in hospitals. These adolescents had chronic illness that required regular short-term hospitalisations. They can manage their daily injections at home but will stay overnight in hospital for a full blood transfusion process during weekends. Their school activities and social life were often interrupted. Many of these young patients obtained their emotional support through interaction with other patients. Some ward nurses volunteered to listen to their problems and interact informally with these adolescents. In the 30th anniversary of the hospital (in 1993), the movement of a public hospital "to promote comprehensive and integrated patient services" was publicised and the establishment of a new patient care structure was intended to encourage active staff, patients and community participation in the treatment process (Chang & Chan, 1995). The objectives of the PRC were to provide a higher level of patient support through guidance, education and training and to relieve stress and strain of patients. These were to be achieved by developing patient support groups, providing educational programmes for hospital staff and volunteers on patient support and improving access to health information and community resources for patients and families.

5.2.2 Physical arrangement to invite community partnership

This early PRC had a similar set up to some hospital resource centres in the North America (discussed in Chapter 3). A trained social worker with community work background was employed to operate the centre. The Centre, started as a small drop-in office, located near the main entrance and adjacent to other hospital patient support services such as medical social work department and chaplain's office. It has an information display corner. The office has a size of 200 square feet. The new initiative was intended to be a small-scale experiment, funded through community donation.

5.2.3 The management

The PRC in the QEH had its line of responsibility under the Public Relation Office in the beginning. A hospital general manager from allied health section was assigned to supervise the development of the PRC. A steering group was set up inviting representatives from different departments and outside parties such as tertiary training institutes. The Hospital Chief Executive (HCE) chaired the meetings. The sum of HKD $1.2 million, obtained through hospital charity activities, was expected to last for a 3- year experimental phase. By 1995, the management of the PRC moved under the clinical services.

5.2.4 Involvement of medical staff and medical orientation

The responsibilities of the PRC social worker included organising patient activities, training programs and developing information resource packages. The PRC started off by liaison with medical staff in the development of user-friendly health information leaflets. Health information for patients was specially designed to serve the general public. It involved translation of medical knowledge into Chinese language. These new information leaflets contained no technical jargon, but colourful and attractive design, and enlivened with

cartoons. Some doctors found the work interesting and enthusiastically assisted in the selection or translation of the materials.

5.2.5 Patient-centred Programs

The PRC adopted a patient-centred approach and all activities were to be organised in response to different patients' requests. Initiatives from all patients were regarded as important. Four disease-related groups, e.g., the Cooley anaemia, burn-injured, neuro-surgery and diabetic groups, pre-existed informally before the establishment of the PRC, were invited to move their activity site from hospital wards to the PRC. Five chronic patient groups were formed at its initial stage and the diabetic group was split into young and older groups later. The number of disease-related patient groups gradually expanded. The PRC provides program fees and staff provides some guidance but minimal assistance in the development process of patient self-help programs. These programmes were expected to promote health and quality of life of patients with chronic illnesses.

5.3 Emergence of different patient resource centre models

The QEH, being a leading hospital due to its history and size, expected its PRC approach to be widely considered as a model by other hospitals. Quite different from the original thoughts that derived from this pioneer model, within the same year, a different model was established.

5.3.1 Cancer Patient Resource Centre (CPRC)—total care for cancer group

The second Patient Resource Centre, developed by the Queen Mary Hospital (QMH) in the same year focused only on one specific disease-related patient

group. The support to other patient groups was to be continued through the medical social workers from the Social Welfare department. The needs of the cancer patients were considered to be special and more risky than other patient needs. It had similar physical design but a nurse and a social worker were employed to start the services. The needs of cancer patients were identified specifically to age and treatment programs. Examples of these patient groups included adult naso-pharyngeal carcinoma (NPC) group and breast cancer (Ca Breast) and children cancer groups. The objectives of a CPRC fostered its special attention related to the care of patients with critical illness and support to their families in going through death and dying. The Cancer Research Foundation fully funded this Cancer Patient Resource Centre (CPRC). The objectives of the CPRC included:

- Promotion of self-help and mutual help among cancer patients to strengthen morale and surviving pain

- Library service for cancer patients and families

- Counselling service for cancer patients and families, to relieve stress and develop positive living and confidence

- Mobilisation of community participation and support for cancer patients

- Public education about cancer treatment

5.3.1.1 Service priority for life-threatening disease group

Cancer disease has been "the top killer" in Hong Kong for many years. Culturally, the topic on death from an illness, which caused "unnatural" death, is also a stigmatised illness (Chan and Lam et al, 1997). QMH attended the taboo issues associated with cancer by giving professional advice to patients

and families. In contrast to the pioneer PRC model in QEH, which emphasised patient empowerment and self-help, the CPRC in QMH offered mostly direct professional intervention.

5.3.1.2 Addressing patient needs in using cultural medicine

The common practice of Traditional Chinese Medicine (TCM) by cancer patients, particularly when western medicine has limitation to provide complete treatment was discussed in the hospitals through the introduction of the CPRC patient-initiated activities. This was a new departure for the QMH, a western-oriented medical training hospital that did not provide any basis for staff to be involved in unconventional medicine. The hospital has seen the psychosocial and cultural needs of patients in using TCM. It was regarded as important by some medical staff that such involvement of the hospital would smoothen patient non-compliance problems (discussed in Chapter 2). Before this time, patients could not even discuss their choice of traditional medicine as an alternative to their treatment. The action taken by the training hospital to recognise a non-western orientation to health was well received by patients, who expressed gratitude openly in the public.

5.3.1.3 Patient preference and alternative medicine

The five oncologists interviewed in the five CPRCs later developed were agreeable to the promotion of alternative medicine for those patients diagnosed with a terminal stage. Their views were that most western-trained doctors could not offer much advice, except listening and sharing patients' concerns. However, such discussion activities could often bring to an agreement about interference on hospital treatment by choices or activities that were not recorded formally. There were also concerns about over medication by two courses of treatment taken simultaneously. Most patients and doctors had accepted that sequential application of different modes of treatments would be

more appropriate. In this study, (although this cannot be generalised beyond these oncologists seen), the oncologists were happy with the achievement of resolving a long-standing cultural issue in their patient's choice of treatment.

Some Chinese medicine practitioners were invited to provide educational activities in QMH. A variety of alternative healing programs such as "Chi Qong" (a marshal art that enhances blood circulation and physical strength), Reiki (a spiritual practice), or Yoga was organised by and for patients. Most patients and their families, as reflected in the patient interviews in this study, believed that traditional medicine could improve immunology thus, the chance of survival of patients with a terminal illness.

Many patients began to share information among themselves about Chinese medicine and effects of it. Activities on cultural medicine were very well attended. Stories about the magical use of herb and other treatment methods were shared freely in the CPRC. In fact, some commercial activities took place in the CPRC. The financial concerns of buying some expensive Chinese drugs turned into bulk purchase service, which lowered the cost of the drugs. For example, the "Ling Chi" (herb that commonly believed to be able to treat cancer and improve immunology) was bought in bulk and the sale to anyone concerned was reported in newspaper (Ming Pao, 1998) as it never happened before.

5.3.1.4 Health-related Quality of Life programmes for young patients

Parents with children suffering from cancer disease were not satisfied with the CPRC activities. Their participation in the development of children cancer services resulted in an innovative activity specially designed for paediatric patients with a critical illness. The parents established the Children Cancer Fund, to separate their concerns from the adult patients. Overseas specialists

were invited to train parents or to conduct play and "laughter" programmes in the hospitals for the young sufferers. Two major goals, fun and laughter, were identified by parents as important components to balance the treatment process. The parents felt if their children have shorter life expectancy, they should have equal opportunity to laugh and enjoy life. There was strong linkage between the parents and mutual support manifested when a child passed away.

5.3.1.5 Successes and positive feedback

The CPRC marked a different patient care approach in Hong Kong. In 1994, such an initiative was recognised as a positive approach to address the needs of those with critical illnesses. The management accepted the effectiveness of such approach, described as changing the disease-focused approach to a warm and genuine caring perspective, and the operation cost of a CPRC was to be absorbed by the hospital annual budget. Subsequent to the confirmation of the role of a CPRC in QMH, five other hospitals developed their CPRCs. A list of the hospitals that established CPRC is listed below. (Figure 5.3.1)

Figure 5.3.1 The five public hospitals with Cancer Patient Resource Centre

Hospital	**Name of the patient service structure**
Queen Mary	Cancer Patient Resource Centre
Tuen Mun	Cancer Patient Resource Centre
Pamela Youde Nethersole Eastern	Cancer Patient Resource Centre
Prince of Wales	Cancer Patient Resource Centre
Queen Elizabeth	Cancer Patient Resource Centre

5.3.2 Patient Resource and Social Centre --Psychiatric services

The third PRC model was established by a psychiatric hospital, the Kwai Chung Hospital (KCH). The KCH serves only psychiatric patients. A Psychiatric Patient Resource Centre was developed to consolidate 12-years' experience in patients' pre-discharge program in KCH. The occupational therapists and nurses worked jointly and developed the hospital pre-discharge ward into a patient centre with social emphasis. More "social resource" material was provided to prepare patient discharge when they return to the community. The nature of "Social Resource" has highlighted as significant in the integration of care for the psychiatric patients who would continue their rehabilitation in the community. There were no new information leaflets developed by the PSRC. Instead, popular reading material use and television videos were provided for patients. A social worker was employed to provide support to the families. Family members of the younger patients, mostly middle-aged mothers, were involved in the pre-discharge interviews or guidance session. The Centre intended to support patients' employment and to strengthen family relationship. Employment supports such as photograph taking and job application, interviewing skill and dress code advice was provided by the hospital. During the researcher's visit to the PSRC, the staff sincerely commented that such approach was effective, in particular, the training of social conversation was practical in job interview. A job was essential for a young patient to become a member of the community.

5.3.2.1 Needs related to the length of stay in hospitals

Another psychiatric hospital with similar background, the Castle Peak Hospital (CPH), modified the KCH approach and designed a Social Centre model to serve other social aspect of patient needs. This social centre model was to enhance quality of life of the psychiatric patients. There was no social centre

specifically established for psychiatric patients in the community. The average length of stay of the psychiatric patients in KCH and CPH were as long as 6 -12 months respectively. The hospital-based social centre now provides psychiatric patients a place to interact informally and socially inside a hospital environment.

5.3.2.2 Standardised psychiatric patient service delivery

Although the two psychiatric hospitals took slightly different approaches to address the needs of their patients in the beginning of the development process, a consensus model was achieved by the two hospitals. The names of the two new hospital structures, PSRC in KCH and PRSC in CPH, became standardised into Patient Resource and Social Centre (PRSC). (Figure 5.3.2)

Figure 5.3.2 The two psychiatric hospitals with social centres

Hospital	**Name of patient service structure**
Kwai Chung	Patient Resource and Social Centre
Castle Peak	Patient Resource and Social Centre

5.3.3 Shared care approach-- linking up the private practitioners

Caritas Medical Centre (CMC) established the fourth PRC model. While the PRCs in QEH, QMH and the psychiatric hospitals were given different names to the centres; the PRC of the QEH has the same name as the one in QEH, i.e., the Patient Resource Centre.

The CMC, however, adopted a different approach that had made it distinct from the other three (QEH, QMH and psychiatric hospital models were discussed in sections 5.2, 5.3.1 and 5.3.2). This PRC implemented total patient care through its linkage with the private doctors in the community. The

discharged patients from CMC, sometimes, attended private clinics. There was no patient services provided by private practitioners' clinics. Some patients return to hospital not for medical treatment but for supportive programmes (Chapter 7 has data on patient support programmes for different patient groups as provided in the community).

The PRC in CMC took the initiative to form a patient service network with the private doctors. It opened one-third of its service quota to those patients using private services. These private patients could self refer themselves or through the private doctors to make such arrangement. However, for CMC patients, the attendance of educational health programmes by these patients who used private clinics would be charged with a higher fee, compared to CMC patients. The experience of such shared program and cost approach, as reported by staff and patients, was positive and had significant to the public hospital. For example, the hospital dietician provides nutritional information, recipes, and alternative meal preparation methods for diabetic patients. These services would not be available in private clinics. The diabetic patients have choice to see their own private doctor if they can afford. The clinics are often closer to their homes and less crowded. Feedback from dieticians, hospital staff and other community providers on hospital services used by private sectors would be discussed in Chapter 6 (section 6.2).

5.3.4 Patient Resource Centre with a New Town approach

The joint efforts between the public hospitals and community were strengthened by the total patient care approach. Two new acute regional hospitals, built in mid 1990s, adopted a community approach in their patient service development.

5.3.4.1 Integration of health and social needs

The Tuen Mun Hospital (TMH), newly built to serve population in a new town had experienced some patient admissions due to similar social problems. The admissions related to youth suicides or problem gambling and loan shark issues were identified by the hospital as high risk and thus required different strategies to address such specific needs in a new town. Three prioritised service approaches were trial by the TMH.

Issues such as isolation, work stress and financial issues resulted in problem gambling were tackled through stress management training by prevention programs conducted by clinical psychologist. The TMH also invited three targeted service groups from the community to participate in hospital activities. A social worker would co-ordinate hospital staff to support such hospital-patient interaction and a hospital administrator would recruit these community groups to join the hospital volunteer activities. To emphasis on its preventive approach and socially focused, the centre was named as a Community Services Centre (CSC).

5.3.4.2 Administrative and professional collaboration

The role of hospital administration to link up with its community in the primary health prevention was formally defined in this approach. Professional psychological support to school teachers who had to work with young people in the community directly was a secondary prevention approach for the high suicidal rate identified in this particular community. The CSC also organised preventive activities for young people, perceived by the hospital as an attempt to address the "over-demanding" school issue on students. These students were also invited by the hospitals to join volunteer activities, through which social

and recreational programs were organised as "reward program" for their involvement.

The three specific groups: the secondary school students, adult workers and housewives were recruited through liaison with schools, offices and other community social centres. The hospital management offered flexible timetables for these volunteers. For instance, housewives could volunteer between school hours of their children. Secondary students came after school. The working adults volunteered during weekends or in the evening. The hospital also established this network within the local community. Unlike the other PRCs, where social workers or nurses played the major role, in the CSC, the administrator and psychologist took the more active roles.

5.3.4.3 Hospital role in developing a healthy community

The TMH staff discussed their concept of total patient care with the researcher in the site visit. As the administration had encouraged positive aspect and mutual benefit through hospital and community partnership, the building of a healthy community would become their ultimate goal of a total patient care. For instance, the young volunteers serve the elderly patients by accompanying them during their stay in hospitals learnt to interact with the elderly patients. Their life experience had extended beyond their school life.

5.3.5 Patient network approach --Community and Patient Resource Centre

The Pamela Youde Nethersole Eastern Hospital (PYNEH) was built around the time as the TMH but it served an old district in a mixed industrial and residential area in Chai Wan. The hospital name indicated its influences from three major groups in its establishment, i.e., the government (Pamela Youde, wife of the late governor), religious (Nethersole group) and the local community group (Chai Wan is in the Eastern district of Hong Kong).

5.3.5.1 Hospital networking with high risk community

The PYNEH adopted a community approach for its total patient service initiative. Its approach was different from the TMH by its targeting strategies and linkage with the community. It focused with the most high-risk client group, for example, there were policemen who shot themselves after having trouble from habitual gambling and unable to return money to loan sharks. Clinical psychologist in PYNEH offered professional intervention to these policemen and their families. The hospital-community linkage was established with a smaller group, i.e., the Police Department, located across the street from PYNEH. The major target group that PYNEH identified for its total patient care development was the working adults who had different stresses from their employment, and illness that led to changes in job status.

5.3.5.2 Ex-patient support networks

The PYNEH shared the same orientation but modified the volunteer approach of that in TMH. The PYNEH focused on the strength and experience of those patients who had gone through a hospital treatment program. A new "Rehab Power" concept was developed. For those patients who had completed treatment, these services would be continued to prepare them to move onto self-sufficient activities.

The "Rehab Power" was promoted by the hospital as an important personal experience and also a resource to support other patients. The focus of the PYNEH was to develop these patient resources. It carried a new PRC name, the Community and Patient Resource Department (CPRD), which highlighted its collaboration with the community, specifically with the ex-patient groups. In its first year report, such involvement to maximise health benefits for patients and the community was discussed *(internal report in PYNEH, 1996)*. The hospital

provisioned a site for patient volunteers to experiment their mutual benefit activities through the development and management of "tuck shop" which carry patient daily use items. It resembled a convenient store. The patient items on shelf ranged from magazines, diabetic blood sugar testing strips, consumable catheters and others. No Chinese herbs or medication were involved. This tuck shop was also a place where some patients could re-establish a work patterns, for instance, those with severe chronic disease or psychiatric problem.

This tuck shop model was emulated in many hospitals, and in hospitals which did not establish any PRC (e.g. the Shatin Hospital). The Rehab Power tuck shop had become a self-financed and patient-managed facility, found in hospital lobby.

The role of the hospital to facilitate interfacing between the hospital and a specific functional community of ex-patients was achieved through the objectives:

- To promote mutual help among patients and their family members, through encouraging mutual help groups and providing better access to information

- To provide psycho-social support to patients through support groups and educational programmes, in order to optimise the patients' ability to cope with disease and treatment

- To promote community participation in patient care and the hospital service, with the aim of establishing a supportive network to address patient needs

- To serve as an information resource and referral centre for patients, family members and the community

- To promote health awareness within the community, in order to achieve better health care and more effective prevention

A new team of four social workers was employed by the hospital to deliver the patient programme. As an integral part of the hospital, funding was provided from the hospital account. Examples of the ex-patient network approach were listed in Figure 5.3.5

Figure 5.3.5 Examples of ex-patient support provided by the Community Patient Resource Centre

Ex-patient Networks	**Hospital Involvement**
Community Rehabilitation Network	Hospital staff to provide health talks on different chronic diseases and training for the Community Rehabilitation Network
Down Syndrome Association	Training of social work students in their work with clients with Down Syndrome and their parents
Glaucoma Association	Joint educational programmes on nutrition and eye problem for in-patients and ex-patients held in the hospital
Stoma Association	Joint project to prepare patients to manage colorectal (artificial rectum) at home
Cardiac ex-patient groups	Staff to provide knowledge on heart problems for the patients
Community and youth centre in Eastern District	38 hospital visits 9 volunteer training activities 28 service projects
"Rehab Power" patient items tuck shop	Hospital to support ex-patient volunteers in its tuck shop --the sale of patient items

Source: PYNEH report 1996 (with permission)

5.3.6 Health Resource Centres

The United Christian Hospital (UCH) developed a different PRC that emphasised health-related services for the community. This first Health Resource Centre (HRC) provided health education material, including video, educational packages and equipment to serve patients and the general public. A nurse educator was appointed to organise regular health talks to promote health awareness in the community.

The PRC models discussed in sections 5.2 - 5.3.4, involved only large public hospitals, sized over 1000 hospital beds. The UCH, a medium-size general hospital) developed a different approach to expand their patient care by a Health Resource Centre (HRC). The HRC focused on provision of health information. Other hospitals with similar size, for example, the Ruttonjee Hospital (RH) readily established a similar approach. The health information available for patients and the community was considered to be most important as far as hospital resources could manage. Six hospitals emulated a similar HRC model. The Prince of Wales Hospital, a large public and teaching hospital (background similar to QEH and QMH), called its centre by a slightly different name, the Health Support Centre. (Figure 5.36)

Figure 5.3.6 The six hospitals with a health resource centre

Hospital	Name of new patient service structure
United Christian	Health Resource Centre
Ruttonjee	Health Resource Centre
Kwloon	Health Resource Centre
Haven of Hope	Health Resource Centre
Hong Kong Buddhist	Health Resource Centre
Prince of Wales	Health Support Centre

5.3.7 "In-between" approach: Combined traditional Medical Social Service cum Patient Resource Centre (MSS/PRC)

There are many small hospitals in Hong Kong. For instance, the Margaret Trench Medical Rehabilitation Centre (MTMRC) has only 80 in-patient beds. The MTMRC established their PRC by its joint operation with the Medical Social Service run by the Social Welfare Department. This PRC, unlikely other PRCs that were set up to separate from the traditional hospital social services provided under non-hospital administration, has its semi-independent administrative structure. There were two social workers in the MSS. One social worker was employed by the PRC and this social worker will be supervised professionally by the social worker in the MSS and administratively responsible to the Hospital Chief Executive. The MTMRC modelled after the QEH, but with smaller scale and served only two patient groups, the orthopaedic and geriatric patients.

5.3.8 Hospitals without a Patient Resource Centres

While twenty-two hospitals were involved in the development of new patient service structures, there were sixteen public hospitals that did not have one after a five-year period of consideration. These hospitals varied in size, location, and nature of patient services. These hospitals included both government and community hospitals. About half of the community did not develop any Patient Resource Centre at the end of this five-year study. Inquiries were made in 1997 and hospital spokesmen replied with hesitation about the development of a PRC in the future. Two larger hospitals, the Lai Chi Kok Hospital and Kwong Wah Hospitals, replied that since the other large hospitals had PRC, they might eventually develop one. Only the Lai Chi Kwok Hospital established a PRC in 1998. For the Kwong Wah Hospital, as informed by a key staff in the hospital, the hospital management had discussed the issue and

confirmed that no PRC would be developed. Table 5.5a provides the distribution of hospitals without a PRC.

