

CPCE Health Conference 2026

Programme Book Reviewing Universal Healthcare Coverage in the Asia-Pacific



Date & Time:

31 July 2026 (Friday)
9:00 am - 5:00 pm (HKT)



Venue:

N203, 2/F, North Tower,
PolyU West Kowloon Campus,
9 Hoi Ting Road, Yau Ma Tei, Kowloon, Hong Kong; &
ZOOM Webinar (Online)

Supporting Organisations (In alphabetical order)



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I. INTRODUCTION

The College of Professional and Continuing Education (CPCE) of The Hong Kong Polytechnic University (PolyU), incorporating the School of Professional Education and Executive Development (SPEED) and the Hong Kong Community College (HKCC), is currently the largest self-financing tertiary education provider in Hong Kong. It has around 10,000 full time students and 2,000 part time students. It offers a range of programmes in many different disciplines including health related programmes at Associate Degree, Honours Bachelor's Degree and Master's levels.

This Conference is the eleventh CPCE Health Conference since 2016 and the theme is “**Reviewing Universal Healthcare Coverage in the Asia-Pacific**”. Speakers for the Keynote Presentations include: (1) **Professor Peter YUEN**, Dean, College of Professional and Continuing Education, The Hong Kong Polytechnic University, to speak on “*Universal Healthcare Coverage in Hong Kong – The Dual Track System*”, (2) **Professor David BISHAI**, Clinical Professor, School of Public Health, The University of Hong Kong, to speak on “*Tradeoffs and Strategies in the Quadruple Aim: Lessons from Hong Kong’s Health System*”, (3) **Dr Somsak CHUNHARAS**, President, National Health Foundation, Thailand, to speak on “*Challenges of Thai UHC after 20 years*”, (4) **Professor Tomonori HASEGAWA**, Professor Emeritus, Toho University School of Medicine, Japan, to speak on “*Universal Health Coverage: Perspectives from Policy, Health Economics, and Quality of Care*”, (5) **Professor Gordon LIU**, Peking University BOYA Distinguished Professor of Economics, China, to speak on “*Universal Healthcare in Chinese Mainland*”, (6) **Professor HU Bing-Jie**, Vice President, Guangzhou Medical University, China, to speak on “*Universal Healthcare in China – Recent Reforms in Greater Bay Area*”, (7) **Professor Dongwoon HAN**, Professor, College of Medicine, Hanyang University, South Korea, to speak on “*Universal Healthcare in South Korea – Lessons for the Asia-Pacific Region*”, (8) **Professor Vivienne Hui ZHANG**, Professor in the Department of Health Policy and Management, School of Public Health, Sun Yat-Sen University, Guangzhou, China, to speak on “*The Role and Implication of Telemedicine in Universal Health Coverage*”, (9) **Professor Zhanming LIANG**, Associate Dean and Academic Head, College of Business, Law and Governance, James Cook University, Australia, to speak on “*Universal Health Coverage Challenges Across the Region: An Australian Primary Care Case Study*”, and (10) **Associate Professor Dr Jukkrit WUNGRATH**, Program Chair, Master of Primary Health Care Management, ASEAN Institute for Health Development (AIHD), Mahidol University, Thailand, to speak on “*Primary Health Care: The Parts of Universal Health Coverage in Thailand*”.

There are five parallel sessions containing a wide range of important topics pertinent to policy and implication, research in healthcare, community-based models, and student presentations.

II. ORGANISATION OF CONFERENCE

Conference Chair

Professor Peter P. YUEN

Dean, College of Professional and Continuing Education (CPCE);
Professor, Department of Management and Marketing, The Hong Kong Polytechnic University (PolyU)

Organiser

Division of Science, Engineering and Health Studies, PolyU CPCE

Centre for Ageing and Healthcare Management Research, PolyU CPCE

Organising Committee

Chair	Professor Ben Y. F. FONG , Professor of Practice, Faculty of Health and Social Sciences, The Hong Kong Polytechnic University
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Secretariat	Mr Tommy K. C. NG , Project Development Officer, Centre for Ageing and Healthcare Management Research (CAHMR), College of Professional and Continuing Education, The Hong Kong Polytechnic University Mr Winston TSE , Part-time Research Assistant, School of Professional Education and Executive Development, The Hong Kong Polytechnic University

Scientific Committee

Chair	Dr Vincent LAW , Associate Division Head, Division of Social Sciences, Humanities and Design, College of Professional and Continuing Education, The Hong Kong Polytechnic University
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Members	Dr Karly CHAN, Senior Lecturer, Division of Science, Engineering and Health Studies, College of Professional and Continuing Education, The Hong Kong Polytechnic University Professor Albert LEE, Emeritus Professor of JC School of Public Health and Primary Care, The Chinese University of Hong Kong Professor HU Bing-Jie, Vice President, Guangzhou Medical University, and Visiting Scholar, Division of Science, Engineering and Health Studies, College of Professional and Continuing Education, The Hong Kong Polytechnic University Dr Wilson KWAN, Senior Lecturer, Division of Science, Engineering and Health Studies, College of Professional and Continuing Education, The Hong Kong Polytechnic University Dr Pimtong TAVITIYAMAN, Associate Division Head, Division of Business and Hospitality Management, College of Professional and Continuing Education, The Hong Kong Polytechnic University
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- Australasian College of Health Service Management
- Centre for Health Education and Health Promotion, The Chinese University of Hong Kong
- College of Nursing
- College of Pharmacy Practice
- DoctorNow NEEDS
- Greater Bay Area Health Information Management Association
- Hong Chi Association
- Hong Kong Association of Family Medicine and Primary Health Care Nurses
- Hong Kong College of Community and Public Health Nursing
- Hong Kong College of Community Health Practitioners
- Hong Kong College of Health Service Executives
- Hong Kong College of Nursing and Health Care Management
- Hong Kong Institute of Asia-Pacific Studies, The Chinese University of Hong Kong
- Hong Kong Public Administration Association
- Hong Kong Telemedicine Association
- Li Ka Shing School of Professional and Continuing Education (LiPACE), Hong Kong Metropolitan University
- Project Concern Hong Kong
- Research Centre for Gerontology and Family Studies, PolyU
- Research Centre for Green Business, PolyU CPCE
- School of Chinese Medicine, The Chinese University of Hong Kong

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- Society for the Promotion of Hospice Care
- The HKMA Institute of Healthcare Management
- The Hong Kong Society for Rehabilitation
- The Society of Hospital Pharmacists of Hong Kong
- Tung Wah College

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III. PROGRAMME

Speakers



Professor Peter P. YUEN

*Dean, College of Professional and Continuing Education (CPCE);
Professor, Department of Management and Marketing, The Hong Kong
Polytechnic University*

BA, MBA [S.U.N.Y. (Buffalo)]; PhD (Birm.); FCHSM (Aust.)

