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Use of Traditional Chinese Medicine in the Hong Kong Special Administrative Region of China

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ABSTRACT

Objective: The role of Traditional Chinese Medicine (TCM) as a part of the Hong Kong health care system was not formally recognized until the handover of the city's sovereignty from the United Kingdom to mainland China in 1997. Population-representative data collected in a Thematic Household Survey (THS) in 2002 provided the first large-scale, cross-sectional study of utilization of TCM after 1997.

Materials and Methods: Face-to-face interviews were conducted with 31,762 noninstitutional and institutional residents, a representative sample of Hong Kong's population of 6,504,255.

Results: Among all respondents, 3.9% preferred TCM when they experienced medical problems. Of those reporting symptoms of medical problems in the 30 days preceding the THS, 1.8% had utilized TCM regularly in the past 6 months; 8.8% had consulted a TCM practitioner, and 2.7% had used TCM over-the-counter products. The utilization rate of TCM for respondents younger than 14 years was lower in all categories. Among patients who claimed to have medical benefits or insurance policies ($N = 12,869$), 14.5% were covered for TCM. Logistic regression analysis showed that preference for TCM was higher among women, older persons, and those with lower scores on the General Health Survey Short Form (SF-12), chronic disease, and higher education levels. Being single, institutionalized, and an older patient with a chronic disease were negatively associated with choice for and usage of TCM. Respondents with a higher education level and chronic disease patients were more likely to have insurance coverage for TCM, while those who were older, chronic disease patients, and single persons were least likely to have such coverage.

Conclusion: Compared to the pre-1997 studies, the THS of 2002 made three novel findings. First, respondents of higher socioeconomic class emerged as a new class of TCM users. Second, there was a low rate of TCM utilization among institutionalized elderly persons. Lastly, older respondents were less like to be covered by TCM insurance. This paper discusses the issues raised by the THS of 2002 and suggests areas for future research, including a better understanding of TCM accessibility among the elderly and possible financing opportunities for community TCM services.

INTRODUCTION

Traditional Chinese Medicine (TCM) is one of the most popular forms of complementary and alternative medicine (CAM) in East Asia, and is an integrated component of China's health care system.[1] However, this was not the case for Hong Kong until recently. During the British colonial period, TCM, despite its long history of usage and practice, was left outside the mainstream in Hong Kong, while allopathic (Western) medicine dominated the health care system.[2] Following the handover of sovereignty of Hong Kong from the United Kingdom to China in 1997, the Hong

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Kong Special Administrative Region (SAR) Basic Law came into effect, and the development of TCM in the city was explicitly encouraged.[3]

The development of TCM was highlighted in the first policy address of the Chief Executive of the Hong Kong SAR in October 1997.[4] Subsequently, Hong Kong passed the Chinese Medicine Ordinance in 1999, which embarked the formal regulations of TCM practice. It also serves as a first step in integrating TCM and allopathic medicine with one another.[5] In the same year, the Chinese Medicine Council of Hong Kong (CMCHK) was established to facilitate the regulatory process. In the first round of registration exercises, in November 2002, 2384 TCM practitioners were granted formal recognition, and in May 2003, when manufacturers and traders were invited to submit their applications for product licenses, the regulations were extended to cover all Chinese herbal products. The assessment of product license applications is now underway. The context of these developments is a health care system in which primary care is primarily private but hospital care is tax-based and funded with minimal charges to members of the Hong Kong population.

Currently, three local universities in Hong Kong have established 5-year full-time undergraduate degree courses to train future TCM practitioners. TCM services have been funded both in collaboration with the nongovernmental organization sector (e.g., charity groups) and since December 3 via the public medical sector.[6] The government has promised to establish a total of 18 public TCM clinics throughout the districts of the Hong Kong SAR.[7] Located in allopathic public hospitals, 6 TCM clinics have been opened in the past 6 years, and demand for such service has been increasing.[8] Recently, public demand for integrative medicine services in government-funded health care establishments has been highlighted in the media, and especially the possibility of receiving integrated treatment in inpatient settings. Although there has been much debate between patients, allopathic physicians, and TCM practitioners, an explicit policy for such integrated treatment has yet to be established.[9]

Studies done during the colonial period showed that users of TCM are mainly older, female, and have chronic diseases, and have poorer health and are in a lower socioeconomic bracket.[10–13] To investigate the changes in the pattern of utilization of TCM after the handover of Hong Kong, we analyzed data from the Hong Kong SAR government's census-based Thematic Household Survey 2002 (THS 2002) to describe the demographics and socioeconomic characteristics and health status of users of TCM. We also analyzed their TCM insurance coverage.