Figure 5.3.7 Distribution of public hospitals not having a PRC (as of 1998)

Government Group	Community Group
Fanling	Cheshire Home (HK)
Tsan Yuk	Cheshire Home (Shatin)
Shatin	Duchess of Kent
Siu Lam	Fung Yiu King
St. John	Kwong Wah
Tang Siu Kin	MacLehose Medical Rehabilitation Centre
	Nam Long
	Our Lady of Maryknoll
	Tung Wah Eastern
	Wong Tai Sin

5.4 Variations of the new patient care structures

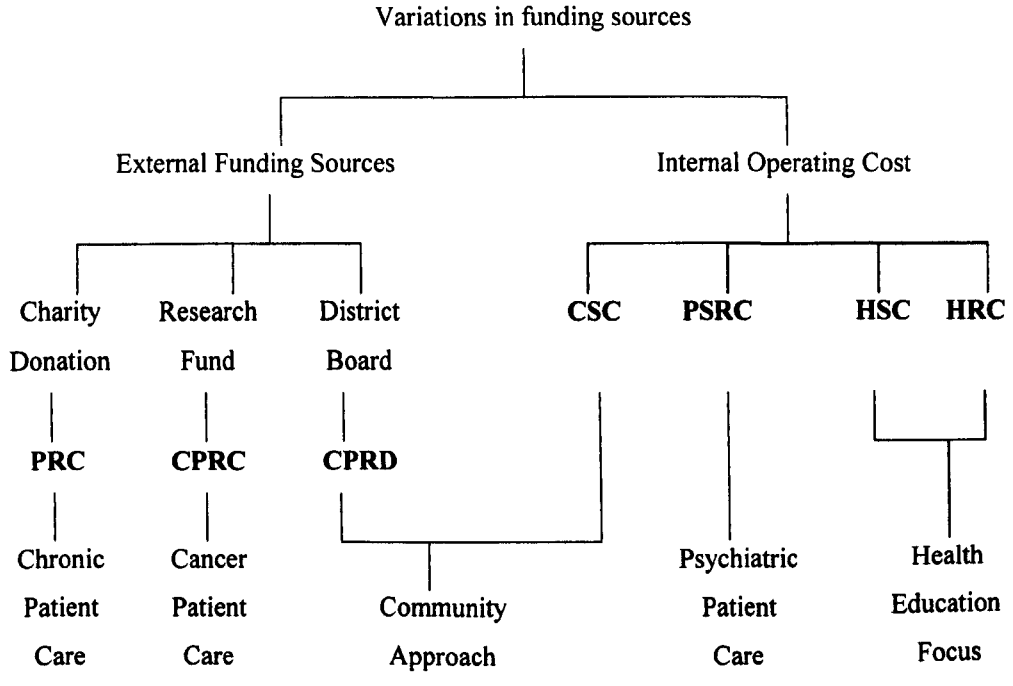
Although all the hospitals had indicated interest in the concept of total patient care, the evidence from this study suggested that a full implementation of a total patient care policy did not happen at the end of a five-year path-finding process. During the five-year period of "experimentation", some of the twenty-two hospitals that developed a new PRC structure had established another PRC to serve a specific patient group (i.e. the 5 Cancer Patient Resource Centres CPRCs) within the same hospital environment. The differences in the development of total patient care were questioned from time and time. The size and the resource, according to the findings, were not key determinants to hospital involvement in the development of total patient care. The following sections will summarise observations from the study with an intention to provide some possible explanations.

5.4.1 Financial sources of influences

There were different sources of financial funding involved in the development of new patient care services. Charity donation, research fund and district board had been invited to contribute in the cost of employing new patient care staff. Some hospitals were able to mobilise internal resources and develop their new service structure. Figure 5.4.1 illustrated that some influences are possible from the funding body on the development of cancer patient service (CPRC). However, external funding sources and the influence from funding body for the general patients in the QEH (PRC) did not occur. Internal hospital funding could have developed into PSRC in KCH and other Health Resource Centres HSC or HRC). It was interesting to find out from the study that both internal and external funding could result into similar community-oriented patient service approach (CPRD and CSC) in different hospitals. (Figure 5.4.1) It was thus, as a preliminary conclusion, funding source alone would not determine the orientations of patient care development.

Tables 5.4.1 Development of new patient care models (Variations in funding sources)

Development of new patient care models



5.4.2 The size of hospitals and its financial strength

The large hospitals were expected to have more financial resources to manoeuvre. Nine out of eleven large hospitals developed new patient service structures to implement total patient care. There were also smaller hospitals, which developed PRCs. The average size of the twenty-two hospitals with PRCs was 892 beds, twice as much as that of the hospitals without a PRC (an average number of beds was 387 beds). (Figure 5.4.2)

Figure 5.4.2 Comparison between size of hospitals with PRCs and no-PRCs

Hospitals with PRCs	**Hospitals with no-PRCs**
Average number of beds in the 22 PRC Hospital group = 19619/ 22 = 892	Average number of beds in the 16 no-PRC hospital group = 6194/ 16 = 387

5.4.3 Difference in the pace and involvement in developing total patient care

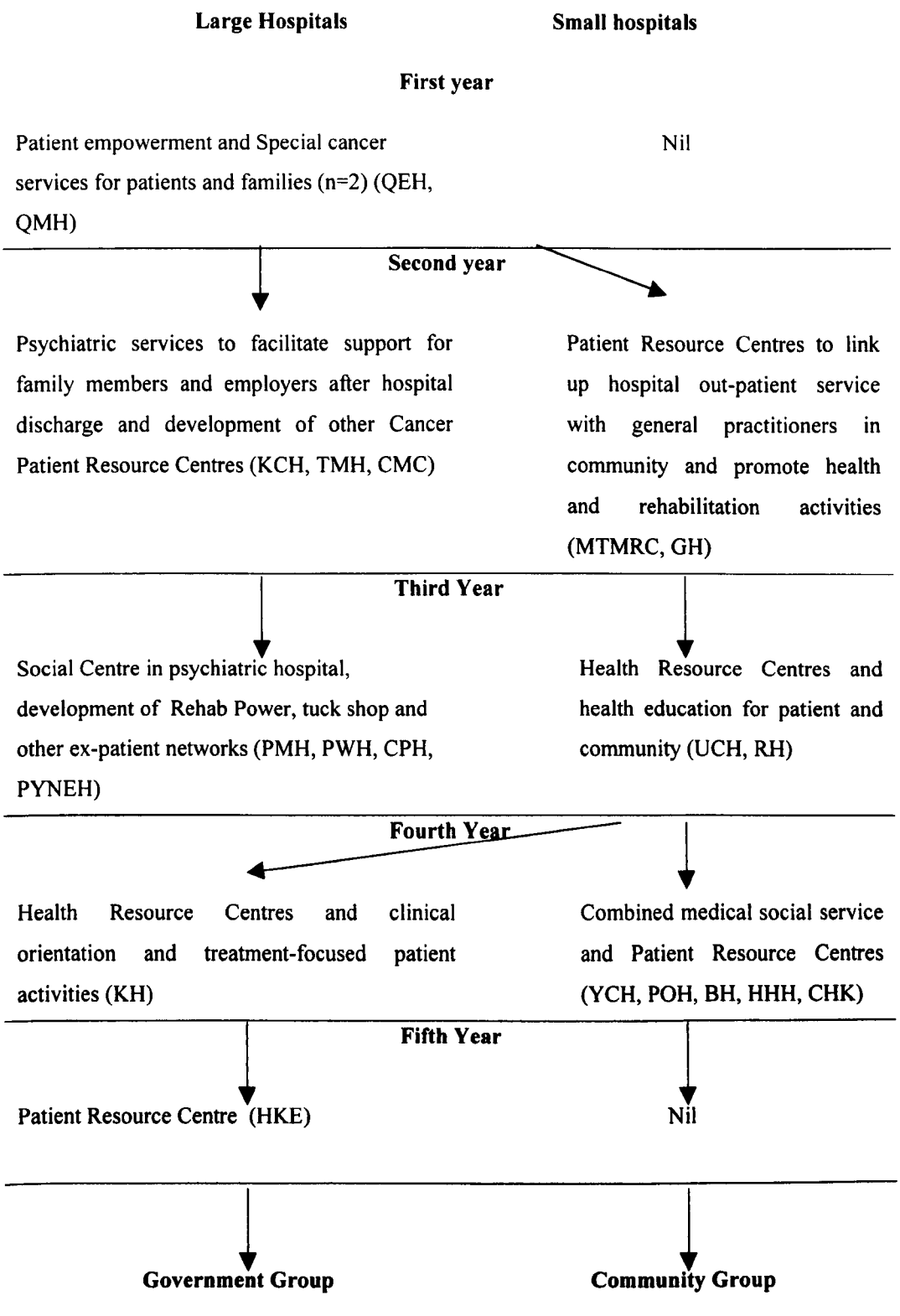
There was also difference in the pace of developing new patient structures. In the first year of the development of new services, only the large hospitals were involved. Starting from the second year, both large and small hospitals developed their new service simultaneously. The involvement of such development in the medium-size hospitals did not begin until the third year when the Grantham Hospital had a new and different focus in their patient care. The other medium hospital, the United Christian Hospital also chose a Health Resource Centre model.

The involvement of the large public hospitals seemed to take the lead in its pioneer patient care models. However, new models emerged in different hospital settings. As it is the purpose of this study to understand the historical

influences on the development of patient care approaches, the government and the community groups (historical factor) of public hospitals will be analysed with respects to its size (operational factor) and historical aspects in the following sections.

The pace of development of total patient services in the government hospitals was observed to be more active with continuously development in the PRCs throughout the 5-year period. The community hospitals did not start with the government hospitals in the first year. There was less variety of models in the community group. The development of the community hospital group was concentrated within a period of three years. However, there was emulation of models between the groups starting from the fourth year. (Figure 5.4.3)

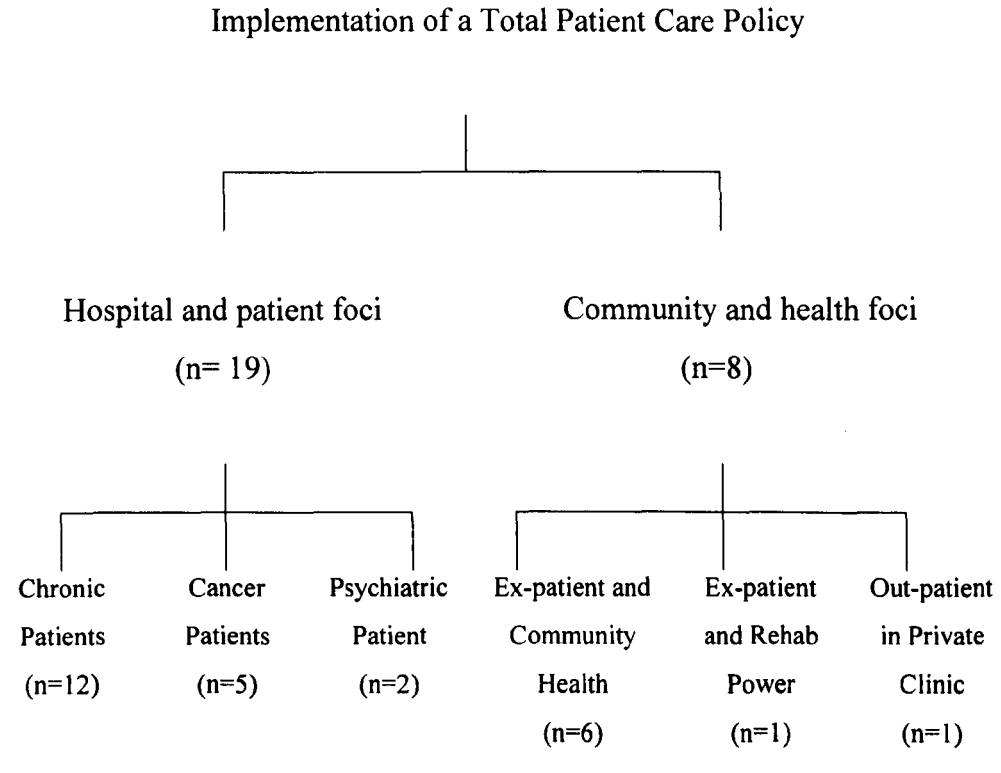
Figure 5.4.3 Chronological development of PRCs in Hong Kong (1993 - 1998)



5.4.4 Different patient care approaches

There were twelve Patient Resource Centres (PRCs) and other health and community focused models developed. The PRCs focused on delivering patient-centred service at a patient-user level through self-help, peer group development and family support activities. The two social resource centres (PRSC/ PSRCs) for psychiatric centres also had similar orientations but with a stronger emphasis to introduce social and recreational service into the hospital by a new structure similar to a community service centre. Staff shared with the researcher that there was as a lack of support for the psychiatric patients and their families in the community. Thus, the need of such structure within hospital environments was justifiable. There were six Health Resource or Health Support Centres (HRC/ HSCs) established to enhance patient support through health information or educational programs. Community Service Centre and Community Patient Resource Department (CSC/ CPRCs) were two models initiated by two government hospitals to implement a total patient care policy. (Figure 5.4.4)

Table 5.4.4 Different orientations in the Patient Resource



5.5 Analyses on the development of different total patient care models

5.5.1 History of the hospitals and demographic factor

The development of the new community-focused approach in TMH and PYNEH marked a different trend of patient service development in the government hospitals.

The experience in Hong Kong has suggested that the older the hospitals, there was a likelihood to have a larger group of chronic patient requiring follow-up services. Their needs accumulated across time inside the hospitals had raised demands for changes in patient support services. In 1990, there was an estimation of 223,000 chronic patients attending public hospitals for follow-up

services (Chan, Wong et al, 1992). The QEH and QMH had addressed the needs of chronic patients through the development of patient-centred approach. The two hospitals adopted different approaches with different orientations on who should have priority to the new and comprehensive care mode of services. The other large hospitals, five of which developed both Patient Resource Centre and Cancer Patient Resource Centres to address the different concerns of their patients and some chose to develop one of the two.

Contrast to the experience of these old hospitals, the new hospitals did not have an existing demand from its accumulated chronic patient population. The expectation on these two hospitals to select either a Patient Resource Centre or a Cancer Patient Resource Centre to start their patient care model did not occur. These two new hospitals appeared to start from a community and preventive orientation for their patient care development.

Table 5.5.1 Comparison between old and new hospitals in patient service approaches

Hospital and demographic factors

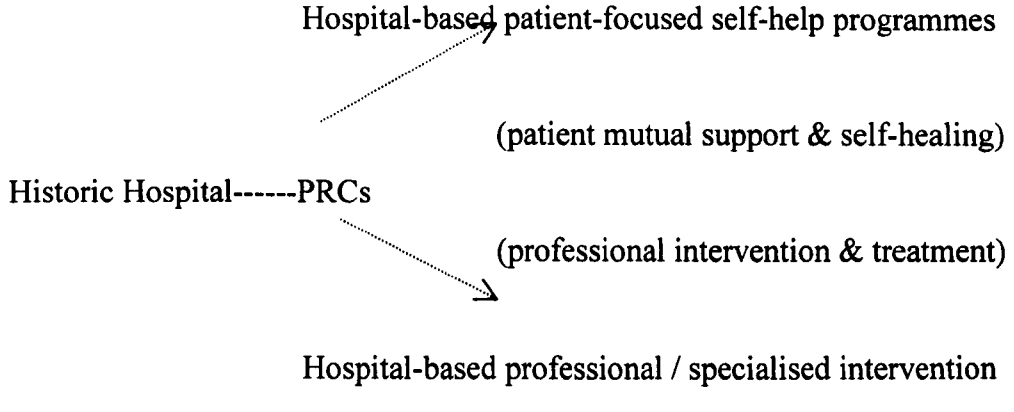
Historic Hospitals (Built in the 1960s)		**New Hospitals** (Built in the 1990s)	
Hospital-oriented	**Total Care Initiatives**	**Community-oriented**	**Total Care Initiatives**
QEH	Chronic Patients self-help activities	TMH	Early Community Network and Prevention
QMH	Specific disease groups and Professional Intervention/ treatment	PYNEH	Ex-patient Support Network and Integration

The determinants discussed by Wolinsky (described in Chapter 2) were applied to analyse the differences in the development of the various PRC models. The four different approaches adopted by the four large government hospitals were branched from hospital orientation into different patient service delivery. (Sections 5.5.2 - 5.5.5)

5.5.2 Organisational factors

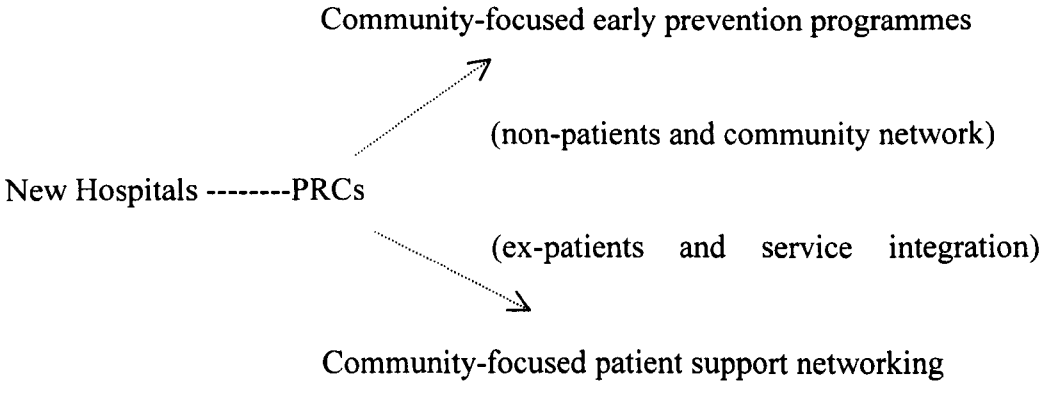
The two historic hospitals developed different service delivery approaches. The QEH focused on patient peer support programmes while the QMH provided direct intervention from professional staff.

Fig 5.5.2a Professional intervention in historical hospitals



The two new hospitals, TMH and PYNEH, had involved different manpower in the new patient services. The objectives of the two PRCs were different. TMH focused on primary prevention and community health promotion. PYNEH focused on secondary prevention, working on the problems developed from illness and established preventive goal.

Fig 5.5.2b Community-focused services in new hospitals



5.5.3 System factor

All eight large government hospitals developed one while two-third of the large community hospitals did not establish any Patient Resource Centre. The Kwong Wah Hospital was the only large public hospital that did not have a PRC. It maintained its solidarity from other public hospitals with similar financial and nature of patient service background (Table 5.5.3a).

Table 5.5.3a Distribution of new establishment of patient care structures (large hospitals)

a) Large hospitals (n=11): 1000 beds and over			
PRC establishment	No.(%)	No new establishment	No.(%)
Government group	**8 (100%)**	**Government**	**0**
Community group	1 (33%)	Community	2 (66%)

All five medium community hospitals developed new patient care structures, four of which had their Health Resource Centres. Yan Chai Hospital had a PRC. The four community hospitals that had a HRC were of religious

background, i.e., the United Christian Hospital, the Haven of Hope Hospital, the Ruttonjee, which was associated with overseas missionaries in its early development to serve the lung patients and the Hong Kong Buddhist Hospital. (Table 5.5.3b)

Table 5.5.3b Distribution of new establishment of patient care structures (medium hospitals)

b) Medium hospitals (n=9): 400 beds to 1000 beds			
PRC establishment	No.(%)	No new establishment	No.(%)
Government group	2 (50%)	Government	2 (50%)
Community group*	**5 (100%)**	**Community**	**0**

*Four of these five PRCs were known as Health Resource Centres

About half of the public hospitals were small hospitals with size less 400 hospital beds. The development of PRCs in these small hospitals was low as compared with the large and medium hospitals. The demographic and resource factors could be argued as most influential factors. However, there were more government hospitals which established patient resource centres in the government group than the community group. The pattern of development of total patient care was more varied in the small hospital groups. (Table 5.5.3c)

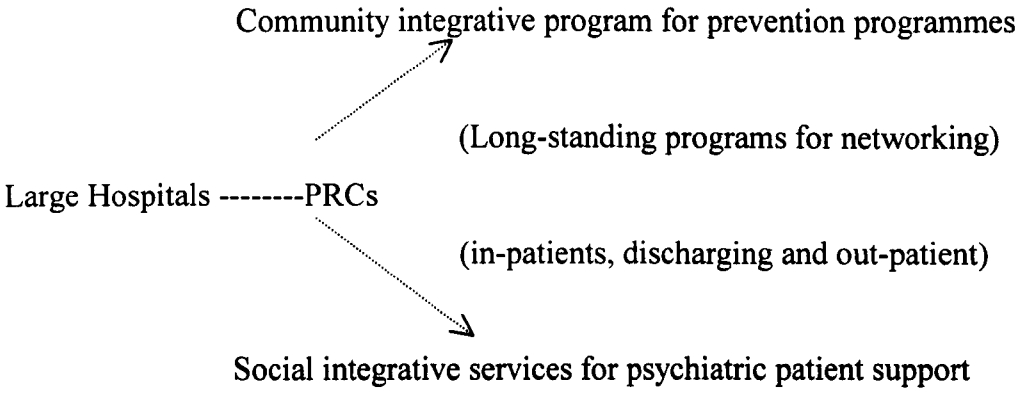
Table 5.5.3c Distribution of new establishment of patient care structures (small hospitals)

c) Small hospitals (n=18) : Less than 400 beds			
PRC establishment	No.(%)	No new establishment	No.(%)
Government group	2 (33%)	Government	4 (66%)
Community group	3 (25%)	Community	9 (75%)

The establishment of new PRCs in large hospitals tended to provide long-standing and integrative programmes for patients (e.g. QEH, QMH, PYNEH, and KCH). The medium-sized hospitals tended to provide health educational programme on a small scale.