Universal Healthcare Coverage in Hong Kong – The Dual Track System

Prof. Peter P. Yuen is Dean of the College of Professional and Continuing Education (CPCE) of The Hong Kong Polytechnic University (PolyU). He is also Professor of PolyU's Department of Management and Marketing. He received his Bachelor of Arts degree in Cellular and Molecular Biology and Master in Business Administration degree from the State University of New York at Buffalo, USA, and his Doctor of Philosophy degree in Health Economics from the University of Birmingham, UK.

Prior to his appointment as Dean of CPCE, Prof. Yuen held a number of management positions at PolyU, including Associate Vice-President (Management), Director of the Public Policy Research Institute, and Head of the Department of Management. He was also the founding Director of the Doctor of Business Administration programme in the Faculty of Business.

Prof. Yuen's research mainly focuses on public policy formulation and evaluation, and health services management. He is the Co-Editor-in-Chief of Public Administration and Policy and an Editorial Committee member of Asia Pacific Journal of Health Management. He was also a consultant for the Hong Kong Special Administrative Region (HKSAR) Government and the Bauhinia Foundation on a number of public policy related projects including the West Kowloon Cultural District, Sustainable Built Environment, Subsidised Homeownership, Managed Care in Hong Kong, and Health Systems Reform.

Prof. Yuen is currently the immediate Past Chairman of the Federation for Self-financing Tertiary Education (Hong Kong). He has served as a member of the HKSAR Government Manpower Development Committee, Health and Medical Development Advisory Committee, and the Committee on Self-financing Post-secondary Education. He is a founding Fellow of the Hong Kong College of Health Services Executives, and an Honorary Fellow of the Australasian College of Health Services Management. He once served as Vice-President of the Chinese National Institute of Health Care Management Education, and President of the Hong Kong Public Administration Association.



Professor David BISHAI

Clinical Professor, School of Public Health, The University of Hong Kong

Tradeoffs and Strategies in the Quadruple Aim: Lessons from Hong Kong's Health System

Professor David Bishai is a Clinical Professor in Public Health at the School of Public Health, The University of Hong Kong. He served as Director of the School from 2023 to 2026. Prior to joining HKU, Professor Bishai had served as Professor at the Johns Hopkins Bloomberg School of Public Health for 27 years and served in the government as a health officer for the state of Maryland in 2021.

As a world-renowned educator, researcher, and practitioner, Professor Bishai has made lasting contributions to scholarship. A leading health economist, his research focuses on the performance and financing of global public health activities, primary healthcare, vaccines, and health disparities. He is the author of two books and more than 260 peer-reviewed scientific publications, and has raised USD50 million in grant support from NIH, CDC, World Bank, WHO, ADB and foundations. His award-winning courses on systems thinking and health economics have reached over forty-thousand students. As President of the International Health Economics Association, he helped to establish a global mentoring network for early career researchers. During his government service, he used local evidence to eradicate racial gaps in COVID vaccination.

Professor Bishai maintains certification by both the American Board of Internal Medicine and the American Board of Pediatrics. He received his Bachelor of Arts from Harvard in Philosophy and Physics, his Masters in Public Health from the University of California at Los Angeles, his Medical Doctorate from the University of California at San Diego, and his Doctor of Philosophy from the Wharton Business School at the University of Pennsylvania.



Ms Selina LAU

Chief Executive, Hong Kong Federation of Insurers

The Role of Private Health Insurance in UHC – Panel Discussion

Selina is the Chief Executive of the Hong Kong Federation of Insurers (HKFI), a trade body with 133 insurers operating in Hong Kong which represents over 90% of the market share. Selina has accumulated extensive management and communications experience in the field of

insurance since she joined the HKFI in 1997. In addition to overseeing the operations of the HKFI and its 30+ technical committees and various consumer education and communications projects, she also spearheaded a number of significant initiatives for the industry, including the Insurance Fraud Prevention Claims Database, the award-winning Motor Insurance DLT-based Authentication System (MIDAS), the Hong Kong Insurance Awards, etc.

Externally, she is a member of the HKSAR Government's Shenzhen-Hong Kong Financial Co-operation Committee, Hong Kong Insurance Authority's Insurance Advisory Committee, and Road Safety Council. She also serves as a member of the Hong Kong Science and Technology Parks' Data Governance Steering Committee, International Data Industry Alliance Council, Capacity Building Working Group under the Centre for Green and Sustainable Finance and Insurance Training Advisory Committee of the Qualifications Framework. She has been appointed by the Hong Kong Tourism Board as the Hong Kong Convention Ambassador.

Ms Lau is appointed by the Lingnan University as a Member of the Advisory Board on Risk and Insurance Management. At the same time, Ms Lau also serves as a Member of HangSeng University's Executive Master of Science in Insurance Programme Advisory Committee.

On the international front, Ms Lau serves the East Asia Insurance Congress (EAIC) as Secretary & Treasurer. She is also a member of the Nomination Committee and Education Forum of the International Union of Marine Insurance (IUMI). In 2021, 2022 and 2024, Ms Lau has been elected Asia's Elite Women in Insurance Industry by the Insurance Business Asia.

Ms Lau holds a Bachelor of Arts Degree from the University of Hong Kong, majoring in English and Translation. She also acquired a Master Degree in Communications and New Media at the City University of Hong Kong. She is a graduate of the seventh class of the Chinese Academy of Governance (Hong Kong).



Professor Ben Y. F. FONG

Professor of Practice, Faculty of Health and Social Sciences, The Hong Kong Polytechnic University

The Role of Private Health Insurance in UHC – Panel Discussion

Prof. Ben Fong, a specialist in community health, is the Professor of Practice in the Faculty of Health and Social Sciences at PolyU and the Director of the Centre for Ageing and Healthcare Management Research at CPCE.

Prof. Fong received his medical training at the Royal Prince Alfred Hospital of The University of Sydney, Australia, where he was also awarded the Master of Public Health degree in 1989. He has also achieved post-graduate qualifications in Medical Administration, Community

Medicine, Family Medicine and Occupational Medicine. Ben has taught Medical, Nursing and Chinese Medicine students, and supervised postgraduate candidates in Public Health, Family Medicine and Healthcare Management for years. He has honorary appointments in Family Medicine at both The Chinese University of Hong Kong (CUHK) and The University of Hong Kong, as well as in the School of Chinese Medicine, the Hong Kong Institute of Integrative Medicine, and Hong Kong Institute of Asia-Pacific Studies at CUHK. He is also an Adjunct Professor in Public Health & Tropical Medicine in the College of Public Health, Medical and Veterinary Sciences at the James Cook University, Queensland, Australia.

In over forty years of his professional career, Prof. Fong has served in public, private and university healthcare facilities both in Hong Kong and Sydney. He has commissioned and managed two local hospitals, including Ruttonjee Hospital and a new private hospital, Union Hospital. He has also served as the Director of University Health Service of CUHK, and as the Deputy Medical Superintendent of Prince Henry Hospital, a teaching hospital of the University of New South Wales, Australia. Academically, he has contributed to publications, books and public talks, particularly in community health.