MATERIALS AND METHODS

The THS 2002 was conducted from May to July 2002 by the Census and Statistic Department (CSD) of the Hong Kong SAR government. All household samples were collected via face-to-face interviews during personal visits by trained enumerators. The THS 2002 covered the entire land-based population of Hong Kong, including institutional (including homes for elderly people with mental illness, mentally retardation, and blindness and other physical disabilities) and noninstitutional residents' subgroups. A total of 31,762 persons were interviewed, comprising 29,561 non-institutionalized (response rate: 97.2%) and 2111 institutionalized (response rate: 78.4%) individuals. All sample data were weighted to achieve population representation, using standard census methodologies used by the CSD. The total sample represented 6,504,255 persons of the local general population of Hong Kong.

Socioeconomic and demographic data, scores on the General Health Survey Short Form (SF-12), the presence of chronic illness, and health-related behavior were recorded in the survey. TCM utilization was considered as the use of one of the three common domains of TCM in local practice as defined by the CMCHK: Chinese herbalism, acupuncture, and bone setting.[5] Specific questions included in the survey are listed in Table 1.

Statistical analysis

To establish a comparison with pre-1997 results, potential demographic, socioeconomic, and health-related factors including gender, age, marital status, education level, household type, presence of chronic disease, SF-12 scorings, smoking habit, and drinking habit were chosen to describe TCM use, with reference to previous studies. These potential factors were entered simultaneously into a multiple logistic regression model to evaluate their main effect on TCM utilization. In addition, their two-way interactive effects on TCM utilization were assessed through a forward stepwise selection strategy. In general, this process added the most significant interactive term (i.e., the term that would result in the largest likelihood ratio statistic) to the logistic regression model at each step, and was continued until no factor not included in the model made a significant ($p < 0.05$) contribution. SPSS for Windows Release 14.0 (SPSS Inc., Chicago, IL) was used for statistical analysis. Income was not included in our analysis, since only the heads of households were asked to provide such information in the survey. Educational attainment is considered a proxy of income in the analysis, since the data set indicated that personal income was highly correlated with the respondents' educational attainment (Chi-square linear-by-linear association $p < 0.001$).

RESULTS

Among all respondents ($N = 31,668$), 1221 (3.9%) preferred TCM when they experienced any symptoms of medical problems. Among patients reporting symptoms 30 days

Table 1. Questions Related to TCM Utilization in the Thematic Households Survey 2002

Targeted respondents (base number)	*Utilization pattern*	*Questions*
All respondents (N = 31,668)	Prefer TCM	(1) "If you were sick, would you usually see a Western or a Chinese medicine practitioner?"
Respondents who reported symptoms during the 30 days before survey (N = 7597)	Regular TCM use	(2) "In the past 6 months, do you need to take Chinese herbal medicine regularly?"
	Recent TCM use	(3) "Did you visit a TCM practitioner (Chinese herbalist, acupuncturist, or bonesetter) for the discomfort?"
	Recent TCM OTC use	(4) "Did you consume TCM over-the-counter (OTC) products for the discomfort?"
Respondents who reported having any medical insurance or coverage (N = 12,869)	TCM covered by insurance	(5) "Do you possess any TCM benefit or policy?" If the respondent responded "yes" (5a) "Is a co-payment or a fixed sum required by these benefits or policies?" (5b) "Do these benefits or policies cover the equal amount as your allopathic GP policies did?"

before being surveyed, (N = 7597), 138 (1.8%) reported regularly utilizing TCM services in the prior 6 months. Six hundred and sixty five (665; 8.8%) respondents had consulted TCM practitioners in the 30 days before being surveyed, while 6293 (82.8%) had visited allopathic physicians. Two hundred and five respondents (205); 2.7%) had used over-the-counter (OTC) TCM products, while 702 (9.2%) had consumed allopathic OTC products. Figures for TCM preference, regular and recent TCM use, and recent TCM OTC use were all lower among respondents who were younger than 14 (Tables 2 and 3).