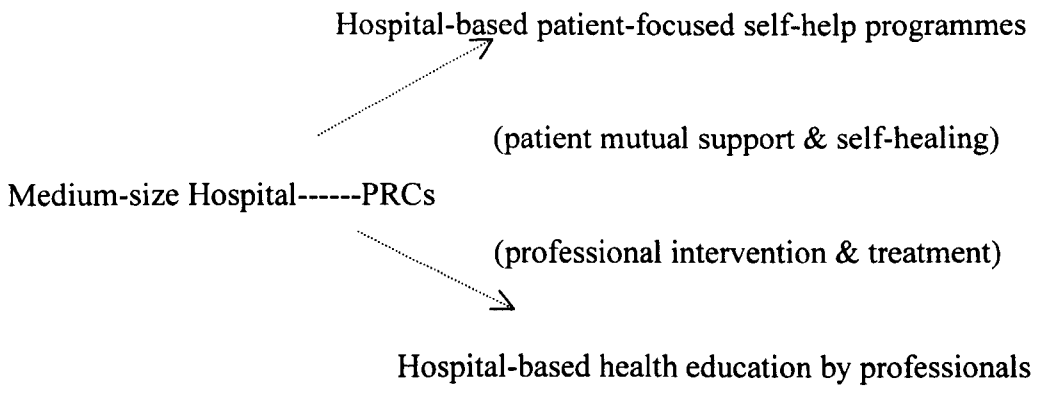
The large government hospitals seemed to provide more "expensive" patient programs which were long-standing in nature and with hospital-focused integrative support program.

Figure 5.5.4a Variations in program design (large hospitals)



The medium size and small hospitals, mostly community hospitals developed different program strategies in their implementation of a total patient care policy.

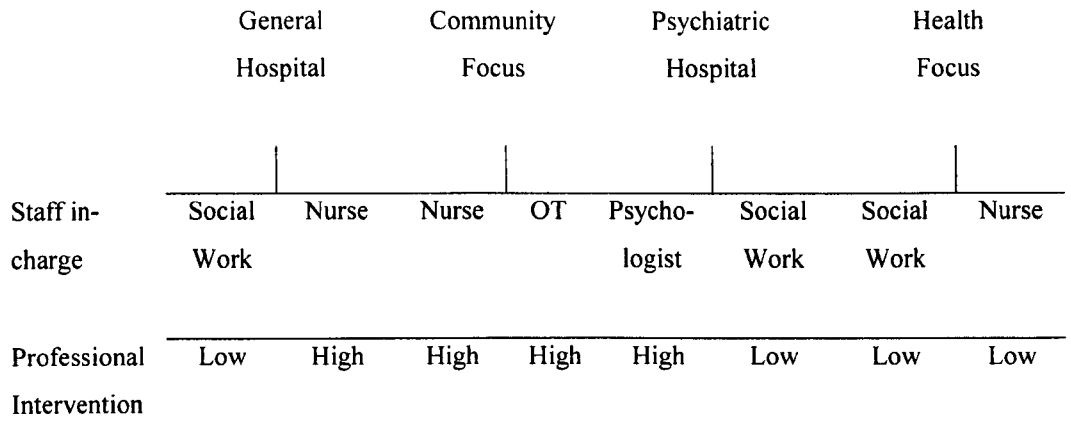
Figure 5.5.4b Variations in program design (medium and smaller hospitals)



5.6 Professional involvement in the development of totality of care models

Most hospitals employed social workers with community work experience to operate the PRCs. However, The Health Resource Centre in-charge, are usually nurses. Occupational therapists are in-charge of Patient and Social Resource Centres in psychiatric hospitals. The new town model (Tuen Mun Hospitals) appointed clinical psychologist and hospital administrator to work with the social worker in the CSC. The emphases on professional Intervention varied in PRCs that have different orientation. Patient Resource Centres that intend to provide patient empowerment activities, e.g., QEH, PYNEH and PWH, had less direct professional intervention but more equipment to facilitate self and peer support activities. Hospitals that provide less costly programmes used hospital funding instead of soliciting community fund. Figure 5.6 provides a summary of the staffing and degree of professional intervention in different PRC models.

Figure 5.6 Variations in staffing and degree of professional intervention



5.7 Multiple sources of influences in the development of total patient care delivery

There were different factors illustrated by the hospitals in the choice of a PRC delivery model. Multiple sources of influences including the hospital background, resource factors and patient variables could have affected the formation of these models. Figure 5.7 further described the variations in staff expertise and the extent of professional involvement in the delivery of total care by different hospitals adopting different approaches. The social approach tended to focus on empowering patients through enhancing their self-help and mutual support activities. The involvement of nurses and allied health staff in both hospital and community foci were often associated with direct professional intervention except in health focus approach, when information was provided through lecturing or small discussion groups.

Figure 5.7 Different strategies in the development of Patient Resource Centres

Hospital factors Affecting service model development		**Patient-focused Support**		**Health-focused**	
		Patient Focus	Disease Focus	Promoting use of alternative healing	Not using cultural medicine
Historic hospitals	Hospital-based patient services	Patient Resource Centre	Cancer Patient Resource Centre	Cancer Patient Resource Centre	Health Support Centre
New hospitals	Community-based preventive activities	Community & Patient Resource Department	Nil Patient's choice: Health Information via computer web page		Community Service Centre
Large hospitals	General hospital	Patient Resource Centre	Cancer Patient Resource Centre	Herbal clinic in community hospital	Patient Service Centre
	Psychiatric hospital	Patient and Social Resource Centre	Patient Resource and Social Centre	Nil	
Medium/ Smaller hospital	Government Hospital	Patient Resource Centre	Nil		
	Community Hospital	Patient Resource Centre/ Medical Social Service	Health Resource Centre	Community health projects	Health Resource Centre

5.7.1 Age-related patient support programs in the community

The needs of the younger patients differed from the adult group were specified by community funding bodies, for instance, the Cancer Foundation and the Children Cancer Foundation. The cancer programs in the Cancer Patient Resource Centres had separated the activities into adult and children groups.

5.7.2 Separation of patient service development and service gaps in the total patient care delivery

It was observed that there was no health preventive approach identified or provided by psychiatric hospitals. Computer facility for patients to access information is provided in the new hospitals, which in fact replaced the health information service provided through printed information leaflets. New hospitals, built with modern information technology facility, have focused on community-based health education instead of individual or smaller group activities in disseminating health information. Some illustrative activities of the PRC can be found in Appendix 7.

Conclusion

Seven major models of total patient care were identified from the study. The implementation of a total patient care concept by different public hospitals can be accounted by their historical background, demographic; organisation and system (including technological) factors were similar to the literature (discussed in Chapter 2). However, there were differences due to historical development of public hospitals and community hospitals. The feedback on the changes in health care system by different stakeholders was collected from focus group discussion. The different opinions, which affected the choices and

perception in the development of total patient care, were examined and reported in Chapter 6.

Chapter 6 Finding II: Different views of the health care stakeholders

The chapter continues with the discussion of influences that affected the implementation of total patient care. The total care model proposed by the Hospital Authority asserted the intention to move away from compartmentalised services by adopting an integrative concept. Opinions from different parties involved in the process of developing co-ordinated services that can meet patient's multiple concerns of patients were considered to be significant by the new system. This chapter summarises the data collected from a series of five focus group discussion sessions. As the focus groups discussions were voluntarily signed up, the focus group membership was not pre-determined by the researcher. The different views of the discussants were summarised into group views representing interests of the different stakeholders, namely, the patients, practitioners, administrators and policy planners.

The common theme of these five focus group discussions was cored around the changing health care environments. These focus group participants were recruited through the Patient Resource Centres and were held in three different hospital settings. Seventy-seven participants involved in the focus group discussions.

Table 6.1 Participation of stakeholders in 5 focus group discussions

Hospital stakeholders	No. of Participants
Patients including ex-patient, out-patients & families	36
Health care practitioners and community service providers	16
Hospital managers and administrators	14
Health educators and policy planners	11

There were ex-patients and outpatients (n=36) participated in the discussion sessions. Frontline staff was multi-disciplinary staff currently involved in direct service to patients. The hospital managers were administrators and policy planners included staff from other government departments, i.e., Department of Health, Social Welfare Department and the policy bureau. Guideline for data collection and information on focus group participants can be found in the Appendix 5.

Due to the large quantity of information collected, the views of different individuals, i.e., the service users, practitioners, the hospital managers and health care planners were summarised as interests representing one of the four stakeholder groups. Only illustrative examples can be cited. A backward mapping sequence was applied to organise and compare views between stakeholders, starting from the bottom to the top levels, in terms of successes achieved difficulties in implementation and concerns for future development. These discussions reflected their opinions on the issues in 1997.

6.1 Patients' perspectives on total care delivery

During the site visits (findings in Chapter 5) and focus group discussions, patients attending the PRCs were positive about the new changes in hospitals. Although the concept of total care was not clear to many patients, patients did not have difficulties to share their ideas about what was needed in addition to medical treatment. The family members also readily provided ideas on how to improve their health-related quality of life. Five major components identified in the focus groups as important will be discussed in 6.1.1. As we can see later, due to the differences in perspectives between stakeholders, the development of the total care concept had hurdles that needed to be leaped.

6.1.1 Developing a patient-centred approach

The users' feedback on the development of new patient care structures are categorised into (a) Physical facility, (b) Peer support, (3) Pleasant encounter or balance to maintain emotional equilibrium, (d) Personal touch and linkage to hospital system and (e) Partnership in the changing process

6.1.2 Physical facility designated for patient use

Patients regarded a small physical setting that provides a comfortable place for their activities as a major step in the development of total patient service. It was pointed out in the discussion group that an office with health information, "home-like" furniture (as distinguished from hospital furniture), air-conditioning and free-of-charge services had made the PRCs become a practical and direct support to patients. Most patients and their families used to go to the hospital cafeteria if they need a space for discussion or just to get away from the medical wards.

As the hospital staff or volunteers are generally allocated a designated lounge or changing areas and sometimes a small pantry to relax, the symbolic importance of making the patient's status equivalent to other hospital groups was recognised by patients as significant. It was also expressed in the group discussion that the value of land was very high in local context, having a PRC in some overcrowded hospital environment, highlighted the development of a patient-centred approach.

This special allocation of space also extended to equipment supplies in some hospitals such as the Prince of Wales Hospital, which provided a photocopying machine. The photocopier was seen as valuable support for patients and families who would otherwise have to go outside the hospital to make copies of health information or other related medical document.

Exception: A chronically ill patient in QEH, who went to a PRC on daily basis, commented that the renovated public hospital environment with air-conditioning was a "luxurious" comfort during summer. This patient lost her job after having a chronic illness. At the time of the discussion, the patient did not find any activities such as "Rehab Power" tuck shop that was later developed in the PYNEH; her daily presence in the hospital had raised concerns to staff and administration.

6.1.3 The formalisation of patients' mutual support activities

Medical and professional support programmes are characteristics of the formal caring system. The exchange of peer experience and health information between patients had always been common but was not usually recognised within hospitals. Patients and their families indicated the value of a PRC that could facilitate the mutual help among patients. The sense of "we" or "sharing the same boat" has helped to eliminate some of the loneliness and to ameliorate some of the intense emotions experienced during treatment. The enthusiasm of family member who offered a car ride to a weak and fragile patient and also the case of the Chinese herb that was bought in bulk and then brought in to the PRC for sale were prompted in the discussion. Some patients and staff indicated their concerns over safety issues and also if correct information could also be provided by fellow patients. There was attention drawn to the direction of developing informal patient support in health care system. Participants agreed the matching of patients by a trained staff member in the QMH. Both staff and patients viewed it as essential to prevent complications resulting from inappropriate informal support. The QEH asserted that their volunteers were all trained. A PRC staff will train the volunteers who could be a patient or family member. Staff supervision was regarded as necessary by staff to ensure practical and emotional assistance provided to other patients was appropriate.

6.1.4 Patients' personal link to the hospital system

Since the staff involvement was indirect in many PRCs, most patients felt that personal linkage to a complex health environment such as a major hospital was needed. For instance, being addressed by their surname or first name, instead of by a patient or bed number, was a big change in the new health care system? According to the patients, a personalised approach implied the services of a trained worker who understood their medical conditions and who was able to recommend a comprehensive care plan with reference to their medical and psychosocial state. The extended opening hours of the PRCs in most hospitals (e.g. from 9 a.m. to 9 p.m.) was an indication to improve convenience for the families who need to work and could come to use services only after regular office hours.

6.1.5 Positive experience or wellness feelings related to illness

There was discussion on whether the provision of health information packages had improved their sense of wellness. Some patients referred the learning process as "added" value or "bonus" to their illness. The educational benefit did not come directly from the reading material but also the new and positive personal experiences occurred along the process of adjustment. Some PRC members, after becoming a volunteer to other patients, were very pleased with their contribution. They expressed it as a chance to "pay back" the hospital for the kindness of staff and for their treatment. The elderly patients, in particular, expressed negative feeling as being helped or dependent on others. The cultural aspect of chronic illness and stigmatisation was mentioned.

It was agreed by patients attended the discussion groups that a PRC has achieved its purpose through its provision of a physical space where patients could participate in the hospital in order to have a balanced sense of "giving" and "taking". It was not the original purpose of the PRC in this specific area.

6.1.6 Patients as partners in the changing process

Patients' involvement in the hospital changes had often been limited to the medical social work department or through another staff member, for example, a ward nurse. The PRC activities provided more opportunities for patients to organise themselves and collect opinions, representing their views to the management. This was commented on by some middle-aged patients in the focus group meetings as a totally different experience reaching a higher level of achievement in total patient care. However, there were patients expressed their frustration about having inadequate support from the hospital when more resources were advocated. These patients made their request to start a burn-injury patient support centre in hospital and such request was turned down. Their requests could have been addressed if it was raised in the two teaching hospitals that have burn units. Patients as partners in identifying needs and proposing solutions were not realistic. In an occasion, these patients reported that staff told them that "there were other important things waiting to be done."

6.1.7 Five major areas of patients' concerns in new patient services

The five areas of major concerns, two of which -- physical facility and peer group activities --were able to be accomplished in most PRCs or in some hospitals that did not establish a new PRC structure. The emotional aspect, however, was not fully accomplished as it involved different expectations from users and there were administrative concerns raised in this area and the extent patients could fully be represented in the system change. The service co-ordination and who should be a key worker to co-ordinate total patient care will be discussed in section 6.2.

6.2 Practitioner's perspective on practising total patient care

The patient-centred approach that demanded staff to be "friendly" and personal, provide co-ordinated services, improve care practice by having patients as partners was not a tradition in the history of a top-down management in the health care system in Hong Kong (see the discussion in Chapter 3). Some staff who worked in the hospital system for a long time indicated their concerns about the extent of new service coverage and the co-ordination that involved other service providers in the community. These conditions are summarised below.

6.2.1 Major changes to facilitate new practice of total patient care

The development of total patient care has suggested that when patient concerns became the focus, professional boundary that hindered such approach became a "barrier". The existing public service system defined patient care delivery through professional boundaries. As s senior social worker pointed out,

> "Traditional service provision served a person in a defined service site with a specific mandate. Social services, in general, do not provide health input. The health and social service staff carried out different duties. Social centres, home help, community education, day care service, outreach programmes can all serve the same person. The person, however, requires different assessments in different offices." (commented by community hospital representative)

The separation of health care from social services, and different mandate within same service domain, did not facilitate the service integration when a large group of patients with a long time illness required a variety of supports

for their adjustment to that illness. The practitioners were in general not satisfied with the current diversified access and the fragmentation in care plan.

6.2.2 Referral procedure for psychosocial support for patients

The medical referral system had been well established in the health care system. A doctor made order to allied health or other laboratory services. One physician commented, " the continuity of care was not ensured when patients needed to be re-assessed for suitability to patient programs." The physician felt that if the Patient Resource Centre was to support the patient, the doctor's referral to the Centre should be carried out strictly as indicated by the doctor. There were two reasons for this. Firstly, to ensure the best benefits for patient when doctor referred the patients to go to the PRC, the patients should be well received. There might be medical information that a doctor would not relieve when non-medical support was requested. The elimination of any disappointment or frustration, which could be caused by inconsistency between the doctors' office and the PRC, the physician described a situation as illustration. Patients with a terminal disease could accept the failure of their treatment due to the limitations of existing medicine. The doctor's suggestion should therefore be taken as an important step to maintaining the patient's morale. When a patient approached the PRC for psychosocial support in the PRC, "any gesture of failure should be avoided", the physician insisted. This physician also felt "a doctor can act on behalf of the patient" because a doctor has the knowledge about the illness and is thus entrusted by the patient to provide the best care plan". In the discussion, the tradition of medical-dominance in giving prescription to patient was not accepted one PRC staff.

The PRC staff did not agree with the "harmful effect" on patient if an intake or initial screening on their needs was applied. The staff felt that patients should be given an introduction to the scope of services provided by the PRC so that they could make an informed choice. The medical and social science perspectives were obviously quite different in terms of patient rights and

service choices. A person-centred approach can thus be interpreted very differently between social workers and other medical or hospital staff.

6.2.3 Co-ordinators' role

There were other examples cited in the discussion that due to complexity of communication between health care staff and the PRC staff, establishment of a PRC has led to difficulties in the delivery of total patient care. As a PRC staff suggested --the communication issues discussed in section 6.2.2 could be resolved if the doctor made a phone call to the PRC to bring to staff's attention on the patient's special needs. The physician did not find such solution feasible.

Two dieticians, from two different hospitals, had similar strong opinions about how patient services could be best arranged. They felt that patients themselves should make the calls instead of the PRC staff arranging service for them. The dieticians both felt that the patient knew their own food requirements best and that it would be easier to establish specific treatment goals tailored to their preference and eating habits.

6.2.4 Patient's direct access and self-referral

The physician, dietician and social workers, however, all made the similar observation that sometime it was easier for a patient to make their own requests directly as they always had the right as a patient to request services from the hospital. Patients who were able to do so were those who could express their needs openly and directly. The group agreed that there were many patients who needed to be empowered in order for them to express their needs more verbally and to be able to request assistance. As it was observed earlier that there were some negative cultural values on being a patient and asking help. It will be seen later that the practitioners' view contradicts with administrators' concerns in system management.

6.2.5 New skills and cross-disciplinary training: patient empowerment

The use of therapeutic interventions such as art therapy to assist patients to express the experience of suffering or change in their self-image due to illness was brought up in the discussion. This newly introduced therapeutic intervention in the Patient Resource Centre was commented as one of the many interventions that facilitated an integrative approach through the encouragement of patient to express themselves. As some group participants pointed out that, "probably due to cultural pattern of feeling embarrassed by asking help", verbal expression was not easy. Expressive art therapy was a good means to provide non-verbal communication that might bring out "the internal mechanism to awareness" (as one staff described) and the sharing on illness experience which could also be difficult to be described verbally. Many allied health staff had found such skills interesting and useful. A few participants in the focus groups requested such training to be organised for their self-interests.

6.2.6 Hospital teamwork with community providers

In addition to the internal concerns from patients and hospital staff described above, there were discussions on changes outside the hospitals into the community. The newly introduced "money follows the patient" notion had implication on a patient-centred case management. This new approach, though unfamiliar to many service providers, was perceived by community service representatives as a possible way to resolve the current differences in the resource status between the hospital and the community.

It was calculated in the discussion session that the cost of hospital care for a patient, in comparison with that of community service, for the same individual, was very high. A hospital bed cost about $1.4m per year per person. The same amount could be used to run a social service centre or a 3-year PRC project serving at least 300 chronic patients. Some community providers openly

challenged the hospital team and expressed hostility in the dominance of hospital resources and expertise in patient care. It was evident in the session where community services practitioners were present that those community staff felt the current community service provision was "insufficient to attract patients due to a lack of medical and nursing staff". It would keep making patients ending up in hospital.

The hospital out-reaching initiative that support community service agencies were commented by some community service providers as ineffective.

6.2.7 Hospital-based services and out-reaching support teams

The community service providers also felt, contrary to the problem of lack of health resources in the community, the newly developed district-based community geriatric assessment team (CGAT) were well supported by the hospitals. These teams, distributed in the eight community districts and headed by a medical specialist, had to find contact points in the community. Some community providers were upset about CGATs supporting the sub-standard private care homes.

The controversial views about public funding being used to support profit-making private homes were debated in the group discussion. Some doctors argued that there was need to improve the standard of some of these homes, as their facilities were not funded as a government-aided elderly residential care home. "The elderly clients could be waiting to be admitted into a public care home for 2 - 3 years or longer and had to use these private homes during the waiting period," the geriatricians in the focus group commented. "Providing support to these sub-standard home, will benefit the elderly clients directly," one geriatrician continued, "the training for these staff and in-home consultations for patients would also remove the need for a hospital appointment." Other hospital staff also felt that the objective of these hospital outreach strategies was to work in the community in order to decrease hospital

admissions. In spite of community practitioners who felt the sub-standard private homes should be closed, hospital staff opined that out-reach services were serving system and organisational objectives rather than the concerns of individual private homes.

There was another similar outreach team to serve psychiatric patients in the community, known as the Community Psycho-geriatric Assessment Team (CPAT). One psychiatrist team leader felt there was a difference in the amount of attention given to psychiatric care comparing to geriatric services. In his words, "Psychiatry is often given the lowest priority in medical profession. In a Chinese community, geriatric medicine was given some respect. The psycho-geriatric service would never be given equal funding to implement new services. Staff has to find own time and resource to implement any new initiative." This consultant cited examples to illustrate his frustration at work, "Car parking is the biggest problem in bringing a team of experts for a home visit. The amount of time spent on transportation is tremendous. It is often done after work and no compensation mechanism is ever provided." The difference in staff composition between hospital and community teams is illustrated in Table 6.2.

Table 6.2 Professional staff compositions in hospital and community teams

	Hospital-based	Community-based
Hospital Patient Resource Centre	Social Worker	Nil
Hospital Cancer Resource Centre	Nurse	Nil
Hospital Medical Social Service	Social Worker	Nil
Community Rehabilitation Team	Nil	Social Worker, Occupational Therapist, Physiotherapist
Community Nursing Service	Nil	Nurses
Community Geriatric Team	geriatricians, Nurses and other hospital staff including social workers, physiotherapist and occupational therapist	Nil
Hospital-Community Psychiatric Team	Psycho-geriatricians, Psychiatric Nurses	Nil

6.2.8 Total care team

There was a consensus among the professionals that re-distribution of resource and more formal funding to be transferred into the community. Some hospital staff stated that "In the traditional service delivery system, patients are mainly handled inside the hospital by health care professionals. Social workers maintain the links outside the hospital." One participant commented on the co-ordination of total patient services: "The social work supervisor has the training to co-ordinate the different services. A team composed of a social worker and a nurse can 'tailor-make' a care plan for individual clients with a wide range of

needs, covering physical, social, emotional aspects and morale. This key worker (either a social worker or a nurse) should be able to identify risk and intervene in complex care issues as early as possible. Family issues and other care aspect in community could be well co-ordinated."