Dr Wilson KWAN

*Senior Lecturer, Division of Science, Engineering and Health Studies,
College of Professional and Continuing Education, The Hong Kong
Polytechnic University*

The Role of Private Health Insurance in UHC – Panel Discussion

Dr Wilson Kwan received his Bachelor of Science in Computational Mathematics and Operations Research, and Master of Philosophy in Image Processing from The University of Hong Kong at the Department of Mathematics. Moreover, he has earned his PhD degree in Financial Time Series Analysis from The University of Hong Kong at the Department of Statistics and Actuarial Science.

Prior to joining HKCC, Dr Kwan taught in The University of Hong Kong (HKU), The Hong Kong Polytechnic University (PolyU) and The Hong Kong University of Science and Technology (HKUST). He was also invited to be a visiting lecturer for a post-graduate programme in PolyU at the Department of Logistics. Dr Kwan was a visiting lecturer in HKCC between 2003 and 2006.

Dr Kwan has taught several courses including Business Statistics, Quantitative Methods, Engineering Mathematics, Simulations, Time Series Analysis, and Management Science.



Dr Somsak CHUNHARAS

President, National Health Foundation, Thailand

Challenges of Thai UHC after 20 years

Dr Somsak Chunharas formerly served as Deputy Minister of Health for Thailand and is currently President of National Health Foundation in Thailand, an NGO promoting and coordinating evidence-based health policy and system development. Throughout his career in the Ministry of Health, Dr. Chunharas directed several offices of the Ministry of Public Health, focusing on international health, health policy and system development, international collaboration, health manpower development, and the Bureau of Health Policy and Strategies. He was the founding director of the Health System Research Institute. Dr. Chunharas also pioneered a team working on health economics and health financing capacity building which led to various health reform initiatives over the last 30 years, such as a health promotion fund and the development of the Thai universal health care system. He was recently a Menschel Senior Leadership Fellow at the Harvard T.H. Chan School of Public Health in 2017.



Professor Tomonori HASEGAWA

Professor Emeritus, Toho University School of Medicine, Japan

Universal Health Coverage: Perspectives from Policy, Health Economics, and Quality of Care

Prof. Hasegawa is a Professor Emeritus at the Toho University School of Medicine of Japan. He had his medical education at the Tokyo University School of Medicine, where he also received his Doctor of Philosophy. He was previously a Resident at the Tokyo University Hospital in Internal Medicine.

He is a member of the Japanese Society of Public Health, Japanese Society of Hygiene, Japanese Society of Transplantation, Japanese Society of Hospital Administration, and Japanese Society of Healthcare Management. He also holds membership of the following specialist councils or committees: Ministry of Labour, Health and Welfare, Committee on Disclosure of Healthcare Information, Committee on the Administration of Healthcare Organisations, Cabinet Office Council for Regulatory Reform, Office for the Promotion of

Regulatory Reform and Private Finance Initiative, Japan Council for Quality in Health Care Center for Medical Accident Prevention (vice-chair).

Prof. Hasegawa's research background includes health policy, health economics, and quality assessment of health care.



Professor Gordon LIU

Peking University BOYA Distinguished Professor of Economics, China

Universal Healthcare in Chinese Mainland

Prof. Gordon G Liu, Peking University BOYA Distinguished Professor of Economics, Dean of Peking University Institute for Global Health and Development, and a fellow of the Chinese Academy of Medicine.

Prof. Liu also serves as the Director of PKU China Center for Health Economic Research, and Chair of the Academic Committee for the PKU Institute of Educational Economics. He has held many distinguished roles in public services, including co-organising the “US-China Track II Dialogue on Health”, serving on the China State Council Health Reform Advisory Commission; associate editor for SCI academic journals of *Value in Health* (2001-2012), *Health Economics* (2013 -); and *China Economic Quarterly* (2013-2017), the Editor-in-Chief for *China Journal of Pharmaceutical Economics* (2006 -). Prof Liu obtained his PhD in Economics in 1991 from the Graduate Center at the City University of New York, under the supervision of Professor Michael Grossman. In 1994, he completed his postdoctoral training in health economics from Harvard University, under the supervision of Professor William Hsiao. Prior to joining Peking University, he was on fulltime faculty at University of Southern California, and University of North Carolina at Chapel Hill, and Peking University Guanghua School of Management. He was the 2004-2005 President of Chinese Economists Society (CES), and the 2004-2006 President of the ISPOR Asian Pacific Contortion.

Currently, he is leading two major global health projects: 1) The Planetary Health Axis System (PHAS), an AI driven large model of the multi-axis digital system, aiming to track the global development dynamics and the human footprints against the planetary boundaries; 2) The Survey of Medical Assessment for Robotic Technology (SMART), a nationally multicentered economic panel study on robotic surgeries compared to conventional approaches.



Professor HU Bing-jie

Vice President, Guangzhou Medical University, China

Universal Healthcare in China – Recent Reforms in Greater Bay Area

MD, Ph.D., Professor, Doctoral Supervisor. Currently serving as Vice President of Guangzhou Medical University. A core member of the third batch of Huang Danian-style teacher teams nationwide. Director of the Key Laboratory of Philosophy and Social Sciences of Guangdong Universities for "Health Governance Based on Big Data Utilization". Outstanding Talent in Medical and Health Care (General Practice) of Guangzhou. Visiting scholar at the University of Wales in the UK, and the University of Maryland in the USA. He has long been engaged in teaching and scientific research in forensic medicine and general practice, as well as health management and related research. He has published more than 100 papers in domestic and foreign journals such as Cell Reports and Cell & Bioscience. He has edited 8 textbooks and works, and also has participated in compiling more than 20 other works on general practice, primary care, public health and forensic medicine. He has won 5 scientific and technological awards including the First Prize of Guangdong Province Science and Technology Progress Award, and six teaching awards including the Second National Award for Textbook Construction (Second Prize for Excellent Textbooks) and the First Prize of Guangdong Provincial Teaching Achievement Award.



Professor Dongwoon HAN

Professor, College of Medicine, Hanyang University, South Korea

Universal Healthcare in South Korea – Lessons for the Asia-Pacific Region

Prof. Dongwoon HAN, MD, MPH, PhD is a Professor and Director of the Center for Global Health and Development, the Institute of Health Services Management, Hanyang University. He previously served as a faculty member of the College of Medicine, Hanyang University, and since 2024 has held an appointment as International Faculty of Eminence at Datta Meghe Institute of Higher Education and Research, India. He holds a medical degree from Hanyang University, an MPH from Seoul National University, and a PhD in health service management from the University of Birmingham, United Kingdom.