Among all respondents who claimed to have medical benefits or insurance policies (N = 12,869; 40.7%), 1868 (14.5%) were covered by TCM benefits or insurance, while 10,986 (85.5%) were covered for allopathic treatment only. A lower percentage of respondents younger than 14 years had TCM insurance (12.6%) than those older than this (14.8%). Nine hundred and sixty seven (967; 51.8%) of those respondents with TCM policies or benefits had to make a copayment or fixed sum, while 807 (43.2%) were covered to an amount of benefit equal to that for respondents covered by allopathic policies for outpatient care.

Multiple logistic regression analysis (Table 4) showed that preference for TCM was related positively to a characterized set of demographic, socioeconomic, and health-status factors, including female gender, older age, education above the primary level, presence of chronic diseases, and lower SF-12 physical and mental domain scores. These char-

Table 2. Percentage of Respondents Preferring TCM, Using TCM, or Having TCM Insurance Coverage

		Age (years)					
		<14		*>14*		*All respondents*	
TCM utilization		N	%	N	%	N	%
(1) Prefer TCM	Yes	84	1.8	1137	4.2	1221	3.9
	No	4523	98.2	25,927	95.8	30,447	96.1
(2) Regular TCM use	Yes	6	0.5	132	2.0	138	1.8
	No	1090	99.5	6369	98.0	7459	98.2
(3) Recent TCM use	Yes	41	3.7	624	9.6	665	8.8
	No	1055	96.3	5877	90.4	6932	91.2
(4) Recent TCM OTC use	Yes	14	1.3	191	2.9	205	2.7
	No	1082	98.7	6310	97.1	7392	97.3
(5) Have TCM TCM coverage (partial or complete)	Yes	221	12.6	1647	14.8	1868	14.5
	No	1538	87.4	9463	85.2	11,001	85.5

TCM, Traditional Chinese Medicine, OTC, over-the-counter.

Table 3. Health Care Choices[a] Among Respondents Who Reported Symptoms in 30 Days Before Survey

		Age (years)					
		<14		>14		All respondents	
Health care choices		N	%	N	%	N	%
TCM	Chinese herbalist	40	3.65	530	8.15	570	7.50
	Acupuncture	0	0.00	15	0.23	15	0.20
	Bonesetter	1	0.09	81	1.25	82	1.08
Allopathic medicine	Public sector services	214	19.53	2257	34.72	2471	32.53
	Private sector services	809	73.81	3013	46.35	3822	50.31
TCM OTC	Self use of OTC Chinese medicinal herbs	7	0.64	55	0.85	62	0.82
	TCM OTC proprietary medicine for internal use	7	0.64	58	0.89	65	0.86
	TCM OTC proprietary medicine for external use	0	0.00	84	1.29	84	1.11
Allopathic medicine OTC	Allopathic medicine OTC for internal use	47	4.29	592	9.11	639	8.41
	Allopathic medicine OTC for internal use	5	0.64	58	0.89	63	0.83
Allied health professions	Occupational, physical, or speech therapies	2	0.18	33	0.51	35	0.46
	Other complementary and alternative therapies	0	0.00	1	0.02	1	0.01
Self care	Diet modification	1	0.09	9	0.14	10	0.13
	Took rest only	10	0.91	197	3.03	207	2.72
	Other self care	1	0.09	9	0.14	10	0.13
	Ignore symptoms	3	0.27	71	1.09	74	0.97
	Unable to recall	0	0.00	1	0.02	1	0.01

[a]Respondents were permitted to choose more than one option.
TCM, Traditional Chinese Medicine, OTC, over-the-counter.

acteristics resembled the pattern for recent use of TCM service except for education and lower SF-12 mental domain score. Recent use of TCM OTC products was associated with older age and regular consumption of alcohol. Regular users of TCM were characterized by a tertiary level of education (community college or higher), being ex-smokers or nonsmokers, having lower SF-12 physical domain scores, and having chronic diseases. Unmarried respondents were less likely to prefer or use TCM regularly, and recent use of TCM was less likely among respondents widowed. Being institutionalized and being an older patient with chronic disease were negatively associated with preference for and any use of TCM. Haing of TCM insurance was positively related to a higher level of education and the presence of chronic disease, and negatively associated with being older or being an older chronic disease patient, and being single.