Some respondents supported this view and pointed out the importance of case management as an approach to provide a comprehensive care package. "Alternatively, all social service units should be linked up with a health input source to develop a strong care network in the development of total care."

6.2.9 Lack of mechanism to ensure quality of service and advocacy service

The question of a lack of advocacy or ombudsmen service in the hospital was raised in the group discussion by some patients who were seriously injured by burns (also discussed in section 6.1.6). These patients expressed their concerns about the difficulty of fully understood by the health care service delivery system. These patients found themselves, "not having enough voice".

Traditionally, medical social service staff often handled patient advocacy. Being members outside the hospital system (medical social workers in Schedule I hospitals are staff from Social Welfare Department), social workers were more comfortable than the other hospital staff to advocate for patients' special requests. Currently, as new social workers were considered as part of the health care team, the advocacy would go to Public Relations Office and the Hospital Administrator would be responsible for action. The practitioners generally agreed that advocacy for patient support need to be improved in the new hospital system. One practitioner commented that "uncoordinated patient care can easily shift the responsibility back to the family. The family is now quite different from the family twenty years ago and some families would not be able to manage well."

6.2.10 Five major areas of practitioners' concerns

Staff involved in the implementation process shared views on many areas related to the development of total care, the five major areas depicted were professional boundaries, referral procedure, responsibility of a total care co-ordinator, resource for hospital and community team and involvement of social service worker with hospital team. Hospital administrators' views are summarised in section 6.3 below.

6.3 Administrators' views on multi-disciplinary total care team

Health care organisational structures that had evolved over years did not seem prepared for an increasing number of clients, from all age groups, having health problems that are chronic. The practitioners from the hospital and the community service facilities did not have a close working relationship to share expertise and resources. The collaborative issue was sensitive when management support was not available. The proposed integrated care approach, which involved multi-disciplinary participation between hospital staff and community service providers outside the hospital system was discussed and summarised below.

6.3.1 Management concerns in the implementation of total patient care

Frontline practitioners who were involved in the patient service activities were generally positive about the new involvement with patients as "it would allow them to get to understand the true personal aspect in caring." A few staff had been promoted through their participation in the new patient initiative shared the thought of "having a bonus", but not as major motivation for service. Most staff felt "the hospital has never been so human or lively." Hospital

management had expressed different and mixed feelings in the implementation of total patient care.

6.3.2 Financial containment

The hospital managers perceived the degree of enthusiasm and energy brought into system delivery changes as a success of the changes. It was supplemented by administrators in the discussion that "as long as there is no budget problem". It was shared in the interviews that the concept of total care could be "more important than the building of a new structure". One senior medical consultant, who was also involved in case management and community care research studies, expressed what he believed:

> "There is no such thing as a perfect patient care approach nor case management method in Hong Kong. It will be too political to give out authority for case managers to work on resource or service purchase for patient care. Expectation for a full reform to build structure to implement person-centred care is not appropriate." (commented by government hospital representative)

6.3.3 Dealing with emotional and spiritual intensity in a medical setting

Hospital environments were known by its calm and cold images. Patient satisfaction and change of physical atmosphere took place since 1993. The PRC approach emphasised the right of patients to express feeling and participate in the changes of hospital system. "It is ideal for doctors to encourage the patient to maintain high morale in going through the treatment process." However, the worries about patients "over-sharing their deep feelings to other patients when going through a difficult moment" and the use of hospital for less medical purpose were discussed. The use of volunteers, even trained by staff, during emotional moments of patients and "the dangers of leaving vulnerable patients in some emotional moments to a volunteer" became

accountability issues of the administrators. Such intensity and the process of providing informal support in a hospital were described by manager and staff as "might not be less costly" than any formal intervention.

6.3.4 Service extension in hospital and professional alignment

The professional boundary that was discussed in section 6.2.2 as a barrier to the development of a patient-oriented total care approach also required management in the alignment of responsibilities. These hospital multi-disciplinary staff expressed different concerns for the management to consider in the development of total patient care. As the hospital consisted of a high percentage of professional staff, the following paragraphs illustrated some different views when actual responsibility had to be assigned.

Nurses' opinions

Nurses gave their comments in the discussion that, "Doctors who can provide detailed information about the diagnosis and prognosis will facilitate the internal network within the hospital." These hospital nurses felt they were not experts in working with volunteers and patients who had completed their treatment process could be involved in giving peer support to other patients.

Dieticians' opinions

Dieticians in different hospitals had different opinions to their involvement in the Patient Resource Centre (discussed in section 6.2). In one hospital, the dietician found networking with external parties, the general practitioners in the community "a new and exciting challenge". The experience of translating professional expertise into introducing day-to-day cooking techniques for the elderly was positively reported. In another hospital, the dietician preferred to work closely with the social worker, who could answer the social issues related to diet, such as the financial allowance for special diets and so forth. In another

hospital, the dietician was quite uncomfortable with being contacted by the PRC staff. The dietician observed, "We have a very heavy workload. The doctor is the only person who sends us medical orders and we schedule to meet the person in a ward."

Occupational therapist's opinions

Occupational therapists also involved in some Patient Resource Centre programmes. The PRC of the QEH obtained funding from the "Employee Re-training Board" (a government organisation providing job-related skills) to carry out a pilot retraining programme for chronic patients who lost their job due to chronic illness such as diabetes or renal problems. The PRC staff was successful to negotiate jobs from the hospital cafeteria for some middle-aged patients. The occupational therapist in the Patient and Social Resource Centre continued the traditional psychiatric patients' "canteen" as an employment-training program to prepare psychiatric patients to work in fast-food restaurant. Comparing the comments from different occupational therapists, occupational therapists in the QEH were pleased to work with social worker in the PRC and that some of the social workers' jobs "are now done by us".

6.3.5 The development of "Rehab Power" in hospitals

The conflict between the PRC staff and other staff involved in psychosocial support for patients was shown in the scope of service and extent of emotional support to be covered. Staff opinions were torn between two extremes of feelings in the continuous expansion of patient support. The CPPD in the PYNEH had perceived a different development of patient-focused resource building mechanism. The new direction for those patients who have completed treatment programme to support others undergoing treatment. The experience of patients, as valued by patients as significant emotional support (discussed in Section 6.1), could be formalised and managed with professional support. In addition, the opening of a patient convenience store (patient products) in the

PYNEH also marked a new trend to offer the development of "Rehab Power" to hospital ex-patients who encountered employment or adjustment difficulties in the community. The initial format of the "Rehab Power" was to provide chronic patients and psychiatric patients a tuck shop, which served as a work-site as well as convenient store for other patients. The patient-outcome approach had resolved some controversial views between patients, practitioners and administrators.

6.3.6 Total care and implications for overall hospital performance

The senior administrators in hospitals, including those with clinical background and non-clinical managers, shared three main concerns in the development of total care. These concerns were related to (a) the impact on overall hospital performance, (b) patient flow and service priority that could utilise hospital resource appropriately and (c) staff readiness to work with patients in community setting.

In 1997, the total number of attendance in all hospital PRCs was 101,000 (internal report from Hospital Authority Head Office). There was no study or evidences that correlate the implementation of total care and its impact on the health care system. Some hospitals began to consider if some of the patient care could be handled jointly by hospital and the community. The health care planners further discussed this view as summarised in next section.

6.4 Health care planners' view : the future of patient care

The concerns about resources under an atmosphere of containment and hospital partnership with other service providers were collected from focus group session followed by subsequent interviews with key decision-makers.

6.4.1 Global influences on health care policy and planning

The health care planners in the policy office considered the global experience of budget cut in hospital services as similar in local situation. A stricter requirement on service justification was expected. The overseas experience of resource cuts through elimination of clinical service in some hospitals was cited. For instance, the Nethersole Hospital, which was traditionally a maternity hospital, had to relocate from the city to New Town since the birth rate has dropped and the city population is ageing. This drastic experience did not happen in the health care history and local hospitals had considered this experience a threat. The issue of whether the PRCs would be eliminated or not if total patient care could not be fully implemented was related directly to the cost of its maintenance. The principle obtained in the discussion was if PRCs would be continuously funded by the community, such existence would not be a problem. (In 1998, the Hospital Authority had established a Hospital Authority Charity Foundation to co-ordinate the community donation for hospital development in patient services.) The use of PRCs was therefore, not given more stringent control in order to allow more flexibility to expect individual patients' concerns. A policy planner pointed out that "having staff to feel they could handle patient care is more important for staff to be told by top-management how to implement a total patient care policy." Staff training aspect on total patient care was further discussed in later section.

6.4.2 Re-structuring the medical, health and social service structures

As some medical consultants (discussed in section 6.2), also leaders and executive partner of the Hospital Authority Head Officer indicated worries of the improvement of public hospitals as setting a "potential bomb" to the over-use of the system, "such tension would need to be handled by system re-structuring." However, this view contradicted with another consultant who felt "as re-structuring never happened before", many new problems would be generated the example he used was: "There were two major psychiatric hospitals in Hong Kong in medical history. An international standard of 0.9 beds per 1000 was achieved as planned. The service re-structuring is now changing the dynamic by giving resource to local districts. The decentralised approach could affect present leadership of the hospitals. A new linkage will need to be established if service is to be standardised again." The concerns he expressed was not only as "a stronger competition between public hospitals and new disruptions in the working relationship to be resulted", but also some dis-satisfaction from experienced staff who involved in different changes across time.

This consultant pointed out that experienced staff always knew how to survive and maintain work satisfaction by "discharging" the patients with more behavioural or difficult problems. "Good" psychiatric patients would be kept because it causes less caring efforts.

Screening of new and "difficult" patient will be harder as it is a negative reinforcement to the system. There will be more difficult patients to be kept in the community." The total care approach could not benefit from such experience if the hospital "would keep the better patients and discharged the worst cases into the community, where health care resource was less than a hospital.

6.4.3 Overseas reference and international standing

Some policy planners responded to the changing patient scene in the community by focusing on the position of Hong Kong in the "world statistics". "Hong Kong is comparable with overseas experience. The doctor's ratio is comparable to other Asian countries by now." His view on "statistics often referred as an indicator of the success to the present care delivery systems was not enough to the current problem of the system. The historical issues in our health care system and its improvement through transfer to district-based or the bottom day-to-day co-ordination level is the major issue. This issue has already existed for a few decades. There is not much reference from overseas models." In particular, he continued that "the traditional reliance on the British health care system will no longer apply". He also provided an example that previously, patients having "complex" medical problems could be sent from Hong Kong to the United Kingdom" or suggestions could be solicited from overseas consultants. However, he recognised that overseas consultants could only provide technical and medical support. From what was told in these interviews, the policy planners have confidence in the future development of "advanced technological support" as "Hong Kong had gone through a lot of changes and established own expertise." However, the friendly and 'closer to home' approach in health are development that was still at a conceptual level which required more trial and application in "its partnership and community approaches in the service delivery."

6.4.4 Role of traditional medicine

The Queen Elisabeth Hospital was a "flag-ship" of the Hospital Authority (described by two policy planners) while the Kwong Wah Hospital was another "flag-ship" of the community hospital group. The KWH has become a HA hospital in the 1990s, however, it continued to implement its own service directives. For instance, the planner in the KWH shared his view about

provision of free traditional Chinese medicine clinic in a public hospital. As the involvement of the patients is very different from the patients attending the western clinic (discussed in Chapter 1), there were two different philosophies of patient care existed in one hospital. The Chief Hospital Executive of the KWH did not think there was any contradiction. In fact, during the visit to the herbalist clinic, the researcher was quite surprised with the way of preparing same herbalist medicine, a recipe by cooking 300 herbal components, to serve all 1000 patients attending the clinic in the same day. This recipe had actually two formats, a general one and another one for patients who might be allergic to some herbal ingredients. This practice was different from the laboratory style, as patients will be given more specific prescriptions.

The holistic care concept and Chinese traditional medicine that has received global attention in modern medical history, to the management group in Hong Kong, was "coming too soon".

6.4.5 Ceiling policy and cost implications

The cost containment, as perceived by the policy planners, was not difficult to be achieved once a ceiling policy is applied to contain overall resource allocation. The re-structuring of funding system, re-distribution between hospital, health and welfare sectors had implication on a global health policy, which was perceived "not to come along easily" by the top management. An interview with the Secretary of the Health and Welfare Bureau confirmed that the ceiling policy could be applied until the financial resource through tax or other means was re-defined.

The policy planners shared some views on the future of care direction as guided by some of the following remarks:

"Many people don't pay tax in our system. Our small tax base needs to be changed if the government is to shoulder more responsibility for health care." (commented by SHW)

"Waiting time was used as a mechanism to balance government responsibility and person's own choice. A person who can afford private care will get service immediately without waiting. The government will provide and improve the provision to the extent the system can manage, beyond which patients have to wait for the service if it is overcrowded. The government cannot spend unlimitedly on health care. Competition for resources must be understood." (commented by DSHW)

"The long term care direction in patient care provision, theoretically works. However, the health care financing needs to be resolved first." (commented by DSHW)

"Our system was too proud for its cost-effectiveness for too long. The new improvement in patient care finally started in the last few years. Any cost due to changes is worthy." To him, the path-seeking process through the total care concept was important, as it would set the foundation for latter changes. (commented by a legislative council member)

6.4.6 Total care by same staffing?

The management teams, as discussed in section 6.3, had expected highly competitive situation to occur in the full implementation of changes in the future. Under a cost contained policy, the hospital would either utilise staff from the Social Welfare Department in the hospital; however, a rotational system would only allow frontline social workers to stay on the job for a period

of 2-3 years. The other way was the hospital would be working closely with community providers who were not familiar with hospital system. Some changes in leadership could be expected if the patient care would continue between health and social sectors.

An administrator who also involved in policy planning described that "Similar to what happens in the business world, small fish will be swallowed by big fish". The expansion and changes in the health care system would lead to amalgamation of health services.

The survival of those who can "prove to be useful to be hospitals" and sometimes "Patient care activities would become catching the keyword and changing staff titles in order to identify with the trend." The description matched with the change of the name of some hospital department, for instance, the QMH, changed the volunteer and chaplaincy departments into a PRC. The introduction of a new service approach that did not match with hospital expectation might not be favourable for a genuine concerns as it would delay the transition and total patient service might take many years to accomplish" one policy consultant concluded.

6.4.7 Development of ambulatory service and community care

The community hospital group, represented by the KWH, had expressed keen interests to bring patients back into the community by its development of ambulatory service in the hospital. The Hospital Chief Executive commented, "Shortened length of stay and decline of resource will be the future reality for the health care system. However, the personal aspect will be given more attention as compared with the conventional in-patient practice. The hospital should advance towards ambulatory service by improve the technological level to apply in-hospital care through outpatient services. For instance, some eye

surgery which required 4 in-patient days can now be performed on a day service without hospital admission." Community support for their patients, according to the HCE, would be well supported by their medical social workers and allied health staff who worked closely with the community.

6.4.8 Hospital leadership in total patient support

The leadership in patient care development, as described by some senior administrators who worked in hospital system for more than 30 years, was split into three major groups. The three leaders were (1) the QMH as leader in the teaching hospital, (2) the QEH as the leader in the government hospital and (3) the KWH as the leader of the community hospitals. Some "healthy" competition to gain recognition on total patient care was expected to result into a balanced medical and social orientation in patient care. However, some executives also commented that "establishing uniqueness in order to strengthen the hospital or department image will be inevitable". Both administrators and policy planners agreed that "the relationship of a hospital with the public is important".

6.4.9 Changes in hospital and community environment

The linkage between the hospital and the community, as discussed in above section, was expected to be closer than ever. It was shared in the discussion group that "In order to promote the public image, the staff had to adjust their language to a non-jargon and friendly format. The Canadian system recommended a Grade 5 level for reference materials developed to serve patients and families."

A clinical specialist expressed frustration in the meeting. He shared his newly developed interest in writing "cynical" poems. The "open style" of the hospital

had brought new adjustment to his life. The experience of some community hospitals, illustrated by the UCH representative, was that "The community assessment geriatric was built on the experience of the UK and Australia. Such approach was intended to become a gate-keeping mechanism and to reduce patient cost. This service applied locally had served the frail and elderly clients with different intention. The name of the services had caused confusion." He strongly supported the traditional practice in public hospitals.

6.4.10 Conceptual learning and building clinical skill mix

The establishment of the Hospital Authority in 1990 had resulted in an increase of executive and managerial positions. The experienced clinical staff who also became executive partners of the Head Office was given management training opportunities. These new middle to top managerial positions, however, were expected to be reduced when "the reform is completed." For example, some newly created program managers might not be required when program directions are consolidated and integrated. The structure of an overall supervisory board was not clear at the time of the study. The concerns in the amalgamation process and potential asset transfer between hospitals and departments could be expected to create some anxiety in the system stability, in particular to the leader and senior staff. Some conflicts between the administrator and policy groups were reported. However, these staff also indicated their enthusiasm in the learning of new skills, both clinical and managerial. The new concept of total patient care and its implementation were of interest to them. It was reflected in the number of articles submitted for discussion in the Hospital Authority Annual Convention (1996, 1997, 1998, 1999).

6.4.11 A short time frame for policy change

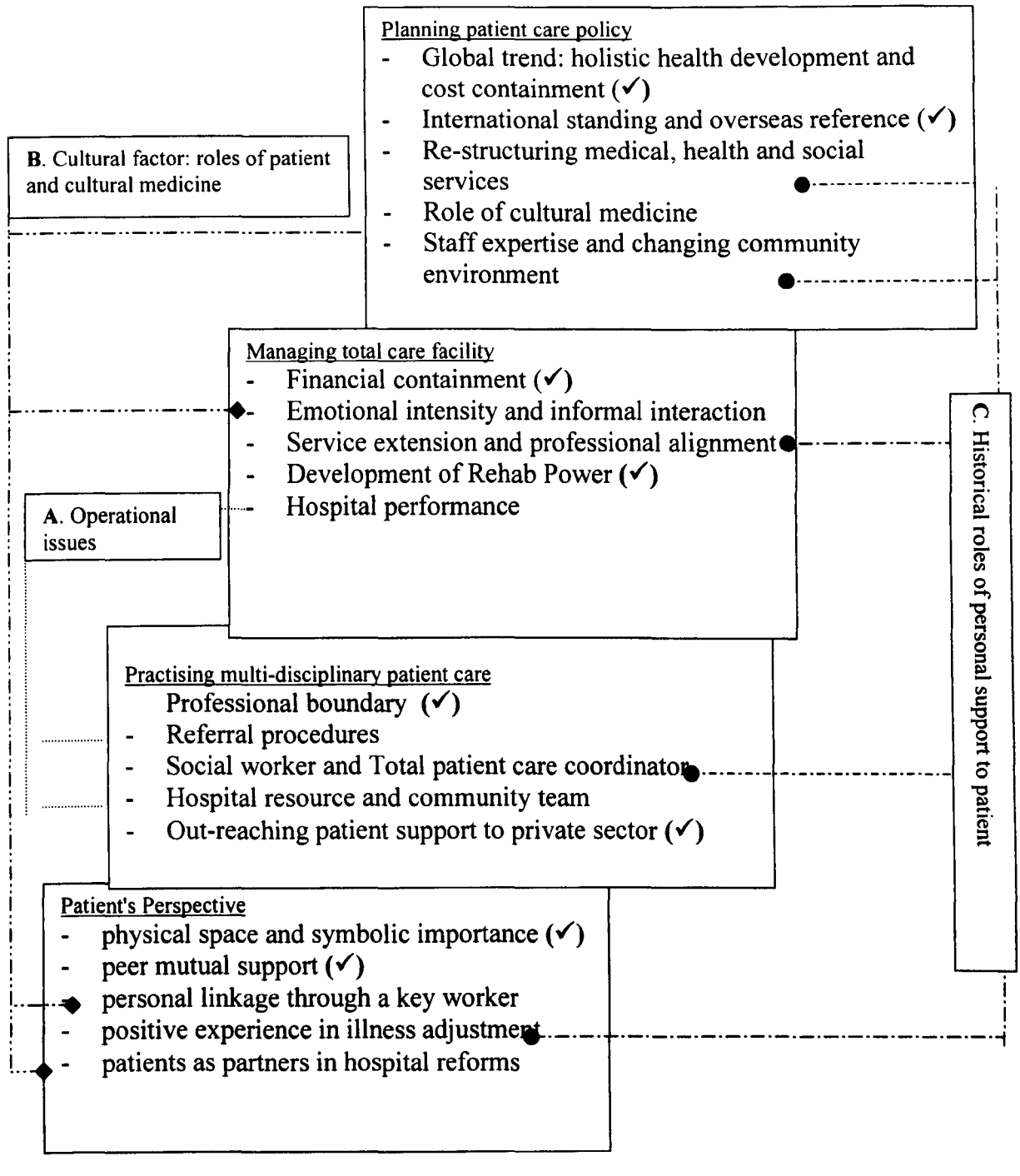
There was a pressure to make changes before 1997 when Hong Kong was returned to the Chinese Government. The relative short time frame to implement reform, which departs from an old existing system, was described in the discussion as " a hot but not new issue that was discussed twenty years ago but never formally discussed." "The pace of development in the community also affect the development speed." The pace of changes within 1993 - 1998 as told by some participants, "was too soon and too short". This comment was similar to that as described in section 6.4.4.