His work spans health policy research, provider payment reform, and integrative medicine. He maintains an active research programme on traditional and complementary medicine use across

diverse populations and settings, with publications in journals including BMJ Global Health, BMC Complementary Medicine and Therapies, Frontiers in Pharmacology, and Cancers. He remains actively engaged in policy advisory roles with the Korean central government, Seoul Metropolitan Government, and local governments on health system strengthening and health planning. Internationally, he has undertaken WHO consultancies and ODA assignments across Asia, Africa, the Middle East, and Latin America. He serves on the editorial boards of and as a peer reviewer for international journals including BMC series journals, The BMJ, and Frontiers.



Professor Vivienne Hui ZHANG

Professor in the Department of Health Policy and Management, School of Public Health, Sun Yat-Sen University, Guangzhou, China

The Role and Implication of Telemedicine in Universal Health Coverage

Professor ZHANG, Hui is Professor in the Department of Health Policy and Management, School of Public Health, Sun Yat-sen University in China. Her research interests are health policy evaluation, health insurance reform, economic burden of diseases, and telemedicine evaluation. She is now the committee member of Health Insurance Committee of China Health Economics Association; the member of Public Economics Committee of China Health Economics Association; and the member of Health Economics Association of Guangdong Province. She has got more than 10 grants including the National Natural Science Foundation of China; the Natural Science Foundation of Guangdong Province; China Medical Board Open Competition Research Project, and published more than 50 international and domestic journals such as Social Science & Medicine, Health Policy and Planning, Journal of Healthcare Leadership, Journal of Medical Internet Research and others.



Professor Zhanming LIANG

Associate Dean and Academic Head, College of Business, Law and Governance, James Cook University, Australia

Universal Health Coverage Challenges Across the Region: An Australian Primary Care Case Study

Professor Zhanming Liang is an internationally recognised scholar and academic leader specialising in health management competency, digital health workforce development, and

health systems leadership. She is Associate Dean (Research Education) and Academic Head (Governance, Management and Tourism) in the College of Business, Law and Governance at James Cook University. Her research has established foundational models and globally validated frameworks, including the widely adopted Management Competency Assessment Program (MCAP) tool, with strong translational impact across diverse health systems.

Professor Liang has an extensive publication record and leads major national and international workforce development initiatives, most notably the Commonwealth-funded National Commissioning Training Program, which integrates contemporary theory, empirical evidence, and practice-based learning. She brings a distinctive career spanning clinical practice, senior health service management, and academia, enabling her to bridge research, policy, and practice. Her sustained international leadership is reflected in long-standing multidisciplinary collaborations, doctoral supervision across multiple countries, editorial roles in leading journals, and her service as President of the Society for Health Administration Programs in Education (SHAPE).



Associate Professor Dr Jukkrit WUNGRATH

Program Chair, Master of Primary Health Care Management, ASEAN Institute for Health Development (AIHD), Mahidol University, Thailand

Primary Health Care: The Parts of Universal Health Coverage in Thailand

Dr Jukkrit Wungrath is a distinguished academic and researcher currently serving as the Associate Professor, ASEAN Institute for Health Development (AIHD), Mahidol University, Thailand. He was the Head of the Department of Public Health at the Faculty of Public Health, Chiang Mai University. Dr Wungrath's primary areas of research expertise include vulnerable populations health, ethnic minority health, maternal and child health, and community nutrition.

Moderators of Keynote Presentations



Professor Ben Y. F. FONG

Professor of Practice, Faculty of Health and Social Sciences, The Hong Kong Polytechnic University



Professor HU Bing-Jie

Vice President, Guangzhou Medical University, China



Dr Vincent LAW

Associate Division Head, College of Professional and Continuing Education, The Hong Kong Polytechnic University



Dr Pimtong TAVITIYAMAN

Associate Division Head, College of Professional and Continuing Education, The Hong Kong Polytechnic University

Moderators of Parallel Sessions

Session A: Policy and Implication



Dr Oscar CHIU

Senior Lecturer, College of Professional and Continuing Education, The Hong Kong Polytechnic University



Dr Chung-bo LEUNG, MH

Lecturer, College of Professional and Continuing Education, The Hong Kong Polytechnic University

Session B: Research in Healthcare



Dr Karly CHAN

Senior Lecturer, College of Professional and Continuing Education, The Hong Kong Polytechnic University



Ms Sue KWOK

Lecturer, College of Professional and Continuing Education, The Hong Kong Polytechnic University

Session C: Community-Based Models



Dr Fiona CHEN

Senior Lecturer, College of Professional and Continuing Education, The Hong Kong Polytechnic University



Dr Sally NG

Senior Lecturer, College of Professional and Continuing Education, The Hong Kong Polytechnic University

Session D: Student Presentations I



Dr Kelly MA

Lecturer, College of Professional and Continuing Education, The Hong Kong Polytechnic University



Dr Ricky LEUNG

Lecturer, College of Professional and Continuing Education, The Hong Kong Polytechnic University

Session E: Student Presentations II



Dr Wilson KWAN

Senior Lecturer, College of Professional and Continuing Education, The Hong Kong Polytechnic University



Dr Gloria LAI

Lecturer, College of Professional and Continuing Education, The Hong Kong Polytechnic University

Programme Rundown

Time	Event
9:00 am – 9:30 am	Reception and Registration
9:30 am – 9:45 am	Opening Address by Guest of Honour Dr. Cecilia FAN, JP (<i>Acting Secretary for Health, Health Bureau, HKSAR</i>)
SESSION I	
Moderator: Prof. Ben Y. F. FONG (<i>Professor of Practice, The Hong Kong Polytechnic University</i>)	
9:50 am – 10:10 am	Universal Healthcare Coverage in Hong Kong – The Dual Track System Prof. Peter P. YUEN (<i>Conference Chair and Dean, PolyU CPCE</i>)
10:10 am – 10:30 am	Tradeoffs and Strategies in the Quadruple Aim: Lessons from Hong Kong's Health System Prof. David BISHAI (<i>Clinical Professor, School of Public Health, The University of Hong Kong</i>)
(online) 10:30 am – 10:50 am	The Role of Private Health Insurance in UHC – Panel Discussion Prof. Peter P. YUEN (<i>Conference Chair and Dean, PolyU CPCE</i>), Ms Selina LAU (<i>Chief Executive, Hong Kong Federation of Insurers</i>), Prof. Ben Y. F. FONG (<i>Professor of Practice, The Hong Kong Polytechnic University</i>), Dr Wilson KWAN (<i>Senior Lecturer, Division of Science, Engineering and Health Studies, PolyU CPCE</i>)
10:50 am – 11:30 am	Morning Tea Break
SESSION II	
Moderator: Prof. HU Bing-Jie (<i>Vice President, Guangzhou Medical University, China</i>)	
11:30 am – 11:50 am	Challenges of Thai UHC after 20 years Dr Somsak CHUNHARAS (<i>President, National Health Foundation, Thailand</i>)
11:50 am – 12:10 pm	Universal Health Coverage: Perspectives from Policy, Health Economics, and Quality of Care Prof. Tomonori HASEGAWA (<i>Professor Emeritus, Toho University School of Medicine, Japan</i>)
12:10 pm – 12:30 pm	Universal Healthcare in Chinese Mainland Prof. Gordon LIU (<i>Peking University BOYA Distinguished Professor of Economics, China</i>)
(online) 12:30 pm – 1:00 pm	Q & A and Discussion
1:00 pm – 2:30 pm	Lunch at conference venue
SESSION III	
Moderator: Dr Vincent LAW (<i>Associate Division Head, College of Professional and Continuing Education, The Hong Kong Polytechnic University</i>)	
2:30 pm – 2:50 pm	Universal Healthcare in China – Recent Reforms in Greater Bay Area Prof. HU Bing-Jie (<i>Vice President, Guangzhou Medical University, China</i>)
2:50 pm – 3:10 pm	Universal Healthcare in South Korea – Lessons for the Asia-Pacific Region Prof. Dongwoon HAN (<i>Professor, College of Medicine, Hanyang University, South Korea</i>)
3:10 pm – 3:30 pm	The Role and Implication of Telemedicine in UHC Prof. Vivienne Hui ZHANG (<i>Professor in the Department of Health Policy and Management, School of Public Health, Sun Yat-Sen University, Guangzhou, China</i>)
3:30 pm – 4:00 pm	Networking Break