DISCUSSION

Analysis found that the demographic and socioeconomic patterns of TCM users among Hong Kong residents in 2002 largely resembled the findings in the pre-1997 period. Women, older people, chronic disease patients, and persons with a poorer health status remained the principal users of TCM in Hong Kong. The popularity of regular TCM use among ex-smokers and never-smokers might suggest a potential role for TCM practice in smoking prevention and cessation. The association between alcohol consumption and use of TCM OTC products could be explained by the local popularity of Chinese herbal wine. A greaer prevalence of coverage with TCM insurance among chronic disease patients could be related to their higher awareness of the need to keep healthy and greater financial need for covering out-of-pocket expenses for TCM services. Nevertheless, our dataset revealed a few novel findings that had not been observed in the pre-1997 studies.

The first characteristic that distinguished our results from those of previous studies was the emergence of a new class of TCM users in the higher socioeconomic group of the Hong Kong population. Before 1997, users of TCM were characterized as being marginalized from allopathic medical care because of their lower socioeconomic status.[10] In our findings, a higher education level was related to preference for TCM, and regular TCM use was strongly associated with tertiary education (odds ratio [OR]: 43.85; $p < 0.001$), which is a previously unseen pattern in Hong Kong. Analysis of the same data set, showed the monthly prevalence estimates of TCM practitioner visits to have a bipolar pattern in association with monthly household income, with respondents who earned < $HK 5000 ($US < 645) or ≥ $HK 40,000 ($US ≥ 5,158) having the highest visit frequencies

Table 4. Demographic and Socioeconomic Patterns of TCM Utilization: Fitted Logistic Regression Models