6.4.12 Standardisation of patient care

In line with the development of total patient care concept, there were other resource clustering and management restructuring within the hospital system. The geographic health service re-distribution to ensure service equity and efficiency took place and was not totally welcomed by all staff (commented by psycho-geriatricians in previous section). The policy planners from the Head Office naturally also inclined to consider a similar path for the development of geographical patient service groupings. It was commented that networking and better collaboration in service delivery were important. "The variety of services should be clustered along with that of the general medical service cluster. There are eight medical clusters in different districts. Therefore, the present psychiatric service should be clustered from 6 different regions to a eight-cluster design." What the psycho-geriatrician was concerned about the split of services from two major psychiatric hospitals into 6 regions would be further decentralised and diffused into the 8 general medical practice clusters. "If all specialist medical service could be integrated into one mainstream medical service medicine, then a person or family-oriented health care model can be achieved", this specialist commented.

6.5 Mapping the different views in the development of totality of care

There were different views from the hospital stakeholders about the development of a totality of care system. Their views were summarised in terms of successes that were achieved (denoted by a check "✓ " mark in Figure 6.3) and the unresolved issues which had been reported by different views of the stakeholders. The differences when mapped among the different stakeholders' group had suggested that these unresolved issues were closely associated with the historical and cultural factors in Hong Kong. Figure 6 is a simplistic representation of the different views. The circuit A represented issues between the practitioners and the management in the patient care procedures, care resources and hospital performance which needed to be resolved. The other circuits, B and C, represented more deep-rooted issues related to historical and cultural factors. The circuit B is factors that involved cultural definitions of roles of patients, the traditional medicine, the emotional and personal experience of patients within a public hospital system. The circuit C seemed to reflect concerns in all four levels, i.e., who is the patient care co-ordinator and key worker, how professional alignment should be conducted and the restructuring of the medical, social and health domains. Similar to the findings in Chapter 5, the historical and cultural factors were persistent in the development process of a total patient care system.



(✓) denotes a satisfactory remark on the completion of objectives

denotes general operational concerns (circuit A)

denotes unresolved cultural issues (circuit B)

denotes unresolved historical issues (circuit C)

Figure 6.3 Mapping different perspectives in devleoping total patient care

Conclusions

This chapter summarised the findings from focus group discussions. The four major groups of participants in the health care system had different perspectives, varying from those of direct beneficiaries through service changes to those involving in practising, administer and planning a new system. Some of the issues discussed were resolved with consensus while most of the historical and cultural issues remained unresolved. The following chapter will continue with the different policy and practice concerns in the implementation of total patient care. In particular, attention will be drawn to the area whether the differences would continue in hospital and community sectors.

Chapter 7 Finding III: Hospital and community leverage in patient care

The different views on the development of a totality of patient care model were discussed in Chapter 6. This chapter continues to examine if the concept of totality of care has some influences from its outside environment, i.e. the community. Those influences could be considered in the future health care planning. This chapter will report on the survey findings. A brief background of the patient care context in 1998, i.e., by the end of a five-year path-finding process is included in section 7.1.

7.1 A growing concern in the community

The population of Hong Kong continued to grow in 1990s from 6.3 millions to over 7 millions by the end of the century (Census and Statistics, 1993, 1997). The length of hospital stay for patients declined with the development of ambulatory care services in hospitals (discussed in Chapter 6). More patients use specialist outpatient services in hospitals.

The number of patients admitted to hospitals for treatment in 1993 was 761,540. This in-patient figure had increased by 30% to 1,000,000 admissions in a period of 5 years. There were 3 millions outpatient attendance in public hospitals in 1993. In 1998, over 7,000,000 patients, twice as many as in 1993, were outpatients of the public hospitals. This increased number of patients living in the community and using outpatient services could be expected to bring a rising demand on personal or health support in the community. The trend of outpatient support in the community to cope with illness-related issues is shown in Chart 7.1.

7.1.1 Survey on community resources to support totality of care

As discussed in the last two chapters, the development of total care concepts brought new changes to the health care systems in Hong Kong. In 1998, there were 110,000 patient service units used in the Patient Resource Centres. There

were 80 new staff employed for the total patient services, supported by community funding. (HA internal report: statistics on PRC activities, 1999). The potential of the community in patient support as discussed in previous chapters of this study, (Chapter 3 and Chapter 5) was undeniable. This potential, established over the years due to historical and cultural influences, was expected to continue.

The following survey was intended to acquire the potential support outside the hospitals which could bring to a full transformation of total care delivery. The perception of the hospital practitioners, who as representatives of the hospitals and nominated by the Hospital Chief Executives as key workers to implement total patient care, had completed a survey to provide their perceptions on the five areas that Rothman (1994) had discussed as important for the service integration. The findings from the survey will be reported in the following sections.

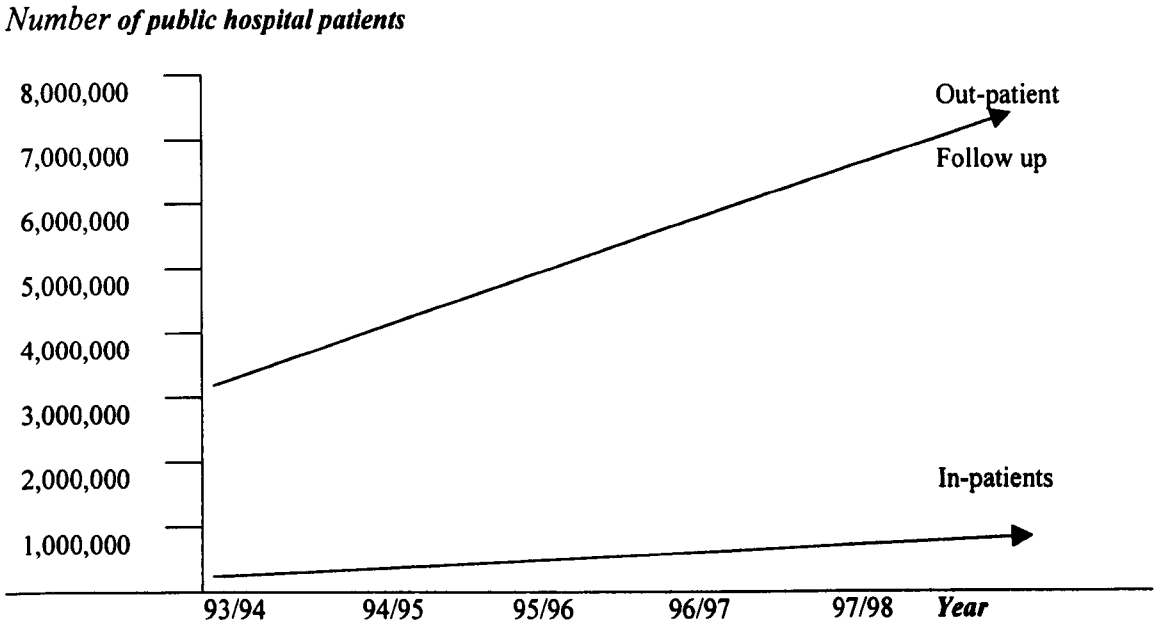


Chart 7.1 Hospital in-patient and outpatient services between 1993 - 1998

7.1.2 The ten selected hospital target groups

The hospital planners had selected priority patient service areas for individual hospitals to consider in their total patient care delivery (HA annual plan, 1996). In spite of the different hospitals' initiatives to seek pathway to develop total patient service, the HA head office, had traditionally relied on hospital-based structures in its delivery of patient care. The ten diseases and patient-related groups that the hospitals had set its priorities for service development were described in Chapter 3 (Figure 3.6).

As discussed by Evans and Stoddart (1991), the health care system is interactive with other components in the community. The transition of patient care development, expected to be developed hand in hand with other patient services the community, was inquired with an intention to search for potentials in the community as a leverage to hospital total patient care model. The survey results will be reported in the following sections.

7.2 The Survey

The following survey data should reflect the socio-cultural context of patient care in 1997. Representatives of all 38 hospitals, staff assigned by the hospitals to develop total patient care, were invited to provide their views by completing a questionnaire (Appendix 6). The respondents had to provide their views on the five areas of community support (Rothman, 1994) for the ten priority service groups. Their views on the five areas were scored individually on a 5-point Likert scale. The data will be reported and analysed in the following sections.

7.2.1 The responses

The questionnaires were sent to all 38 public hospitals in the first week of March 1997 to the Hospital Chief Executive offices. All hospitals were invited to nominate their staff, who were full time employees and currently involved in the implementation of total patient care, to complete the survey forms. Each hospital could nominate a maximum of four staff, which was an estimate of the maximum number of staff involved in each hospital. The completion of the survey was voluntary. The questionnaire was to be returned within a week anonymously.

7.2.2 Representation of survey

Seventy-four questionnaires were returned. Six hospitals (Castle Peak Hospital, Fanling Hospital, Hong Kong Eye Hospital, Siu Lam Hospital, St. John's Hospital and Lai Chi Kok Hospital) did not return any questionnaire. Fanling Hospital, Siu Lam Hospital and Lai Chi Kok Hospital did not develop any PRCs.

7.2.3 Staff involved in total patient care

Most of the hospital staff (68%) involved in the implementation of total patient care had four or more years of experience in working with in-patients. Many of these staff was senior staff who joined the public hospital system before the establishment of the Hospital Authority. (Table 7.2.3a and Chart 7.2.3b) There were more responses from the acute and general hospitals (50%) than other types of hospitals, which resembled the dominance of acute hospitals in the public health care system in Hong Kong (Table 7.2.4a and Chart 7.2.4b). The social workers and nurses were the two major health and social professionals (74%) who were nominated by the Hospital Chief Executives to complete the survey form. However, there were 11% of medical staff representation, comparing to 6% of the overall medical staff distribution in public hospitals.

In this study, there was also a higher percentage of allied health staff (14%), including occupational therapists, physiotherapists, pharmacists and psychologists, compared to a percentage of 7.7% in the hospital employee distribution. The staff involvement in total patient care implementation was not restricted to social workers that traditionally worked as major linkage between the hospital and the patient groups.

7.3 Survey Findings

7.3.1 Patient support in the community

The involvement of patient care in the community was scored from point 1 to point 5 to indicate the development of different services from less than one year (point 1) to over 10 years (point 5) for the ten patient groups. The survey finding suggested that such development was relatively recent. The overall involvement of the community to support specific patient groups was between 2 – 4 years, which coincided with the time when hospitals began to take initiatives for the development in total patient care. The overall average time period of community patient care development was scored 2.7. Among the different age groups which the hospitals had given priorities, the support for elderly patients were more established. The services for some age-related illnesses such as stroke, diabetics were perceived as more established than other patient groups (mean scores for these groups were above 2.7)(Fig 7.3.1).

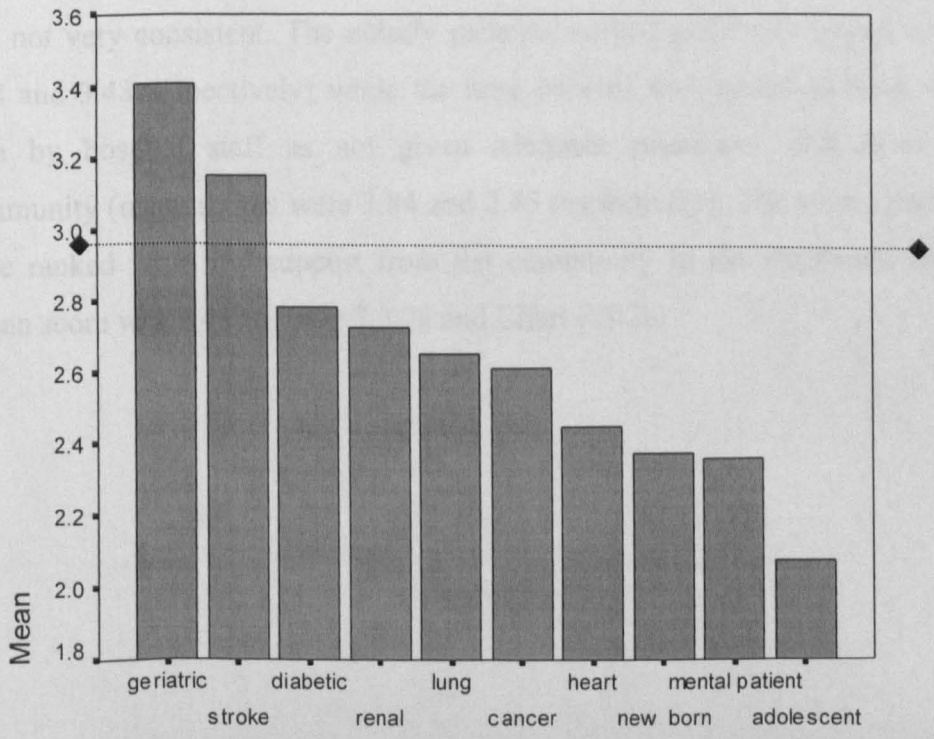
Table 7.3.1 The establishment of disease and patient services in the community (mean scores)

Establishment of community services for disease and patient groups (n=67)	Mean scores
(a) More established	
Geriatric	3.4
Stroke	3.1
Diabetic	2.9
Cancer	2.8
(b) Average establishment	
Renal	2.7
Heart	2.5
New born	2.4
(c) Less established	
Lung	2.3
Mental patient	2.3
Adolescent	2.0

Overall average score =2.70 (between 2 –4 years)

The development of geriatric-related support seemed to be consistent with the tradition of supporting elderly members in the Chinese community (Chart 7.3.1a).

Chart 7.3.1a Difference in historical establishment of patient support in the community



As the population in Hong Kong is ageing, there was also more attention given to support elderly persons who live in the community. The Department of Health established the Elderly Health Centres. The Social Welfare Department developed the Elderly Carer Support Centres. These programs were developed rapidly between 1993 – 1997. On the contrary, there was not much support for the adolescents who had chronic illnesses. The young patients' needs identified by QEH was therefore significant, as those needs were not recognised in the community.

7.3.2 Emotional support towards different disease and patient groups

The community attitudes also varied. The sentiments for different disease and illness influenced the development of patient services. A score of 3 for community attitude implied the attitude was inconsistent and varied. A lower score (less than 3) suggested negative community attitude towards certain disease or patient groups. A higher score (more than 3) implied positive attitude.

The community attitude was scored as a mixture of varied negative and positive attitude. An overall average of 3.06 was scored, suggested the attitude was not very consistent. The elderly patients, ranked positively (mean scores 3.58 and 3.43 respectively) while the lung patients and mental patients were seen by hospital staff as not given adequate emotional support in the community (mean scores were 2.84 and 2.45 respectively). The young patients were ranked with low support from the community in the emotional aspect (mean score was 2.45). (Table 7.3.2a and Chart 7.3.2b)

Table 7.3.2a Supportive attitude in the community (mean scores)

Community attitude towards Different diseases and patients	Mean
(a) positive	
geriatric	3.58
stroke	3.43
cancer	3.27
diabetic	3.27
new born	3.13
heart	3.08
renal	3.06
(b) negative	
lung	2.84
mental patient	2.45
adolescent	2.45

Overall average score = 3.06

Chart 7.3.2b Positive community attitude (mean scores > 3.0)

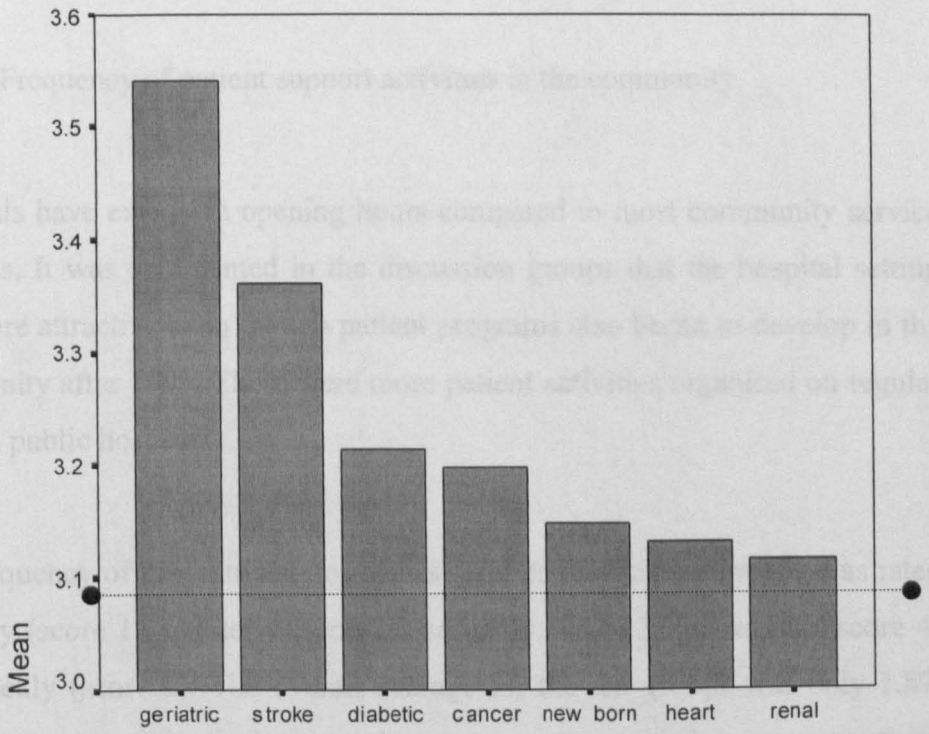
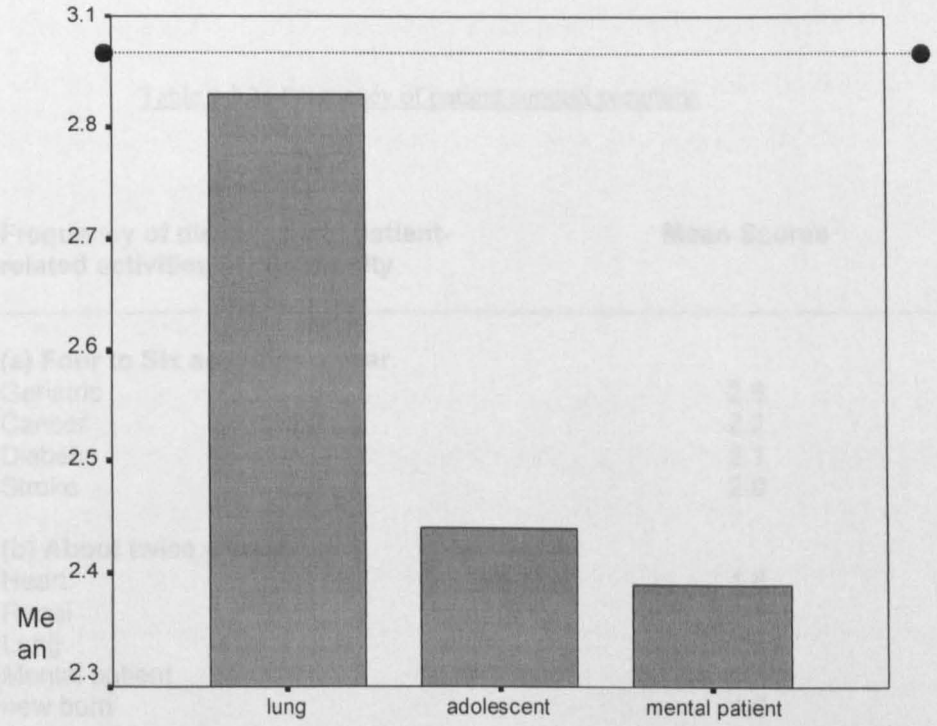


Chart 7.3.2c Negative community attitude (mean score < 3.0)



7.3.3 Frequency of patient support activities in the community

Hospitals have extensive opening hours compared to most community service facilities. It was commented in the discussion groups that the hospital setting was more attractive even though patient programs also began to develop in the community after 1993. There were more patient activities organised on regular basis in public hospitals.

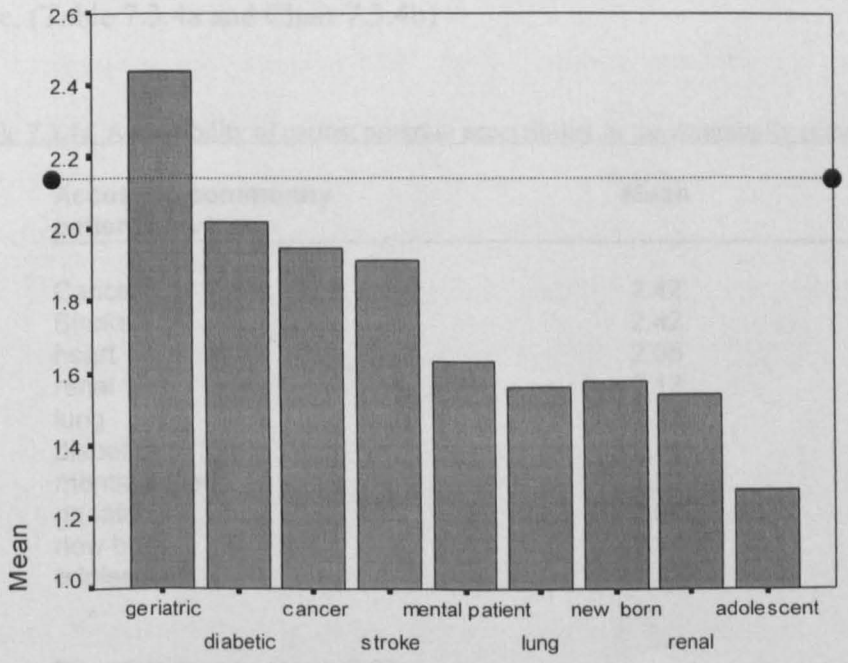
The frequency of programmes for disease and patient-related groups was rated annually (score 1), quarterly (score 2), monthly (score 3), bi-weekly (score 4) and weekly (score 5). The overall average for the ten groups was only 1.87, implying most of the patient activities were not provided once every three months in the community (Table 7.3.3a and Chart 7.3.3b). Some patients might

only find programs for them in the community once or twice a year. The cancer, stroke, geriatric and the diabetic patients or their families had more community supportive programs, between four to six times a year.