SESSION IV

Moderator:

Dr Pimtong TAVITIYAMAN (Associate Division Head, College of Professional and Continuing Education, The Hong Kong Polytechnic University)

4:00 pm – 4:20 pm	Universal Health Coverage Challenges Across the Region: An Australian Primary Care Case Study Prof. Zhanming LIANG (Associate Dean and Academic Head, College of Business, Law and Governance, James Cook University, Australia)
4:20 pm – 4:40 pm	Primary Health Care: The Parts of Universal Health Coverage in Thailand Associate Professor Dr Jukkrit WUNGRATH (Program Chair, Master of Primary Health Care Management, ASEAN Institute for Health Development (AIHD), Mahidol University, Thailand)
4:40 pm – 5:00 pm	Q & A and Discussion

PARALLEL SESSIONS

2:30 pm – Session A: Policy and Implication

4:00 pm Venue: WK-N201

Moderators: Dr Oscar CHIU (PolyU CPCE) & Dr Chung Bo LEUNG (PolyU CPCE)

- (1) **A Third Option: Cross-Boundary Healthcare in the GBA as a Response to Hong Kong's Ageing Challenge** (Jessie ZHANG, Our Hong Kong Foundation)
- (2) **The perspectives of public governance: how digital inclusiveness programs promote the digital usage among the older adults in Hong Kong?** (Gigi LAM, Bobo LAU, Fan LUI, Alex KS CHAN, Hong Kong Shue Yan University)
- (3) **Improving Healthcare Financing Policies for Cross-Border Healthcare between Hong Kong and mainland Greater Bay Area cities: a Proposal of a Policy Study Using Mixed Methods and System Dynamics Modelling** (Zhengwei HUANG, The Chinese University of Hong Kong, Ben Y. F. FONG, PolyU)
- (4) **Extending Universal Health Coverage into the Workplace: An Operational Navigation Framework for Workforce Well-Being in the Asia-Pacific Region** (Jose PINTO, José C. ALVES, City University of Macau)
- (5) **Sustainable Financing Strategies for Universal Health Coverage: A Comparative Analysis of Singapore and Hong Kong** (Wilfred Wan Kei LIN, HerbMiners Informatics Limited)

Session B: Research in Healthcare

Venue: WK-N213

Moderators: Dr Karly CHAN (PolyU CPCE) & Ms Sue KWOK (PolyU CPCE)

- (1) **A qualitative study exploring healthcare practitioners' views on chronic stroke survivors using outdoor exercise facilities and associated spaces in public parks for community-based self-managed physical activity** (Janet Lok Chun LEE, The Hong Kong Polytechnic University; Alex Wing Kai WONG, Shirley Ryan AbilityLab; Patrick Wai Hang KWONG, Marco Yiu Chung PANG, The Hong Kong Polytechnic University)
- (2) **Prevalence and Severity of Problematic Smartphone Use Among University Students in Hong Kong: A Comparative Psychometric Analysis** (Louis LAM, Teddy CHAN, Fowie NG, Tung Wah College; Cheuk Ki LAM, Korean International School)
- (3) **Barriers and Facilitators to MIND (Mediterranean-DASH Intervention for Neurodegenerative Delay) Diet and Forest Bathing Adherence in Older Adults: Insights from a COM B-Informed Process Evaluation** (Katherine Ka Yin YAU, Samuel Yu Sum TAM, Angela Ka Wing CHUNG, Tung Wah College; Queenie Pui Sze LAW, The Hong Kong Metropolitan University)

(4) **From Bench to Community: Exosome-Based Cancer Immunotherapy in Primary Health Care Models** (Abhimanyu THAKUR, *Delhi Pharmaceutical Sciences & Research University*)

(5) **Strengthening Community Emergency Response Capacity through Basic Life Support Training among Civil Defense Volunteers in Rural Thailand** (Foontip SRIRAWONG, Phubodin YANCHAI, Phuriphat WASUNTHARANURAK, Rifhan AMIYA, Santi INKONG, Nittiya NONTUNHA, *Kasetsart University*)

Session C: Community-Based Models

Venue: WK-S215

Moderators: Dr Fiona CHEN (*PolyU CPCE*) & Dr Sally NG (*PolyU CPCE*)

(1) **Social Prescribing: Expanding UHC Service Coverage through Community-Based Models** (Dorothy YEUNG, Dicky CHOW, Esther LOH, *Our Hong Kong Foundation*)

(2) **"Seeing the Warmth": A Community-Based Photovoice Intervention to Support Caregiver Well-being Within Universal Healthcare Frameworks** (Man Chi CHUNG, Ka Hung CHAN, Luis DOS SANTOS, *Hong Kong Shue Yan University*; Chung Yue SIU, *Saint Francis University*)

(3) **A Novel Community-Based Multi-Organ EIT Framework for High-Throughput Population Health Screening** (Jen-Chien LAI, Mo Kwan HO, *E-SENSE Innovation & Technology*; Fung Ting KWOK, *Hong Kong Young Women's Christian Association*; Kiyumi LAM, Wan Yin LO, *E-SENSE Innovation & Technology*; Monica WONG, Mitzi, *Lee Leung Yin Ping Charitable Foundation*; Andrew LAM, *Los Angeles Chinatown Service Center*; Faye CHAN, *The University of Hong Kong*; Bradley J. EDELMAN, Russell W. CHAN, *E-SENSE Innovation & Technology*)

(4) **From Pilots to Policy: Institutionalising Social Prescribing in Hong Kong's Primary Care System** (Esther LOH, Dicky CHOW, Dorothy YEUNG, *Our Hong Kong Foundation*)