Demographic and socioeconomic factors	*Preference for TCM*	*Regular TCM use*	*Recent TCM use*	*Recent TCM OTC use*	*Possession of TCM insurance benefit or policy*
Adjusted OR (95%)					
Sex					
Male	1.00	1.00	1.00	1.00	1.00
Female	1.50***	1.08	1.58***	1.04	1.042
	(1.28, 1.74)	(0.69, 1.68)	(1.28, 1.97)	(0.73, 1.50)	(0.92, 1.18)
Older age (years)	1.03***	1.02	1.02**	1.03**	0.98***
	(1.02, 1.03)	(0.99, 1.06)	(1.01, 1.03)	(1.01, 1.05)	(0.97, 0.99)
Marital status					
Married/cohabiting	1.00	1.00	1.00	1.00	1.00
Single	0.82*	0.48*	0.86	1.00	0.78**
	(0.67, 1.00)	(0.25, 0.93)	(0.66, 1..12)	(0.62, 1.62)	(0.67, 0.91)
Separated/divorced	1.03	1.22	0.75	1.46	1.06
	(0.74, 1.44)	(0.60, 2.47)	(0.46, 1.21)	(0.76, 2.80)	(0.73, 1.54)
Widowed	0.78	0.36*	0.62*	0.85	0.85
	(0.59, 1.02)	(0.16, 0.80)	(0.41, 0.92)	(0.50, 1.46)	(0.47, 1.54)
Education level					
Below primary	1.00	1.00	1.00	1.00	1.00
Primary	1.45**	1.05	1.36	1.12	2.31*
	(1.13, 1.86)	(0.56, 1.95)	(0.95, 1.94)	(0.69, 1.84)	(1.05, 5.07)
Secondary	1.41*	1.57	1.36	1.03	2.69*
	(1.08, 1.84)	(0.81, 3.04)	(0.93, 1.99)	(0.59, 1.80)	(1.24, 5.86)
University	1.49*	2.91**	1.49	1.05	3.76**
	(1.10, 2.04)	(1.35, 6.28)	(0.97, 2.30)	(0.53, 2.11)	(1.72, 8.21)
Household Type					
Household	1.00	1.00	1.00	1.00	
Institutions	0.41***	0.19*	0.03**	0.39*	N/A[a]
	(0.25, 0.66)	(0.05, 0.83)	(0.00, 0.22)	(0.17, 0.87)	
Presence of chronic disease					
No	1.00	1.00	1.00	1.00	1.00
Yes	3.84**	43.85***	3.52***	2.33	1.76*
	(2.37, 6.23)	(8.64, 222.46)	(1.94, 6.39)	(0.82, 6.65)	(1.01, 3.07)
Older chronic disease patients	0.97***	0.96*	0.97***	0.98*	0.99*
(Age × presence of chronic disease interaction)	(0.96, 0.98)	(0.93, 0.99)	(0.96, 0.98)	(0.96, 1.00)	(0.97, 1.00)
Higher SF-12 physical domain scoring	0.99**	0.95***	0.99**	0.99	0.99
	(0.98, 1.00)	(0.94, 0.97)	(0.98, 0.99)	(0.97, 1.01)	(0.98, 1.00)
Higher SF-12 mental domain scoring	0.98***	0..99	1.00	0.98*	1.00
	(0.98, 0.99)	(0.97, 1.01)	(0.99, 1.01)	(0.97, 1.00)	(1.00, 1.01)
Smoking habit					
Smoker	1.00	1.00	1.00	1.00	1.00
Ex-smoker	0.80	2.54*	1.11	0.88	1.28
	(0.59, 1.10)	(1.04, 6.21)	(0.73, 1.70)	(0.48, 1.62)	(0.96, 1.71)
Never-smoker	0.92	2.56*	1.10	0.97	0.89
	(0.76, 1.11)	(1.19, 5.50)	(0.83, 1.47)	(0.63, 1.50)	(0.76, 1.04)
Drinking habit					
No	1.00	1.00	1.00	1.00	1.00
Yes	1.28*	0.39	0.80	1.67*	1.12
	(1.04, 1.57)	(0.14, 1.08)	(0.57, 1.13)	(1.06, 2.61)	(0.94, 1.34)

[a]Because the majority of institutionalized respondents' health care depends on publicly funded allopathic care, the factor of institutionalization was not included in the model.

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$; other nonsignificant factors were excluded from the final model.

TCM, Traditional Chinese Medicine, NA, not applicable.

as compared with all other income brackets.[14] These results suggested that TCM services continued to be used by the lower socioeconomic groups in the Hong Kong population, with a simultaneously rising popularity of TCM among the higher socioeconomic groups following the 1997 handover of Hong Kong. The lower income groups' choice of TCM could be linked to their poorer health status, while the higher income group's choice could have been related to their purchasing power in obtaining additional care. In a broader context, such change could be attributed to the Hong Kong government's formal recognition of the TCM profession, which began after the establishment of the Hong Kong SAR. Regulation has transformed the previously chaotic TCM practice into a recognized profession. The licensure requirement for all TCM practitioners has facilitated the accessibility of formally trained practitioners and has increased the public's confidence in the safety of using TCM modalities.

In conjunction with the effect of enhanced TCM education and research among local tertiary institutions, more affluent groups in Hong Kong would appear to have become more willing to choose treatment from TCM, allopathic, or integrative medicine for their health problems.[2,15] In addition, given the highly westernized environment of a former colonial city that characterizes Hong Kong, factors related to the use of complementary and alternative medicine (CAM) in the West may also explain the phenomenon of increased use of TCM in Hong Kong. Commonly cited reasons for the use of CAM, such as patients' rising demand for holistic care, self care, a need for health promotion and maintenance, and the quality of consultation[16] may also lead patients to consult TCM practitioners, since traditional Chinese healthcare has since its origin several thousand years ago had a strong emphasis on the concepts of personalized care, balance of bodily factors, and disease prevention. Last, but not least, the change in national status of Hong Kong may have triggered cultural responses to a greater appreciation of traditional Chinese custom and values including TCM, particularly among more educated groups.[2] Currently, there is still a lack of data concerning the reasons for TCM use in Hong Kong and China, and further research on this issue is therefore warranted.