Table 7.3.3a Frequency of patient support programs

Frequency of diseases and patient-related activities in community	Mean Scores
(a) Four to Six activities a year	
Geriatric	2.6
Cancer	2.2
Diabetic	2.1
Stroke	2.0
(b) About twice a year	
Heart	1.6
Renal	1.6
Lung	1.8
Mental patient	1.8
new born	1.6
Adolescent	1.4

Chart 7.3.3b Frequency of patient programs provided in the community



The opening of the Elderly Health Centres (Department of Health), the Elderly Carer Support Service Centres (Social Welfare Department), the expansion in the number of Elderly Day Care Centres (Social Welfare Department) and the Elderly Day Hospital (Hospital Authority) appeared to have improved the out-patient support in the community. However, the results of supporting a particular age-related patient groups seemed to outpaced the access of patient support to other age groups.

7.3.4 Access to community support

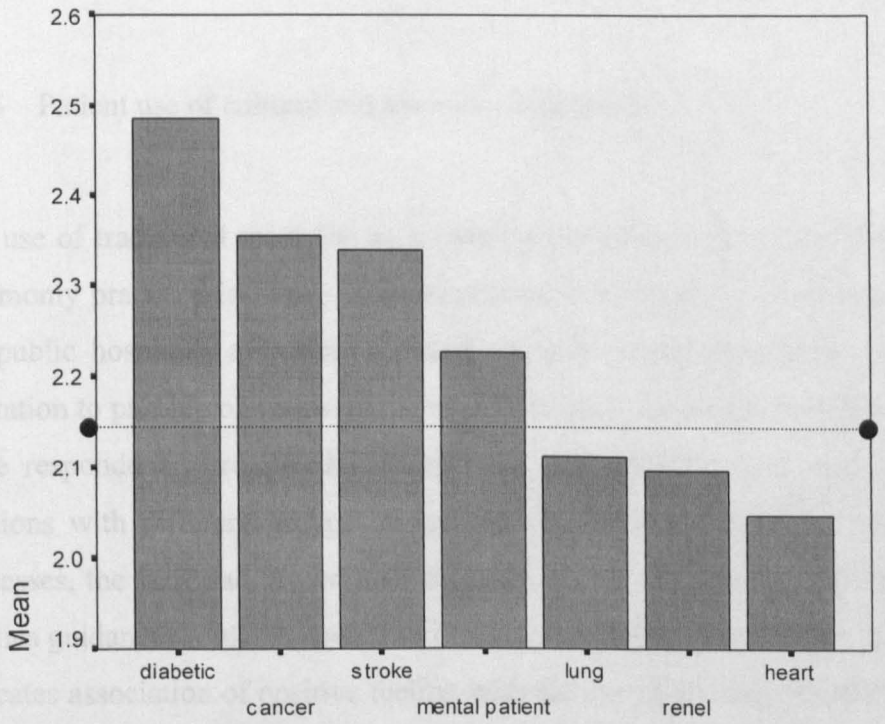
The access to patient support programs in the community was rated from 1 to 5. A score of 3 implied the programs were accessible. A higher mean score (scored above 3) suggested that individual assistance was available to serve different needs, e.g., the younger and older patients with similar diseases. A lower mean score (scored below 3) implied such individual service was not available. An ideal score of 5 implied the service was well established with a "friendly" style. The access was enhanced for full access including 24-hour operation or other convenient locations. The overall average score for the ten patient groups, however, was rated as low as 2.26. The access problem to patient support programs in the community might need more exploration in the future. (Table 7.3.4a and Chart 7.3.4b)

Table 7.3.4a Accessibility of patient program accessibility in the community (mean scores)

Access to community patient services	**Mean**
Cancer	2.42
Stroke	2.42
heart	2.05
renal	2.13
lung	2.22
diabetic	2.55
mental patient	2.21
geriatric	2.64
new born	2.14
adolescent	1.79

Overall average score = 2.26

Chart 7.3.4b Program accessibility for the different disease and patient groups (mean scores)



The impression from hospital staff on community services for patients, as shared between staff and the researcher, was not very positive. The referral procedures were very complicated. For example, stroke patients who applied rehabilitation bus service had reported very discouraging experience to hospital staff. The heart and lung patients, whose mobility needs were less obvious, were likely to be turned down for their request on assisted transportation services.

Despite the hospital staff had also complained about the local transport and parking problems in Chapter 6, the special needs of patients if not carefully attended, would result in a longer stay of patients in hospitals. In other words,

the design of friendly programmes to enhance patient access would link up hospital and its community in the transfer of patients when they are ready for discharge. (Table 7.3.4a & Chart 7.3.4b) For the first time, the mental patients were rated with better access to support programs in the community. Their ability to commute was an advantage for their access to supportive programs.

7.3.5 Patient use of cultural and alternative treatment

The use of traditional medicine as a complement method for self-healing was commonly practised in Hong Kong (discussed in Chapter 1). Staff working in the public hospitals, a western-oriented medical setting commented on their hesitation to provide opinions on the uses of cultural medicine. However, when these respondent were asked if there were any differences in sharing their opinions with different groups of patients going through different treatment processes, the staff had shown their different views. A score of 3, in this area, implies guidance would be neutral or objective. A higher score (mean score >3) indicates association of positive feeling with the use of alternative medicine. A lower score (mean score < 3) implies negative association with the effect of cultural medicine on certain patients or illness groups.

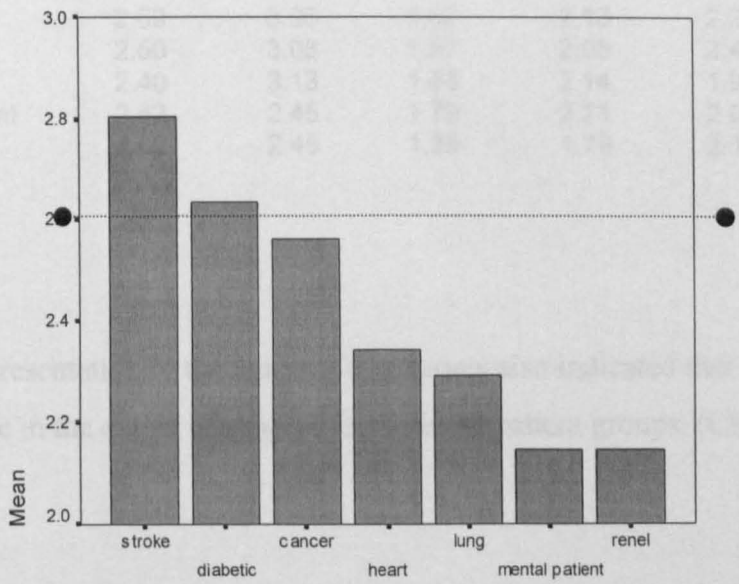
The overall staff impression on the use of alternative medicine was rather negatively and staff intervention or monitoring was recommended. (overall average score = 2.51). The use of alternative medicine by adolescents was considered to be harmful (mean score = 1.95). The use of cultural medicine was rated more neutrally for geriatric and stroke patients (mean scores were 3.11 and 3.04 respectively). (Table 7.3.5a and Chart 7.3.5b)

Table 7.3.5 Patients' use of cultural and alternative healing methods

Use of Traditional Chinese Medicine or alternative treatments	Mean Scores
Cancer	2.76
Stroke	3.04
Heart	2.42
Renal	2.23
Lung	2.44
Diabetic	2.77
Mental patient	2.08
New born	2.14
Adolescent	1.95
Geriatric	3.11

Overall average score = 2.51

Chart 7.3.5b Staff opinion on patient use of traditional and alternative medicine (mean score)



7.4 The differences in community and hospital support for patients

A total care score on community support is illustrated in this study, by a combined score of the five areas of informal support, i.e., the general service

establishment, attitude, frequency of activities, easy access to support and or alternative methods from the traditional Chinese Medical system. The ten total care scores for the ten selected patient groups are shown in Figure 7.4a.

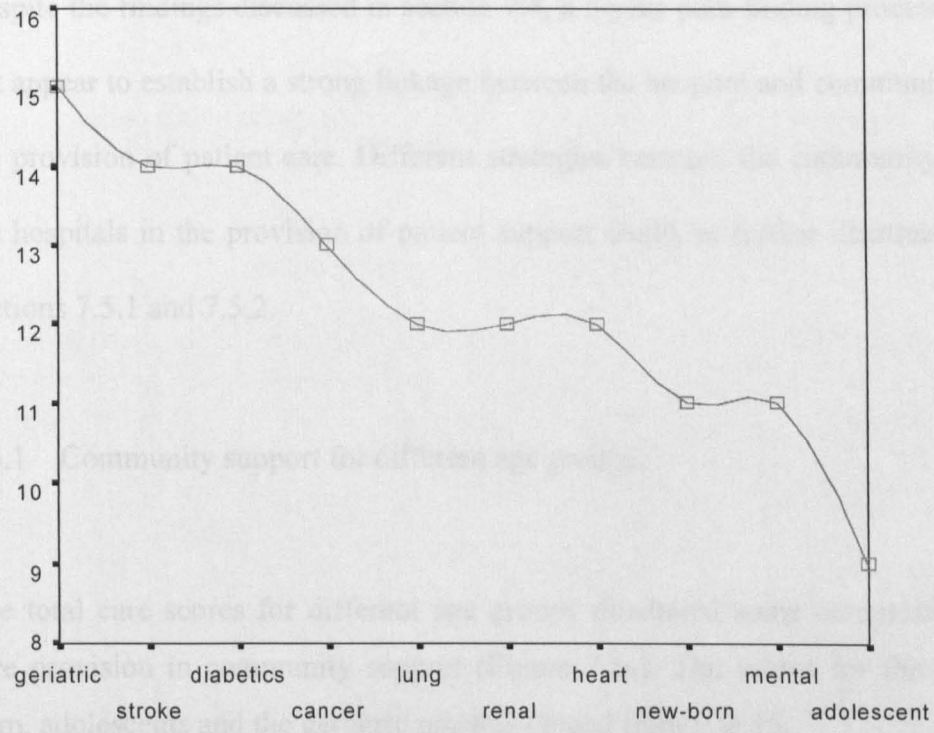
The finding indicated that there was also a wider range of variations in the degree of care provided for different patient groups in the local community.

Figure 7.4a Total care scores of the ten hospital selected patient groups

Community support for Diseases and Patient groups	**Mean Score 1**	**Mean Score 2**	**Mean Score 3**	**Mean Score 4**	**Mean Score 5**	**Total Care Score**
Geriatric	3.38	3.58	2.64	2.64	3.11	**15**
Stroke	3.12	3.43	1.97	2.42	3.04	**14**
Diabetic	2.85	3.27	2.14	2.55	2.77	**14**
Cancer	2.76	3.27	2.18	2.42	2.76	**13**
Lung	2.79	2.84	1.75	2.22	2.44	**12**
Renal	2.69	3.06	1.62	2.13	2.23	**12**
Heart	2.50	3.08	1.57	2.05	2.42	**12**
New Born	2.40	3.13	1.63	2.14	1.95	**11**
Mental Patient	2.42	2.45	1.79	2.21	2.08	**11**
Adolescent	2.02	2.45	1.35	1.79	2.14	**9**

A graphic presentation of the ten total care scores also indicated that there was a wide range in the extent of support for different patient groups. (Chart 7.4b)

Chart 7.4b Total care scores for different patient groups



The lung, renal, and heart patients had similar level of combined support from the community (total care scores for these 3 patient groups were 12). There was a wider range of support provided for patients belonging to different age groups (total care scores for geriatric, adolescent and new-born were 15, 9, 11 respectively).

The attempts of the pioneer PRCs to resolve such differences in supporting the younger patient groups through new patient care initiatives were, therefore, consistent to the original planned goal of developing totality of care for different groups. The perception of the staff and their involvement in practising total care in the hospitals, according to this study, has resulted in the development and implementation of a total patient care concept.

7.5 Total patient care by hospital and community efforts

Despite the findings discussed in section 7.4, a 5-year path-finding process did not appear to establish a strong linkage between the hospital and community in the provision of patient care. Different strategies between the community and the hospitals in the provision of patient support could be further illustrated in sections 7.5.1 and 7.5.2.

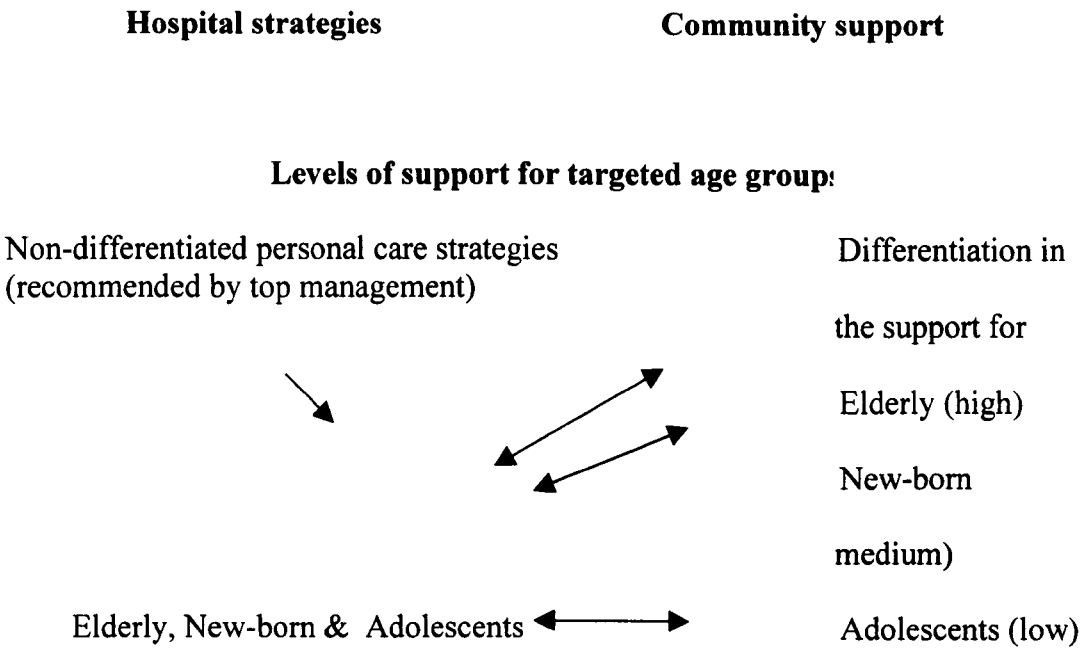
7.5.1 Community support for different age groups

The total care scores for different age groups illustrated some complexity in care provision in community support (Figure 7.5a). The scores for the new-born, adolescents and the geriatric patients ranged from 9 to 15.

The range of variation, when further compared to the original proposed patient care strategies in the hospital plan (discussed in Chapter 3 section 3.6), also highlighted some differences in the strategies to improve totality of patient care, between the hospital and the community sectors.

The hospital planners proposed similar strategy for different age groups for the three age groups. The parallel support offered in the community might not have been taken into consideration. The researcher also interpreted that there was more sophistication in the provision of personal support for different age groups in the community.

Figure 7.5.a Community support for different age groups

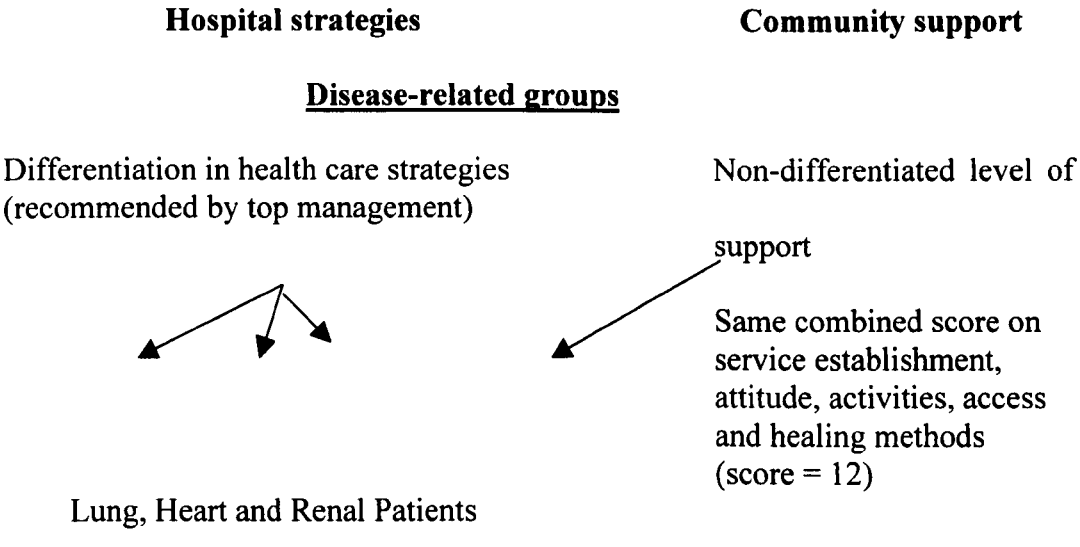


7.5.2 Hospital strategies for different disease-related patient groups

The level of community support for the renal, lung and heart patients was similar in terms of the combined total care score (score = 12 for the three patient groups, Figures 7.5a and 7.5b). There were different health care strategies recommended by the hospital planners (discussed in Chapter 3, section 3.6) for these disease-related patient groups.

The lung and heart patients were recommended to improve on prevention and treatment areas. For the renal patients, hospital planners recommended that this group need more support to manage the equipment and monitor their health condition.

Figure 7.5b Different health care strategies between community and hospitals for disease-related groups



The difference between hospital and community sectors in the support for disease and age groups, were difficult to be explained fully, except the fact that there were differences in terms of sophistication in the support for different targeted groups.

Conclusion

The findings shown in this chapter suggested that variations in patient care could be expected to continue in the health care delivery system. The researcher perceived policy actions might improve such conditions if educational needs of the community in terms of attitudinal changes in community could be specified through a total patient care policy. Alternatively,

the hospitals could be suggested to consider the level of community support for different patients and then match different health strategies for the patients who might require more support in order to achieve a similar or closer to standardised level of care for different patient groups.

Chapter 8 Discussions and Conclusions

This study concerns the different patterns of patient care that have emerged in Hong Kong. The intention of this study is to explore the origins of differences related to the implementation of a single policy. The policy has its intention to move away from compartmentalisation of services, often described as due to historical reasons. The development of a totality concept has an assumption that such transition can meet the expectation of a health care system planned for the new millennium (HA, Annual Plan 1998). The health traditions and their forces on the patient care delivery were not studied in local context. In this study, the empirical data about variations in the provision of patient care suggested that there were multiple sources of influences in the process of change.

As expressed in Chapters 1 and 3 of this study, the Hospital Authority's vision developed from the latest concept of total patient care. The historical or background forces that acted on the development of a new policy were described in Chapter 5. The successes and difficulties in implementing a totality of care concept, with different expectations and interests of the hospital stakeholders, involved in different positions of the changing process, had also reflected some unresolved historical and cultural factors in the delivery of patient care (Chapter 6). The involvement of the community sector in the formal hospital system, since its early history of separating a public hospital system into government and community groups, developed a parallel movement in patient care outside the hospitals. Such development in meeting a larger population of patients living in the community had its potential to further support total patient care in the community (Chapter 7).

The first part of this chapter will elaborate on some of the discussions in the study findings. The second part of this chapter will discuss the policy implications related to patient service integration. Finally, the last part of this chapter will

summarise the "path-finding" experience of the development of totality of care in Hong Kong,

8.1 Multiple outcomes in a single policy implementation

This study observes that a single policy from the Hospital Authority had resulted in multiple formats in the development of patient care. For instance, there were seven models of patient care developed to implement a total patient care policy by twenty-two public hospitals where initiatives had taken place. These seven models continue its existence and they are:

- Chronic Patient Approach (Patient Resource Centre in general hospitals) and the
- Shared Care Approach (Patient Resource Centre to enhance collaboration with private doctors)
- Cancer Patient Approach (Cancer Patient Resource Centre in large acute and teaching hospitals)
- Social Centre Approach (Patient Resource and Social Centre in psychiatric hospitals)
- Community Approach (Prevention and building patient support networks)
- Health Education Approach (Health Resource Centre)
- Combination Approach (Traditional hospital social services and PRC development in small hospitals)

Among these different models of patient care approach (Table 8.1); the cancer patient and psychiatric patient models had achieved a consensus model after a short path-finding process among the hospitals serving majority of two specific patient groups. The support for other patient groups, as the major development of patient-focused services in public hospitals, was found to be more popular in government hospitals than community hospitals. Government hospitals built formal structures while community hospitals converted existing service

features and encouraged more involvement of staff in an informal way. There were more PRCs found in large hospitals, only large hospital did not have one. This hospital has its history as an oldest community hospital (the Kwong Wah Hospital). The Kwong Wah Hospital had once considered joining the other ten large hospitals to build a PRC. However, by 1998, the Hospital decided to remain without one. Their traditions of providing holistic care by the Hospital have resulted in a belief that no new changes could be expected from a new PRC. There was diversity in other new patient care models developed by different hospitals with respects to their hospital or community orientations as discussed in Chapter 5. The extent of community influence in the hospitals was expected to continue both inside and outside a hospital environment.