(5) **A Comparative Study of the Effectiveness of Live and Digital Music Therapy for Individuals Experiencing Emotional Distress in District Health Centres (DHCs)** (Joseph Lok-Man LEE, Helen Shun Mun WONG, *PolyU CPCE*)

Session D: Student Presentations I

Venue: WK-N113

Moderators: Dr Kelly MA (*PolyU CPCE*) & Dr Ricky LEUNG (*PolyU CPCE*)

(1) **Design of a DNA Probe-Based Biosensor for Antimicrobial Resistance Detection** (Sudha THAKUR, Dani S. ASSI, Vellaisamy AL ROY, *Hong Kong Metropolitan University*)

(2) **Artificial Intelligence Analytics for Early Detection of Asymptomatic Ischaemic Stroke in Elderly Populations: A Critical Literature Review** (Ho Ching WONG, *PolyU SPEED*, Fiona CHEN, *PolyU CPCE*)

(3) **Enhancing Community Emergency Response through Robotic AED Delivery and Smart Network Integration** (Cloof Chun Ping SIU, *The Education University of Hong Kong*)

(4) **Evaluating the Clinical Utility of Artificial Intelligence in Brain Tumour Diagnosis** (Gurung AMMAN, *PolyU SPEED*; Fiona CHEN, *PolyU CPCE*)

(5) **Decentralized but Politicized: Primary Health Care and Community-Based Models for Universal Health Coverage in the Asia-Pacific** (Natalie Yee Nam YUNG, *Tung Wah College*)

(6) **Critical Evaluation of Omega-3 Supplementation for Brain Development in Young Children: Evidence Synthesis and Implications for the Hong Kong Context**

(Ho Ching WONG, Nam Kit LO, Tsz Ching KO, Amman GURUNG, Hiu Fung TSANG, Yu Hin LEUNG, *PolyU SPEED*; Karly CHAN, *PolyU CPCE*)

(7) The healthcare needs of Gen Z living in Hong Kong and underlying reasons for accessing cross-border healthcare services in the Greater Bay Area in the post-pandemic era (Kassie Ka Yu CHEUNG, *PolyU SPEED*)

(8) Integrating Zoonotic Surveillance into Primary Healthcare: Mitigating Climate-Driven Rat Hepatitis E Risks in Community Settings in Hong Kong (ARAGON Rochelle Ailie Castro, *PolyU SPEED*; Tommy K. C. NG, *PolyU CPCE*)

Session E: Student Presentations II

Venue: WK-S111

Moderators: Dr Wilson KWAN (*PolyU CPCE*) & Dr Gloria LAI (*PolyU CPCE*)

(1) Applying GIS to recognize Healthcare Service Gaps in society and enhance strategies of Market Penetration (Lok Lam WONG, *Tung Wah College*)

(2) Navigating Care Across Borders: Intergenerational Care Strategies Among Hong Kong Families During the COVID-19 Pandemic (Bowen ZHOU, *Hong Kong Baptist University*)

(3) Feasibility of Continuous Glucose Monitoring (CGM) Adoption in Non-Diabetic Populations for Preventive Health in Hong Kong (Tsz Ching KO, *PolyU SPEED*)

(4) The Effectiveness of Social Prescribing and Time Banking Intervention on Improving Mental Health of Stroke Patient Caregivers (Kiko Ka Yi LAU, *PolyU SPEED*; Fiona CHEN, *PolyU CPCE*; Sally Sin Man WAN, Tiffany Ting Yan CHAU, Ceci Wing Sze MAK, Sylvia Hoi Ching YAU, *PolyU SPEED*)

(5) Breathe Easy, Sleep Deep: HLZ Earbuds as a Non-Invasive Method to Monitor Breathing while Sleeping (Isaac Pak Kiu WONG, *The University of Hong Kong*)

(6) A Systems-Informed Framework for Integrating Obesity and Lifestyle-Related NCD Prevention into Universal Health Coverage: Insights from Nepal (Rubina ACHARYA, Nitikorn PHOOSUWAN, *Thammasat University*)

(7) Debunking the midlife metabolism ‘crashes’: Evidence-Based Interventions for Weight Management- after 30 (Natalie YANG, ARAGON Rochelle Ailie Castro, Atif KASHAF, Tsz Yan CHAN, Wing Shuen TSANG, Hoi Yan WONG, *PolyU SPEED*; Karly CHAN, *PolyU CPCE*)

(8) Exploring University Support for International Student Wellbeing in Australian Universities: A Scoping Review (Beatrice Lai Ling LAM, Christopher BOYLE, *Adelaide University*)

IV. KEYNOTE PRESENTATIONS

Keynote I: Universal Healthcare Coverage in Hong Kong – The Dual Track System

Professor Peter P. YUEN

Dean, College of Professional and Continuing Education, The Hong Kong Polytechnic University

Correspondence: Professor Peter P. YUEN (mstpeter@cpce-polyu.edu.hk)

Abstract

The history of Hong Kong's Universal Health Coverage is examined. The various health financing components are then examined in light of more recent developments -- population ageing and medical inflation. Pressure points in the system and unmet needs of certain socio-economic groups are identified. It points out that the situation is further aggravated by both allocative and technical inefficiencies inherent in both the public and private sectors, creating huge challenges for health system sustainability and meaningful UHC. While the Greater Bay Area has the potential to mitigate some of the problems, there is a need to establish a more formal system to better integrate the various components across the border. Recommendations for the way forward within Hong Kong involve the integration of existing silos, shifting resources away from acute to primary care, and the introduction of a "money follows patients" public resource allocation model to replace the existing block grant allocation arrangement in the public sector. Major reform in private health insurance is also needed. It concludes that greater government stewardship is needed to effect these changes.

Keynote II: Tradeoffs and Strategies in the Quadruple Aim: Lessons from Hong Kong's Health System

Professor David BISHAI

Clinical Professor, School of Public Health, The University of Hong Kong

Correspondence: Professor David BISHAI (dbishai@hku.hk)

Abstract

Hong Kong's health system ranks among the highest globally in life expectancy, yet allocates only 6% of GDP to health expenditure. Despite these achievements, residents face substantial financial barriers to outpatient care, and the public hospital workforce operates under considerable strain. This paradox reflects the inherent tensions of the Quadruple Aim — improving population health, enhancing patient experience, containing costs, and supporting provider well-being — whose objectives do not naturally converge. Evidence from Hong Kong demonstrates that upstream investments, particularly in tobacco control and preventive care, generate virtuous cycles in which health gains and cost efficiency are mutually reinforcing. Conversely, sustained fiscal restraint has contributed to physician undersupply, prolonged waiting times, and elevated rates of provider burnout. Ongoing reforms — including the

Primary Healthcare Blueprint, District Health Centres, and public-private partnerships — represent strategic efforts to restore systemic alignment. Hong Kong's trajectory offers transferable lessons for high-income health systems navigating analogous trade-offs.