The second characteristically unique findings in our post-1997 study were that older patients with chronic disease were less likely to consult TCM practitioners and did not express a preference for TCM treatment when they were sick. Monthly prevalence estimates of visits to TCM practitioners halved from 79.2/1000 persons in the 60–69-year age bracket to 40.4/1000 persons in the $\geq$ 70-year bracket.[14]

We hypothesize that institutionalization was linked to the lower use of TCM among older chronic disease patients. The reasons for such prediction stem from the fact that about 17.6% of the chronic disease patients in the sample were institutionalized, and that in our analysis, institutionalization was negatively associated to TCM use and preference. Given the popularity of TCM among noninstitutionalised elderly persons, it is plausible that lack of accessibility to TCM service in homes for the elderly was a reason for the limited usage and choice of TCM among older patients with chronic disease. In Hong Kong, homes for the elderly are not responsible for their residents' medical costs, and we therefore also suspect that the lower usage of TCM could have been linked to a low income level among patients who were institutionalized. Because the TCM sector is mainly one of private practice, whereas Western medicine services are basically free for disadvantaged persons, a preference for TCM may have been limited by purchasing power. Thus the inaccessibility of TCM services may also have applied in homes for the disabled, since they were also included within the sampling framework of the institutionalized population. Given that TCM may fill certain "effectiveness gaps" for which allopathic medicine does not have a solution,[17] provisions for TCM services targeted to the institutionalized population may be justifiable. Further research on enhancing the choice and accessibility of TCM to institutionalized people is warranted.

The third novel feature in our findings was the pattern of coverage by TCM insurance. In Hong Kong, TCM service is largely private, and patients are required to pay for it on an out-of-pocket basis. Studies in the pre-1997 period found that patients in lower socioeconomic groups preferred TCM because its costs were comparatively lower than those for allopathic physician consultations.[10] After the 1997 handover of Hong Kong, an increase in TCM consultation and treatment fees might have been expected as a consequence of the professionalization and increased legitimacy of TCM. Our analysis indicated that younger people with higher levels of education were more likely to have TCM insurance coverage than the older and poorer segment of the population, who pay for TCM out of their own pockets. However, many of these latter people are subsidized by the Hong Kong government for allopathic medicine, paying only HK$45 (USD $5.78) for a consultation, as compared with $HK120 (USD $15.41) in public TCM clinics. Therefore, habitual users of TCM who are older and from lower socioeconomic groups may face a greater financial burden if they choose TCM treatment. In response to this potential inequality, the government has provided free TCM consultation for persons receiving social security benefits, but a daily quota has been imposed on this, and the extent to which it will resolve inequality in the use of TCM versus other medical services remains uncertain. The development of a public TCM services provision has been slow, with only 6 clinics opened since the announcement that 18 TCM clinics were to be developed in the Hong Kong SAR. Meanwhile, the utilization rate of these public TCM clinics has increased substantially. The number of consultations per month in the three TCM clinics opened in the first phase increased from 3873 in January 2004 to 6803 in March 2005,[8] but the possibilities of continuing to meet such demand by increasing publicly subsidized TCM services is slim, given the current financial cri-

sis of the public health care sector in Hong Kong.[18] Therefore, the issue of financing for broadening TCM services needs to be addressed to ensure equitable access to them. Besides enhancing current government-financed NGO models, new models of provision of TCM services should be extended to include tertiary institutions and possible joint ventures between private providers and the government. More importantly, the balance between satisfying patient choice and justifying government spending should be grounded on clinical evidence. Despite an increasing trend toward an evidence base in CAM, scarcity of clinical and cost-effectiveness research comparing CAM and conventional medical treatment is well recognized.[16] Thus, decision making for an evidence-based health care policy and allocation of finite resources to TCM or conventional medicines remains a difficult task.

CONCLUSIONS

In conclusion, the THS 2002 has provided new information on the utilization of TCM in Hong Kong. This will be further supplemented by subsequent Thematic Household surveys. Meanwhile, the government and policy makers of Hong Kong need to be aware of the potential inequities in the current system for providing health care.

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