Table 8.1 Hospital and community involvement in the development of total patient service

Objectives	**Community Collaboration**	**Hospital Strategies**	**Implementation modes (some examples)**
Improving quality of life of chronic patients e.g. QEH	Community funding	Patient Resource Centre	Patient self-help/ empowerment activities a) Producing new friendly information materials b) Mobilising staff to share and provide informal support
Health maintenance and home-based support programs e.g. CMC	Collaboration with private practitioners	Patient Resource Centre (Shared care Model)	Fee-charging programs for patients attending private clinics
Reducing life-threatening stress through health education in the community, e.g. on taboo issue e.g. QMH	Cultural medicine e.g. Chi Gong, Reiki, Herbal Medicine	Cancer Patient Resource Centre	Intensive counselling e.g. bereavement and promoting positive living a) Professional psycho-social intervention b) Peer Information on Alternative medicine
Ensuring rehabilitation outcomes and community integration e.g. psychiatric rehabilitation	Social conditions in the community e.g., Family support and Employers' preparation in patient discharge	Patient and Social Resource Centre	Family counselling and Discharge planning programmes e.g. job rehearsal, photo-taking service, civil awareness program, social skill training
Early involvement in illness prevention e.g. stress-related issues in community e.g. TMH (CSD) and for patient groups PYNEH (PCRD)	Networking community in different health aspects	Community and Patient Resource Centre	Community education and personal positive development a) relaxation training for community b) volunteer recruitment in positive health action
Supporting healthy actions, e.g. UCH (HRC) or PWH (HSC)	Hospital to link up with primary health within the region (district-based network on specific health topic)	Health Resource Centre	Changing life-style to healthy living and health promotion activities e.g. Anti-smoking, Diet, Exercise
Enhancing practical home-based or daily support Combined/ Conversion to extend existing patient service	Hospital to provide more technical support to enhance home adjustment	Patient Resource Centre/ Medical Social Service	Practical daily support in adjusting to illness Assisted device including Gadgets, equipment etc.

There are other possible explanations to the observation that the government hospitals were more ready to establish new patient care structures. First, medical social workers of the government hospitals come from another government department and new changes would have to go through a higher level of departmental negotiation. The development of a new structure to implement new mandate could be more efficient. The community hospitals had employed their own medical social work staff in its history. The likelihood of assigning same responsibilities to two groups of social workers under the same line of authority (discussed in Chapter 6) had caused some confusion to staff and patients.

The other explanation may be that government hospitals were fully funded by the government and thus these hospitals were more likely to implement a new policy proposed from the Hospital Authority.

However, there is another possible explanation due to different hospital orientations. The government hospitals have relatively been emphasised on the physical or technical aspect of patient care. (Chapter 3) A community-oriented approach has become direction of new government hospitals built in the 1990s. This mission was not considered as anything new to the community hospitals.

8.2 The roots of diversity

The differences in the provision of patient service in hospital were traced back to the different origins of hospital care in local context. There were two groups of public hospitals developed in the last 150 years. The historical reasons related to the development of the two groups of public hospitals, government and community hospitals, which continue to express their differences in the involvement in patient service delivery. By the end of a five-year path-finding process in the development of the totality of care model for patients, the majority of the government hospitals had established a new PRC while half of

the community hospitals did not establish one. Those hospitals that have developed new patient strategies had in fact, involved different extent of community participation in the hospital system.

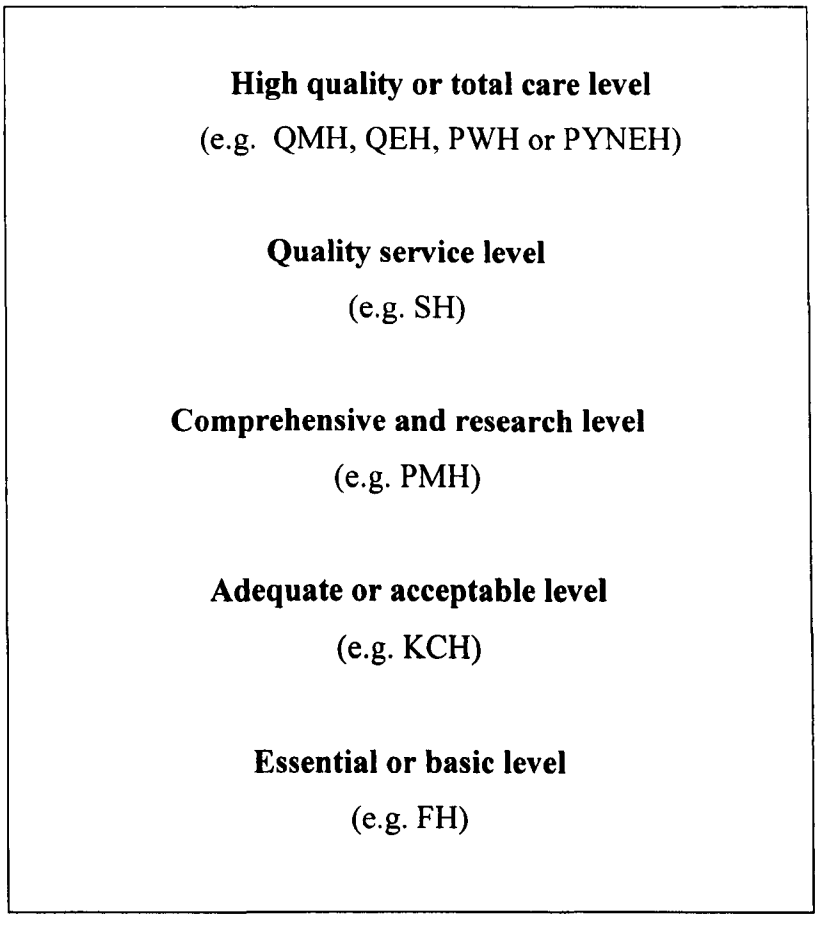
8.3 Comparison of ideological traditions of public hospitals

In 1993, most government hospitals have specified their patient care standard in their hospital mission statements (1993 Annual Report). In spite of the fact that a standardised format of patient care was planned as its ultimate objective, there were differences in the levels of care to be provided by different hospitals. These differences varied in terms of degree of hospital expectation to obtain basic, essential care to an excellent level of total care.

The illustrations discussed in Chapter 3 are listed in a hierarchical order to demonstrate such differences among the government group. A 'ladder' of service levels expected is constructed by examining the key words used in the mission statements of various hospitals, ranging from the basic level to high quality level. (details of descriptions provided in Chapter 3)

As illustrated in the above mission statements, the 'hospitals' commitment to their service requirements was described by different key words such as 'adequate', 'appropriate', 'comprehensive', 'quality', to 'highest possible standard'

Figure 8.3a A ladder of patient service orientations in government hospitals



The community group of hospitals has different expressions in their hospital mission statements. These mission statements declared hospital commitment for patients with a user perspective (Chapter 6). The different patient needs, medical and non-medical, were well included. The concerns for patients were practical in nature, concerning financial and tangible support, home atmosphere, emotional and spiritual care and integrative care for patient in the community integration. The following statements are illustrations of community hospital mission statements stated in 1993 (Detail descriptions listed in chapter 3). (Figure 8.3a)

Figure 8.3b Horizontal range of patient needs defined by community hospitals

The need of financial and tangible support (e.g. DKCH)	**The need of home atmosphere and dignity** (e.g. CH)	**The need of emotional and spiritual care** (e.g. UCH)	**The need of independence and community integration** (e.g. WTSH)

8.4 The leading roles of large public hospitals

8.4.1 The government hospitals

Among government group, the two teaching hospitals, i.e., the QMH and the PWH, had adopted different approaches from other government hospitals in the development of total patient care. The QMH developed only Cancer Patient Resource Centre and combined other existing patient support services into a Patient Resource Centre. The PWH, focused on health aspect, developed a Health Support Centre instead of a Health Resource Centre for their patients and families. Compared to the other mission statements of the non-teaching hospitals, the teaching hospitals had additional roles in research and the development of new medical technology in its implementation of a patient-centred approach.

8.4.2 The community hospitals

There was no specific patterns observed among the community hospitals with respect to their mission statements. There were more variations in the patient

groups and service contents among the different community hospitals. The leading role of the Kwong Wah Hospital in its provision of the Traditional Chinese Medicine for patients and the development of cultural medicine was not reflected from its mission statements.

8.5 No new patient care delivery in some hospitals

The sixteen public hospitals, which did not build new structures to designate new patient service, expanded their patient activities through a closer collaboration with the medical social service departments. For example, the Yan Chai Hospital and the Kwong Wah Hospital, started stroke and heart support groups in their Medical Social Service Departments. The Kwong Wah Hospital, famous for its free Chinese herbalist clinic, developed new preventive health scheme through purchase of new technology to improve the cancer breast-screening service. Its medical social service developed more health related services and prevention program, which was quite similar to that in a PRC.

8.6 A standardised model for all hospitals?

The question whether a common model for all hospitals can be achieved given more time or resources to manoeuvre the differences was asked in the key informant interviews. Two key informants pointed out (discussed in Chapter 6) there was a "flag-ship" effect in the existing public hospital system. It had existed as early as the two groups of public hospitals took place. The effect would likely to continue to influence on the development of total patient care. Selective interests in patient service and its benchmarking in the health care system would obviously be interfering with the development of an integrative approach.

8.6.1 Solutions from the literature

In the past decade, there has been an increasing awareness of the patient right. In the U.K., a Patient Charter has been established to protect the right for patient care. In the context of Hong Kong, the Patient Charter began to apply in early 1990s. The newly enacted legislation such as the Privacy Ordinance and the Anti-discrimination Ordinance would also promote general awareness of the civic right. Apart from the legal factors, there is a drastic increase in number of the self-help patient groups. One of the main concerns of these self-help groups is to act as 'watch-dog' for government policy. Patients are more ready to influence the health care policy. Hospital administrators are becoming more cautious about the views of the public and the patients in the community.

8.6.2 Practice in local context

In the context of this study, the long history of community involvement in the health care system, probably made its provision of patient care less distinct from other service providers (similar to Evan and Stoddart's discussion in Chapter 2). The nature of decision making in health matters where life and death issues, as discussed in the literature (Palmer and Short, 1989, pp.24-25) could have been changed through the hospital approach in empowering their patients. The uniqueness of the leadership role of medical profession as a determinant that shapes and constrains a health policy suggested by Palmer and Short (1989) could be reinforced when individual consumers were unable to distinguish between good and poor services.

Throughout the study, the patients were aware of their own concerns through their participation in self-help and mutual-help services for other patients. The community representation in the hospital was also well developed for a long time.

8.7 Community influence in the hospitals

The community influence in the hospital can be expected to continue. Although the recognition of non-medical components and the significance in patient's quality of life in health care delivery system was relatively recent in government group of hospitals when compared to the health traditions in the community group, there is an obvious development of a closer link between hospitals and the community for achieving total patient care

From the Hong Kong experience, the community hospitals developed more patient care features to support patient-centred approach when compared with the government hospitals. For instance, some community hospitals, such as the WTSH developed its extended care and infirmary sections to serve the frail and dying persons. The Pok Oi Hospitals and Tung Wah Groups developed their patient support services as an expansion to their community social service division, administered under the Tung Wah Groups of Hospitals umbrella organisation. These community hospitals had their strong linkages with social and educational services in the community. The implementation of total patient care through the development of a hospital-based structure, quite obviously, did not arouse any interest to their overall patient service delivery model.

8.8 Hospital influence in the community --total patient care integration

The development of patient services in the community began to develop from the eighties. (discussed in chapter 7) Some community hospital, including the Kwong Wah Hospital, the United Christian and the Haven of Hope Hospitals had indicated their interests in the development of ambulatory patient services (out-patient and day surgery services) during the interviews in this study. The role of a public hospital to connect with local support groups in the community, as the HCE in the KWH said (discussed in Chapter 6), was more important than the expansion of non-medical support to patients in the hospitals.

The new government hospitals, which shared similar views with the community group, were PYNEH and the TMH. These two hospitals were built in the 1990s. The new government hospitals were more ready to develop a community-based orientation. The similarity between the newly developed public hospitals and the historical community hospitals in Hong Kong was an illustration of resolving historical influences.

8.9 Consistency in policy implementation

The first research question which inquired the origins of differences was discussed in section 8.7. The second research question on the consistency of differences to a development of a totality of care model will be discussed below.

8.9.1 A combined mode in the extension of hospital service scope

Although a full transition into total patient care in all public hospitals had not been achieved, the three directions for total patient care strategies were well defined from the process. The advantage of the PYNEH model which identified the strengths of patients, staff and community involvement with a built-in developing mechanism model, compared to other models, had its flexibility to expand patient mutual support, health conditions and healthy community within its own resource available. The complexity of the PYNEH, compared to other Patient Resource Centres, had gained its official recognition from the Hospital Authority. The collective term for total patient service structures, (previously known collectively as the Patient Resource Centres) was officially replaced by the Community, Patient and Health Resource Centre (CPHRC) in 1998, the time when this study has completed. The PYNEH model illustrated the result of a five-year path-finding process in the development of a totality of care model.

A workable formulation of a total care policy will be attempted in the following section.

8.9.2 Combined Patient, Community and Health strategies in new re-structuring

The goals of developing a new paradigm of patient support were discussed by Lathrope (1993, p.90) as:

(1) to improve continuity of care for the patient;
(2) to improve the continuity of professional relationships among care givers and doctors as they collaborate on behalf of patients and
(3) the building of holistic patient care across hospital and community boundaries

The findings of this study suggested the development of the different models of patient care was consistent with the three goals of restructuring new health care delivery discussed in the literature. The new development of patient care in the local context could be considered as appropriate and relevant. First, continuity of patient care began to develop from a hospital-based orientation in the pioneer model in 1993 to expand its patient service scope, which considers comprehensive support to patients.

Second, the roles and functions of medical professionals from hospitals were not limited to medical treatment. A humanistic orientation, such as the psychosocial well being or educational aspect in patient support was seen by the medical professionals as important (e.g. oncologists in the QEH, QMH) after these doctors were involved in the development of friendly information leaflets for their patients. Third, the boundaries between professionals, service sectors (e.g. in CMC where private clinics were linked with hospital patient service) though not totally dissolved, had been weakened when service integration and co-ordination took place actively in the study period.

8.10 Policy choices and implications

About half of the public hospitals in Hong Kong had a community origin. The hospitals have flexibility to use internal through discretion 3% of the hospital annual budget by the Hospital Chief Executives (HCEs). The hospitals could also choose to solicit community funding to support its new service development without adding new financial worries to a cost-contained budget. The cost of developing total patient care in this study, was not significant comparing to the cost of other medical technology and overall expenditure. In 1998, there was over 101,000 patient attendance in the PRCs. The twenty-two hospitals, which had developed such program, covered a total of 70% of public hospital beds (a total of 19489 beds).

The 30% of hospital patients not provided with such services through the establishment of a PRC, however, could approach the medical social service department in those hospitals. Referring back to the first research finding (Chapter 5), individual hospitals were given autonomy to develop new patient initiative by formulating a contextually relevant total patient care model. This was a participatory approach, which invited frontline staff and the patient groups to resolve existing issues by creative and collective means. However, the historical and management influences of individual hospitals would be expected to dominate and continue if no policy guidelines were given.

8.10.1 Policy and Practice: Divergence or Convergence

The financial force that was often regarded in practice and in the literature as the most significant determinant than other social forces, can be refuted by the experience of Hong Kong as the community influence was found to be more persistent. The "unwillingness" of community hospitals to respond to an initiative proposed by the Hospital Authority was resulted (discussed in Chapters 5 and 6).

Policy and Service orientations versus Professional and Patient focused

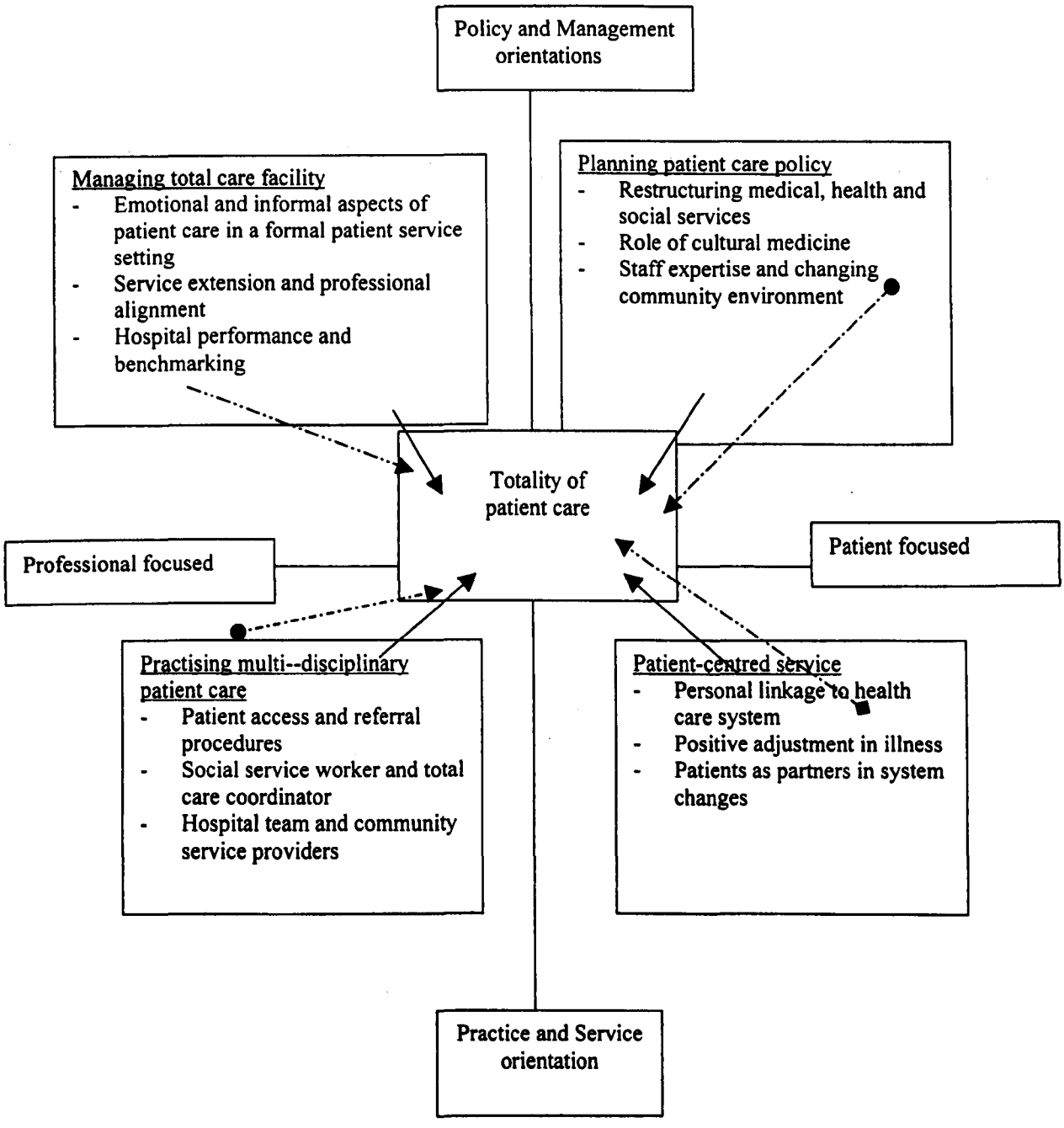
The reluctance of the community hospitals to follow the Hospital Authority's policy is a good illustration of an important policy that could not be fully implemented due to choices in public policy. The Hospital Authority advocated for the establishment of Patient Resources structure as a move for patient-focused service. Most of the government hospitals followed the same direction. However, the community hospitals (i.e. community hospitals) had reservation in the policy. It is evident that a top-down approach was not effective in this context. The hospitals were left to decide on own choices by an ideal concept. This 'bottom-up' or participatory approach was more appropriate as all medium-size community hospitals had participated in such movement. The development of the Health Resource Centre has given another important solution to the development of total patient care. These hospitals could have made simple conversion of existing services. The participation of the community hospitals was significant to the transformation of patient care, if completion transition is to be achieved. It is the view of the researcher that the format or the structure is not the main concern. It is the value orientation of a hospital-community integration that becomes the prime concern of the transition from a traditional mode into a totality model. The flexibility given to the 38 hospitals had allowed a creative design of total patient care delivery. (Figure 8.4)

8.10.2 Towards a full transformed total patient care

New patient service structure in acute hospital settings

The public hospitals are classified by their nature of patient care. The nature of service provided by acute hospitals involved a shorter length of patient stay than a non-acute hospital, e.g., a psychiatric or rehabilitation hospital. An acute hospital, when the length of stay continues to drop, could be expected to require more service extension into the community for patients whose

Figure 8.4 Collaborative efforts and Unresolved issues in the development of totality of patient care



treatment did not bring back healthiness. Similar to the situations encountered by most historic hospitals, such as QEH, there will be more patients attending outpatient services in the hospitals and requiring support in the community. The linkage of these acute hospitals with the community was inevitably essential.

No new patient service structure in other hospital settings

The hospitals that were not involved in the establishment of new patient service structures would have to play a different role in the total patient care system. Patients admitted into smaller and non-acute hospitals tended to stay for rehabilitation or convalescent reasons. These smaller hospitals mostly involved a religious mission or organisational background, for examples, the NLH, CHC, CHs and OLMH, served some specific patient groups who do not have adequate support in the hospitals or in the community. The length of patient stay ranged widely from a week to a year. Some community hospitals, e.g., MMRC and DKCH, selected their choices of serving some specific age groups, i.e. adult or children. These hospitals have expertise in some specific patient groups. Their scope of care, however, would be limited.