Keynote III: Challenges of Thai UHC after 20 years

Dr Somsak CHUNHARAS

President, National Health Foundation, Thailand

Correspondence: Dr Somsak CHUNHARAS (somsak@thainhf.org)

Abstract

Thai UHC was completed in 2002 with the adding of UCS (universal coverage scheme) to the existing 2 smaller systems already covering around 30% of the population. The tax-based UCS allowed the inclusion of “the poor and those in the informal employment, rich and poor”. This was a big policy shift in public finance for health where the poor earlier benefited from the indigent card policies thru “budget allocated to the MoPH for more than 30 years before the UCS started. The UHC Act established a “strategic purchasing organisation” - NHSO (national health security Office) as a semi-public organisation to purchase services from providers, public and private, with a very comprehensive benefit package. The UCS started amidst hopes and fear from all sectors. It has grown in terms of budget and effective coverage with preventing household bankruptcy from catastrophic illnesses and overall reduction of private share in overall health expenditure as 2 key impacts among others. However it has also faced increasing challenges from public providers facing HRH shortage and burnouts along with increasing pressure to allow “users charge” to add to the “marginal if not negative” payment from UCS. Populist policy allowing “free services anywhere” has brought increasing workload to tertiary care facilities. Thai health systems have evolved over 7 decades with emphasis on primary health care and the public sector has been playing crucial roles in serving the majority of the Thai population with strong district health systems working with communities and multiple sectoral partners. The national policy has also emphasised good health as well being rather than only more access to care. Health promotion and development of “healthy public policies” advocated and supported by another 4 major health systems and policy players. The importance of health systems based on primary health care, with continuous systems redesign health promotion and healthy public policies all play important parts in determining the future of Thai UHC with UCS being the core sub-systems. With the rapid and ever changing of the broader socio-economic and political context - aging society, new technologies with high benefits and high cost, populist politics, climate changes and other environmental challenges on health, including potential global pandemics, there are already serious needs for rethinking and redesigning health systems in all fronts that will eventually have impact on UHC. Addressing financing challenges alone will be not only a short-term fix, if not impossible, but more importantly create huge lost opportunities to evolving towards a future-proof, and resilient health systems.

Keynote IV: Universal Health Coverage: Perspectives from Policy, Health Economics, and Quality of Care

Professor Tomonori HASEGAWA

Professor Emeritus, Toho University School of Medicine, Japan

Correspondence: Professor Tomonori HASEGAWA (tommie@med.toho-u.ac.jp)

Abstract

East Asian countries are commonly facing the dual challenges of population aging and declining birth rates. In Japan, both the number and proportion of older adults are projected to increase until around 2040, when the second baby-boomer generation reaches old age, after which they are expected to stabilise.

In an aging society, it is unrealistic for all regions to uniformly achieve nationally defined standards. Rather, each region should identify its priority health issues, build consensus on these priorities, and develop and monitor context-specific action plans. Establishing a robust information infrastructure and fostering human resources to support these processes have become urgent policy priorities.

One common issue that should be addressed across all regions is emergency care for older adults. In many cases, elderly patients presenting to emergency departments have relatively mild conditions. Without appropriate gatekeeping, this places excessive strain on tertiary emergency care centers. Furthermore, insufficient coordination with home-based care and long-term care facilities often results in unnecessarily prolonged stays in emergency departments, leading to functional bottlenecks. Because older adults frequently receive care from multiple providers, standardisation of medical information and the development of interoperable data systems are essential.

To date, Japan's health policy has focused on expanding healthcare delivery capacity to meet increasing demand, particularly by ensuring sufficient numbers of healthcare professionals across occupations. However, such an approach is no longer sustainable. Reform of the healthcare delivery system is unavoidable. Looking toward 2040, the key will be to recognise the healthcare workforce as the primary limiting factor and to identify the optimal mix of services deliverable within this constraint. Traditionally, staffing standards have been used to ensure the quality of care; however, with the advancement of digital technologies, including eHealth and digital transformation (DX), there is a growing trend toward greater flexibility in staffing requirements. The promotion of these technologies should be further accelerated in this context.

This presentation will examine the sustainability of Japan's universal health coverage system, with a particular focus on human resources and community-based healthcare.

Keynote V: Universal Healthcare in Chinese Mainland

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Abstract

TBC

Keynote VI: Universal Healthcare in China – Recent Reforms in Greater Bay Area

Professor HU Bing-Jie

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Abstract

Against the backdrop of advancing Universal Health Coverage (UHC) globally and the strategic integration of the Guangdong-Hong Kong-Macao Greater Bay Area (GBA), this study focuses on the latest reforms of China's universal healthcare system in the GBA, a national pilot zone for institutional innovation and high-quality medical resource sharing. Constrained by the "One Country, Two Systems" framework, heterogeneity of legal systems, and fragmented medical insurance mechanisms, the GBA has carried out all-round cross-border healthcare collaboration covering health promotion, prevention, treatment, rehabilitation, and palliative care. Practices include cross-domain tobacco control, joint chronic disease management with AI empowerment, equal public health services for Hong Kong and Macao residents in the Chinese Mainland, cross-border medical treatment direct settlement, innovative Hong Kong-style general practice and hierarchical diagnosis and treatment, introduction of innovative drugs and medical devices, cross-border rehabilitation standard unification, and whole-life-cycle palliative care cooperation. By drawing on international experience from the EU, Singapore, and the US-Mexico border, the GBA has promoted the integration of medical standards, cross-border payment connectivity, and digital health empowerment, initially forming a full-chain closed-loop UHC pattern with progressive fusion and integrated traditional Chinese and Western medicine. At present, challenges such as ununified cross-border standards, insufficient data interoperability, and unequal benefit coverage still exist. In the future, the GBA will promote the regularisation of rules, trustworthy data sharing, inclusive and equitable policies, and evidence-based scientific assessment, evolving from convenient initiatives to systematic and integrated high-quality healthcare integration. It aims to build a people-centered, resilient regional health governance model with replicable experience, seeking the greatest common denominator of health under institutional differences and providing a reference for Asia-Pacific and global UHC development.

Keynote VII: Universal Healthcare in South Korea – Lessons for the Asia-Pacific Region

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Abstract

Universal health coverage (UHC) in Asia-Pacific is increasingly assessed not only by population enrolment, but also by sustainable financing, strategic purchasing, and financial protection. Korea offers a distinctive case. After introducing mandatory health insurance for large-firm employees in 1977, it achieved universal population coverage in 1989 and consolidated multiple insurance societies into a single national insurer in 2000. Yet Korea's experience also shows that rapid coverage expansion does not automatically ensure adequate financial risk protection.

This paper synthesises Korea's UHC trajectory through three dimensions: breadth of population coverage, depth of service coverage, and height of financial protection. Compulsory enrolment, family-based membership, resident registration systems, subsidies for the self-employed, mandatory provider participation, and single-payer consolidation enabled rapid expansion while strengthening risk pooling and administrative efficiency. The National Health Insurance Service and the Health Insurance Review and Assessment Service further enhanced claims review, quality assessment, and strategic purchasing.