New ranges of disease-focused and patient-focused services

The seven models of new patient care developed by public hospitals had a range of intention to serve total patient care. The different objectives to be achieved by these models are summarised below:

(1) To provide care related to specific needs of a selected high-risk disease-related group such as cancer, or psychiatric patients (general versus specific)
(2) To provide indirect service to patient through community education

(3) To focus on patient's personal development and adjustment in the community including family, employment or other functional environments

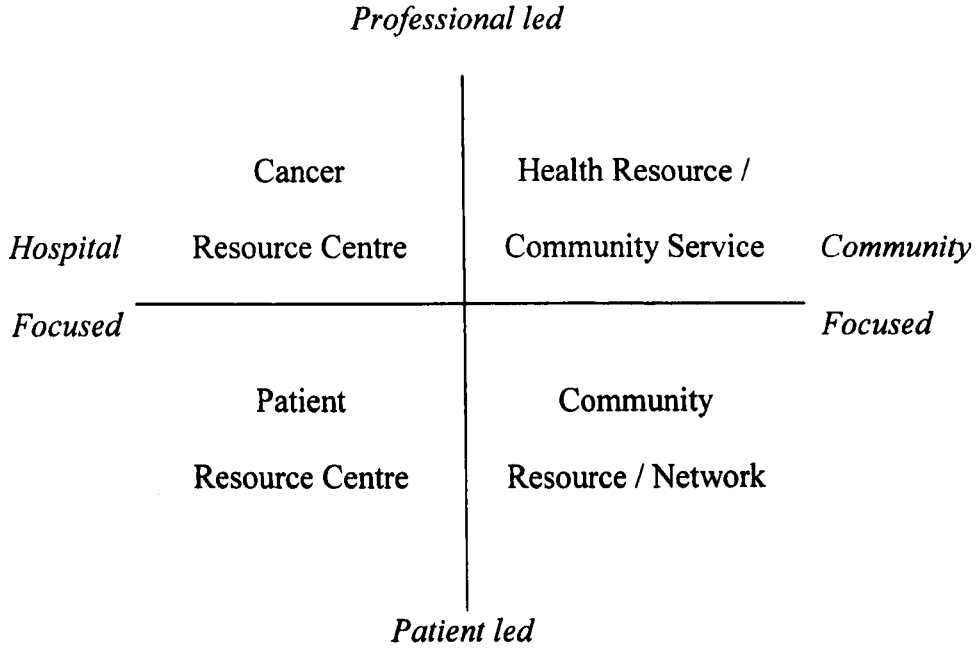
(4) To focus on preventive issue or healthy lifestyle promotion

(5) To utilise existing hospital services in experimenting new initiative

(6) To integrate externally with the community providers

By mapping the models of new patient care initiative identified with the ideological tradition on care provision, a matrix is proposed to summarise the observations from the study. The four categories of care provision, represented by the horizontal axis as the scope ranging from hospital-orientation to community-orientation and the vertical axis represented the in-patient support. (Figure 8.5)

Figure 8.5 Orientation in establishing hospital and community integrative patient support



As illustrated above (Figure 8.5), the four types of new patient care initiative differ from each other in terms of the focus of care and the format of the service provision. These 4 models also differ from each other in terms of the

influences from the medical professionals. For the Cancer Resource Centre and the Patient Resource Centre, medical professionals would play a dominant role through professional intervention and direct service delivery. The Community Service or Health Resource Centre and the Community and Patient Resource Centre focus less on neither diseases nor treatment. The influence from medical professionals would be comparatively lower, allowing more concerns on the psychosocial aspects of care.

The change in professional boundaries

The professional boundaries are often symbolically defined as a line, a region, or a zone that divide, separate, distinguish, set limits, or are the limit themselves. The change of such boundaries is often described as "highly charged" when differences meet and exchanges occur (Halley, 1997, p.151). Friction, conflict, power struggle, maintaining ritual, and resource issues can be expected. The solution to service integration and co-ordination across the boundaries would involve "boundary spanning" at three levels, individual, organisation and the trans-organization levels.

8.11 Three levels of transitions

8.11.1 Transition at Individual Hospital Level

For the individual level, patients concerns become the linking agents at the periphery or boundary between the professionals in the hospitals and service providers in the community. The linkage of two or more system whose goals and expectation are similar or partially conflicting was supported by Leifer and Heber, (1997) and (Miles, 1990).

8.11.2 Transition at Organisational Level

At an organisational level, the public hospitals manage social and medical tasks within its institutional environment. The management has to "filter, protect, buffer, and represent the organisation" to its community (Adams, 1983).

8.11.3 Transition at Trans-organisational Level

The trans-organisational level refers to the interaction within and among networks of organisations working to resolve macro problems which could not be resolved by the organisation alone (Cumming, 1984).

8.12 Patient service integration

As discussed in chapter 6, the hospital stakeholders were concerned about the co-ordination of patient-centred service through a case management system. The Total Patient Care service, involving all three levels of service integration, required strengthening of interdisciplinary teamwork and training.

To implement comprehensive and holistic patient services, the public hospitals, rooted in their historical and cultural underpinning, had to commit for the unique and ever-changing needs of the patients. A closer linkage between the hospital and community could, therefore, ensure the continuity of care for patients and lessen the burden to respond to different social needs of the patients (as discussed in chapter 6).

8.12.1 Centralisation or Decentralisation approaches

The major debate involved in this study was whether there should be policy action to ensure patients could receive similar services in different public hospitals. There are both advantages and limitations for a decentralised patient

care policy. A decentralised policy allows higher degree of flexibility, in particular to different backgrounds of the hospitals. As mentioned in the previous chapters, various hospitals have designed their own service structures based on their historical underpinning. The management approach, the new corporate decentralised bottom-up approach, replacing a traditional centralised top-down approach had caused other controversial issue in terms of policy formulation.

A centralised top-down approach with clear policy directive and standards could reinforce standardised policy outputs. On the contrary, the decentralised bottom-up approach provides autonomy for hospitals to seek appropriateness of service contents in meeting the needs of the various patient groups within any hospital context.

There is no simple answer to this question. There is no single policy which can resolve all problems (Colebach, 1998). From the experience of Hong Kong (findings discussed in Chapter 6), the administrators were of favour to reorganise services through a decentralised approach. The policy planners and the practitioners were looking for a centralised top-down approach, which could be more efficient in terms of monitoring and co-ordination.
However, with the participation of patients and the community in the development process, a decentralised bottom-up approach could be expected to be more appropriate to the specific and unique context of a multiple-hospital system.

With reference to previous government strategies and the new corporate objectives described in Chapter 3, the decision-making process of a total patient care implementation was difficult to draw definite conclusions. For instance, whether the differences in-patient care delivery should be minimised and focused in hospital or community settings could not be answered without referring to the specific hospital, community and patient contexts.

The cultural factors and the historical roots, therefore, are value bases of different hospital that challenges the management team. There was no clear evidence that total patient care improved the hospital performance by its shortening the length of patient stay. However, the stakeholders were in general positive about its development. There was no direct cost to the management office, but there was definitely a social or training cost, either committed by the community or internal staffing or through hospital discretionary budget.

It is the view of the researcher that a clear guideline from the Central Office is deemed necessary to stipulate group action. The individual hospitals would be allowed to have flexibility in modifying the delivery approaches under the same philosophy and the orientation of the Head Office.

8.12.2 Smooth Transition: A Hospital-Community Care Continuum

Totality of patient care to be leveraged through community-based support was discussed in chapter 7. The survey findings from an investigation of local informal support from the community, suggested that there were great diversity and variation in the support of different disease and patient groups. The service establishment, community attitude, frequency of program, accessibility and use of traditional medicine varied in the community-based services for the patients.

The less attended patient groups, for instances, the adolescent and mental patient groups were identified by the hospitals and the shortage of care was now covered by the Patient Resource Centres.

The technological advancement is expected to continue to influence on the patient services, which are highly dependent on the percentage of recovery to pre-morbid state.

The experience of Hong Kong in the development of new patient services had proved to be successful by its availability of patient care structures established in hospitals and in the community. The general public is under coverage of patient support by the community, which appeared to self-regulate with the hospital and formal provision of care.

The informal support and community-based patient services, developed since 1993, were in line with the development of formal patient services. However, some of these services serve same disease-related groups. For example, the stroke and geriatric patients would have greater accessibility of services. Although long term rehabilitation was expected for these patients and families, service overlapping should be prevented.

The equality of service for all the disease and patient groups need more policy considerations. Community education to improve community attitude towards some disease or patient groups is deemed necessary.

8.12.3 Development of Totality of Patient Care

The future of hospital, as the literature forecasted (Vetter, 1998), will likely to be determined by the development in high technology and ambulatory services. The recent development of the public hospitals in Hong Kong, though not all conformed within one single model, had involved the provision of a wider scope of patient service (illustrated by the 70% of public hospital beds covered by the new services provided by the PRC structures in this study).

This large proportion of service newly established to improve patient care has laid a foundation for the future development of patient care continuum between the hospital and the community, which aimed to improve services along with the development of technological and ideological changes in patient care. Service integration, as pointed out by Hassett and Austin (1997), is necessary to maintain effective co-ordination in the delivery of services to patients.

From this study, an integrated framework and some guidelines for a total patient care might incorporate the different concerns of patients and their carers. It was pointed out by the end users (in chapter 6), that personalised feeling and positive experience in going through difficult treatment process would be more important than professional or educational intervention. Patients, who used Traditional Chinese Medicine, were used to a relaxed atmosphere in consultation. McKay (1993) shared the same view that a sense of trust between the patients and the medical practitioner was important in ensuring compliance and effective medical outcome.

For the practitioners, the importance of professional practise to achieve totality was agreed among professionals. The administrators' concerns to maintain cost-containment were not violated.

The policy makers, perhaps, need to provide vision (other than tax base) on some standardised measures or tools to be used across departments and professionals in order to provide common guidelines. To resolve differences between stakeholders' view and have the different views converged into efforts, which contribute into a complete development of totality of patient care system; some common ground needs to be captured. The movement from a hospital-focused approach to a person-centred approach required the alignment of internal and external perspectives into an active interfaces, formulating a systematic and comprehensive interaction between (a) medical professionals and patient continuum and (b) the Hospital management and the community service providers continuum. (Figure 8.5)

Conclusions

A concept of "total patient care" was developed to enhance public hospital service in the early nineties in Hong Kong. The development of such a concept has illustrated some success, through an expansion of new patient service, developed

within a period of five years, serving more than 100,000 patients by 80 full-time time, supported by community funding without direct financial implication from the central hospital management office. The experience in Hong Kong, influenced by the historical differences among public hospitals, has emerged into different models of patient care. In view of previous actions taken to reinforce health policy before the 1990s, this total patient care models implemented by leading public hospitals in Hong Kong, illustrated some successes through the introduction of a corporate and participatory approach. The different models of patient care that each hospital established for its own context have carried the tradition of a hospital-focused orientation. The new hospitals, built with a corporate mission, were more ready to collaborate and re-define total patient service scope at a level which considers the preventive and personal care needs which were similar to the long-established community hospital missions.

It is suggested in the study that totality could be a vague concept, which embraced a number of ideals, values and mixture of orientation. The original propositions of this study has anticipated clear definition of sources of influence and policy action would occur at the end of a five-year period which would remove most inconsistencies due to historical or background influences. Such proposition was partly supported.

In the context of Hong Kong that had a history of being influenced by different health care orientations, and in the light of the development of patient-centred service that will not be "too fast" for the staff and the system, the pace of improvement needs more attention. The difficulty for patient care delivery models to be converged into a standardised model, i.e., to minimise diffusion in system integration, however, has its shortfall when the control on individual hospital choices was not intended within a transitional period of health care development. The complexity and dynamics in bringing health care changes was illustrated from the context of Hong Kong.

The outcomes of this study have led to a few recommendations, including some reconsideration of integrating informal caring from the community to support hospital delivery of patient care. The financial factor, well described in the literature as most essential determinant in patient care services, was not found to be the major determinant in this study. The development of a new concept of patient care, relying heavily on collaborative efforts between the government and the community efforts, could raise more debatable issues among major hospital stakeholders if the trust between parties did not exist. The historical development and cultural factors between hospitals were more influential to interpret and explain how the care concept was perceived and supportive services were formulated.

Three main conclusions drawn from this study included, firstly, a total patient care concept would continue to be interpreted differently because of historical and cultural factors. Secondly, new health care reform that opens the health care system by inviting patients to participate in the decision-making system could lead to more challenges and inconsistencies in the views between professionals and end-users. The management level needs to provide support to the practitioners. Thirdly, policy action to strengthen public hospital patient care by considering how hospital interfaces with other community care providers if it is to be efficiently implemented.

Limitations of the study

The "success" of Hong Kong's health care policy has been proved by its achievement in producing "a healthy and sizeable population of 6 millions with low cost" (Hong Kong Government, 1993). The current attempt to bring new levels of care to hospital patients is expected to generate new knowledge and valuable theory grounded in experience. This may be particularly valuable to Western nation, which have adopted costly high technology medical solutions. Some unique elements in the social and medical systems of Hong Kong can be criticised as limitations of the study. However, as Hong Kong is an

international city and is strongly influenced by global trends, many if not all of the results are expected to provide generalisable.

Appendix 1 Government (Schedule I) Hospitals in Hong Kong (as of 1993)

Code	Name of Hospital	Hospital Size * (beds)	No. of medical staff	No. of non-medical staff	Region
H1	Castle Peak	1741	35	1235	NT
H2	Fanling	100	10	191	NT
H3	Hong Kong Eye	14	42	184	KLN
H4	Kowloon	1012	29	1373	KLN
H5	Kwai Chung	1581	37	1287	NT
H6	Lai Chi Kok	432	3	214	NT
H7	PamelaYoudeNethersole Eastern	600*	112	1281	HK
H8	Prince of Wales	1342	265	3490	NT
H9	Princess Margaret	1158	270	2392	NT
H10	Queen Elizabeth	1923	418	4421	KLN
H11	Queen Mary	1345	256	3590	HK
H12	Shatin	620	17	649	NT
H13	Siu Lam	100	1	267	NT
H14	St. John	93	7	107	HK
H15	Tang Siu Kin	88	24	290	HK
H16	Tsan Yuk	195	9	382	HK
H17	Tuen Mun	1319	213	2339	NT
H38	Tai Po Hospital	In planning stage**			NT
Total	**No. of hospitals=18**	**13063**	**1748**	**23692**	

HK = Hong Kong Island and Outlying Islands Kln= Kowloon Peninsula NT = New Territories

*PYNEH was not fully operated in 1993

**Tai Po Hospital hired a social worker for the Patient Resource Centre in its planning stage

Appendix 2 Community (Schedule II) Hospitals in Hong Kong (as of 1993)

Code	Name of Hospital	Hospital Size by no. of beds	No. of doctors	No. of non-medical staff	Location
H18	Caritas Medical Centre	1386	143	1892	KLN
H19	Cheshire Home (CHK)	90	0	41	HK
H20	Cheshire Home (Shatin)	296	2	196	NT
H21	Duchess of Kent Children's	150	9	277	HK
H22	Fung Yiu King	296	4	218	HK
H23	Grantham	625	35	796	HK
H24	Haven of Hope	257	12	433	NT
H25	Hong Kong Buddhist	353	12	349	KLN
H26	Kwong Wah	1417	184	2513	KLN
H27	MacLehose Medical Rehabilitation Centre	150	1	164	HK
H28	Margaret Trench Medical Rehabilitation Centre	90	1	95	KLN
H29	Nam Long	180	6	174	HK
H30	Our lady of Maryknoll	252	40	569	KLN
H31	Pok Oi	342	31	468	NT
H32	Ruttonjee	490	36	686	HK
H33	Tung Wah Eastern	327	26	506	HK
H34	Tung Wah	787	33	813	HK
H35	United Christian	671	109	1774	KLN
H36	Wong Tai Sin	1003	18	554	KLN
H37	Yan Chai	544	42	922	NT
Total	**No. of hospitals=20**	**9706**	**744**	**13440**	

HK = Hong Kong Island and Outlying Islands Kln= Kowloon Peninsula NT = New Territories

Appendix 3

Fees and Charges in Public Hospitals (as of 1997)

Hospital Services	Daily Charges (HK$)	Cost (HK$)
In-patient Public Ward (3rd class)		
General Hospital	68	3130
Psychiatric Hospital	68	865
Out-patient		
General clinic	37	195
Specialist clinic	44	455
Day Hospital		
Geriatric	55	1430
Psychiatric	55	525
Community Nursing		
General (per visit)	55	360
Psychiatric (per visit)	55	1090
Clinic		
General	37	195
Specialist	44	455
Physiotherapy	44	455
Occupational therapy	44	455

Appendix 4

Summary on the development phases of health care policy in Hong Kong

Process of Policy Development	Issues and Foci	Action to maintain balance
Period I	Demographic / Epidemiological	Tolerance attitude: "No complaint" and non-intervention on traditional medical practice
Period II	Health statistics: Mortality and morbidity	Tolerance over difference in service standard between hospitals : International standard over local standard
Period III	Health financing	Involve community to contribute in public health finance, i.e., to raise fees from 3% to 5% of the actual cost (not implemented due to opposition voice from community)
Period IV	Public health services improvement	Private sector found public sector becomes competitive
Period V	Development of totality of care	Re-structuring of health care system for the future: delivery mode that considers Need, Expectation and "Appropriate" Solution

Appendix 5

Guideline and participant lists for Focus Group Discussion

a) Guideline for Focus Group Discussion

1. In terms of the current provision of patient services, what are the prominent issues of the health policy in Hong Kong?

2. What do you think are the essential needs of patients during the treatment process and the follow-up care when they return to community?

3. What are the requirements for meeting the needs of the patients in a holistic perspective, in terms of the policy, administration, and services levels?

4. What are your views about the integration and co-ordination of patient services provided by hospitals and community organizations?

5. What are your recommendations for improving the quality of patient care in Hong Kong?

b) List of the Focus Group participants

Hospital Stakeholders	**Number of participants**
Patients, including ex-patients	36
Health Care Practitioners and Community Services Providers	16
Hospital Managers and Administrators	14
Health Care Educators and Policy Makers	11
Total	77

c) Major source of key informant interviews

1. QEH
2. KWH
3. UCH
4. Yan Chai Hospital
5. TWEH
6. PYNEH
7. PMH
8. Medical Faculty of the Chinese University of Hong Kong
9. Hospital Authority Head Office
10. Health and Welfare Bureau

Appendix 6

The questionnaire

Instruction: This is a survey on the existing patient support provided in your hospital community. There is no right or wrong answer. Please "circle" the number on the line referring to the patient service areas. Your contribution to the study is appreciated. Thank you.

(1) Establishment of patient or personal service(s) in the community

Establishment of services	No such involvement	Newly involved (e.g. less than 1 year)	Somewhat involved (2-4 years)	Long-standing involvement (5-10 years)	Historically Involved (over 10 years)
Cancer	1	2	3	4	5
Stroke	1	2	3	4	5
Heart	1	2	3	4	5
Lung	1	2	3	4	5
Renal	1	2	3	4	5
Diabetes	1	2	3	4	5
Mental	1	2	3	4	5
Geriatric	1	2	3	4	5
New-born	1	2	3	4	5
Adolescent	1	2	3	4	5

(2) Degree of supportive attitude towards different patient groups

Attitudes	Highly negative	Negative	Varied	Positive	Highly positive
Cancer	1	2	3	4	5
Stroke	1	2	3	4	5
Heart	1	2	3	4	5
Lung	1	2	3	4	5
Renal	1	2	3	4	5
Diabetes	1	2	3	4	5
Mental	1	2	3	4	5
Geriatric	1	2	3	4	5
New-born	1	2	3	4	5
Adolescent	1	2	3	4	5

(2) Frequency of programme or activities provided in the community

Frequency of programmes	Annually	Quarterly	Monthly	Bi-weekly	Weekly
Cancer	1	2	3	4	5
Stroke	1	2	3	4	5
Heart	1	2	3	4	5
Lung	1	2	3	4	5
Renal	1	2	3	4	5
Diabetes	1	2	3	4	5
Mental	1	2	3	4	5
Geriatric	1	2	3	4	5
New-born	1	2	3	4	5
Adolescent	1	2	3	4	5

(4) Accessibility to patient support programmes in the community

Accessibility	Low Accessibility	Some difficulty to access	Accessible	Easy access	Enhanced access (e.g., 24-hour service)
Cancer	1	2	3	4	5
Stroke	1	2	3	4	5
Heart	1	2	3	4	5
Lung	1	2	3	4	5
Renal	1	2	3	4	5
Diabetes	1	2	3	4	5
Mental	1	2	3	4	5
Geriatric	1	2	3	4	5
New-born	1	2	3	4	5
Adolescent	1	2	3	4	5

(5) Patient use of alternative healing methods in the community

Alternative healing	Negative effects	Not effective	Needs guidance	Some positive effects	Positive effects
Cancer	1	2	3	4	5
Stroke	1	2	3	4	5
Heart	1	2	3	4	5
Lung	1	2	3	4	5
Renal	1	2	3	4	5
Diabetes	1	2	3	4	5
Mental	1	2	3	4	5
Geriatric	1	2	3	4	5
New-born	1	2	3	4	5
Adolescent	1	2	3	4	5

Appendix 7

Illustrative new patient activities in the early development of a Patient Resource Centre.

Type of illness and Demands	Needs expressed	Organised activities
Young Diabetic patients No. of patients =35	• Parents and young people's understanding of diabetes and its impact • Mutual sharing among patients and parents and between patients, parents, teachers and health professionals	Promoting acceptance of illness • Joint activities with young diabetic in other hospitals, e.g., study skills and out-door activities • Diet programme • Leadership activity and sharing with elderly diabetic patients on "needle injection" and choice of needles
Cooley's Anaemia No. of patients = 75	• Mutual support amongst patient in bulk purchase of appliances and products • Social and educational activities • Discussion of philosophical issues and medical developments	Empowering self-mastery • Therapeutic art group to enhance expressiveness about difficulties encountered • Volunteer training and In-patient ward visit • Bulk purchase duty and recreational activities
Burn injured patients No. of patients =90	• Coping with severe burn injury: scar, change in appearance due to disfigurement, compliance and use of assistive device • Counselling and knowledge on treatment • Communication between patients, families and medical professionals • Support network among patients	Handling anger • Educational talk • Family activities • Publication of educational Leaflet
Chronic renal failure No. of patients =300	• Mutual support groups for patients and families • Communication between hospital and patients • Patient right and Advocacy	Public concerns and financial implications of home care • Donation campaign • Annual gathering • Job re-training

Source: QEH Patient Resource Centre steering committee report, 1994

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