Korea's early model, however, prioritised breadth over depth and height. Low contributions, limited benefits, high cost-sharing, extensive non-covered services, fee-for-service incentives, and a predominantly private provider market constrained financial protection. A brief comparison with Taiwan highlights that benefit design and cost-sharing structure are central determinants of protection against catastrophic payments.

For Asia-Pacific health systems, Korea is neither a model to adopt uncritically nor a cautionary tale to dismiss. Its core lesson is that durable UHC requires deliberately balancing population coverage, benefit depth, and financial protection from the outset—and sustaining that balance over time.

Keynote VIII: The Role and Implication of Telemedicine in Universal Health Coverage

Professor Vivienne Hui ZHANG

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Abstract

Universal health coverage (UHC) means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. As

digital health develops rapidly, the question is how to translate “coverage” into effective and sustainable access to care. Telemedicine, as an important form of digital health, offers new possibilities for reorganising service delivery, improving patient experiences, and increasing the efficiency of resource allocation. Telemedicine could not only add an online consultation channel, but also use digital connectivity to bridge geographical distances, link specialist expertise with primary care, and support models of continuous care. Telemedicine can be considered as a tool for improving access to health services within UHC.

This presentation will discuss the role and implication of telemedicine in UHC through three main pathways. First, in terms of access to health services, telemedicine can extend remote consultation, specialist diagnosis, follow-up care, and emergency support to primary care facilities and resource-limited areas. Second, regarding quality of care, telemedicine may improve responsiveness, patient experiences, continuity of care, online-offline integration, and coordination between higher-level hospitals and primary care facilities. Third, in terms of financial risk protection, telemedicine might reduce patients’ indirect costs, including travel, accommodation, and time costs, while also support more cost-effectiveness models. Three studies from China will be used to illustrate how telemedicine may improve access to health services, quality of care, and financial risk protection. China’s experiences suggest that telemedicine could be considered as a system-level instrument for advancing UHC.

Keynote IX: Universal Health Coverage Challenges Across the Region: An Australian Primary Care Case Study

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Abstract

Universal health coverage is often framed primarily as a question of insurance and entitlement; however, the Australian experience suggests that the more demanding challenge emerges after coverage is achieved - sustaining a primary care system that remains affordable, accessible, coordinated, and equitable. Australia has achieved notable success through long-standing Medicare coverage, a strong general practice foundation, and high levels of public trust in primary care, yet persistent challenges remain, including rising out-of-pocket costs, workforce shortages and geographic maldistribution, fragmented federal-state responsibilities, and a predominantly episodic model of care. These pressures disproportionately affect Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, people living with chronic illness, and populations in rural and remote areas.

This presentation uses Australia as a case study to examine both the strengths and the limitations of a mature universal health coverage system and provides a brief Asia-Pacific comparison situates Australia within a broader regional context in which the performance of universal health coverage increasingly depends on financing design, workforce capacity,

service integration, and system resilience. Australia illustrates that the next phase of universal health coverage lies not only in sustaining entitlement, but in strengthening primary care so that coverage is translated into equitable care in practice.

Keynote X: Primary Health Care: The Parts of Universal Health Coverage in Thailand

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Abstract

Thailand's achievement of Universal Health Coverage (UHC) in 2002 stands as a monumental milestone in global public health and health equity. However, the sustainability and operational effectiveness of this achievement were not built overnight, nor are they sustained by financing alone. The true engine driving Thailand's UHC success is its deeply rooted Primary Health Care (PHC) system, which was systematically developed over decades preceding the introduction of comprehensive health insurance. This presentation explores the dynamic and critical intersection between PHC and UHC, illustrating how Thailand serves as a model for translating policy into actionable grassroots health development.

The presentation will begin by establishing the historical context, highlighting how early and sustained investments in rural health infrastructure and the equitable distribution of the multidisciplinary health workforce laid the indispensable groundwork for UHC. Rather than viewing UHC strictly through the lens of a health financing mechanism, this session examines how Thailand strategically leverages its primary care architecture to translate financial risk protection into accessible, comprehensive, and high-quality service delivery.

A significant portion of the presentation will delve into the structural and financial synergy between UHC's strategic purchasing—particularly the use of capitation payment models—and the decentralised provision of care. Attendees will be guided through the operational frameworks of the District Health System (DHS) and the Contracting Unit for Primary Care (CUP), exploring how these entities effectively manage resources and ensure that primary care reaches the most vulnerable populations.

Furthermore, the session will emphasise the critical role of community empowerment, civic engagement, and participatory governance within the Thai health system. A central focus will be placed on Thailand's renowned Village Health Volunteers (VHVs). We will explore how this robust network bridges the gap between formal healthcare facilities and local communities, acting as a driving force in proactive health promotion, disease prevention, and grassroots health resilience.

Finally, the presentation will address contemporary challenges facing the Thai health system, including the rapid demographic shift toward an aging society and the escalating burden of non-communicable diseases (NCDs). We will discuss ongoing service delivery reforms, such

as the development of Primary Care Clusters (PCCs), aimed at strengthening the PHC system to meet evolving health needs. Ultimately, this presentation provides a comprehensive conceptual framework, demonstrating that a resilient, well-financed, and community-centric primary care system is not merely a component of UHC, but its foundational pillar.

V. PARALLEL SESSIONS

Parallel Session A: Policy and Implication

A1. A Third Option: Cross-Boundary Healthcare in the GBA as a Response to Hong Kong's Ageing Challenge

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Abstract

Hong Kong faces an accelerating demographic challenge. Elderly service costs have grown at a compound annual rate of 12.27% — nearly three times Hong Kong's GDP growth rate of 4.39% — whilst the city's capacity to expand domestic provision is constrained by persistent land and labour shortages. Conventional domestic solutions are increasingly insufficient to meet this challenge at the scale and speed required.

This research advances a regionally integrated approach: harnessing the Greater Bay Area (GBA) as a strategic partner to address Hong Kong's ageing population challenge whilst generating mutual benefits across the region. Drawing on public survey data (n=1,004), stakeholder interviews, overseas case studies, and desktop research, the study examines whether and how a structured policy framework could make cross-boundary healthcare for retirees a credible, well-supported option.

Hong Kong's healthcare system is approaching a structural breaking point. As the population ages, demand for acute and chronic care is surging at a pace that existing infrastructure cannot sustainably absorb. Hospital bed occupancy already exceeds the recommended maximum of 85%, and specialist outpatient waiting times range from 17 to 80 weeks depending on the discipline. The stark gap between oversubscribed public hospitals and unaffordably priced private providers leaves elderly residents with few viable options — a “missing middle” service that current domestic policy has yet to adequately address.

The GBA, therefore, presents a credible third option. Hospitals in Guangdong offer specialist outpatient consultations and diagnostic imaging at a fraction of Hong Kong's equivalent private costs, whilst facing significantly lower elderly population pressure and shorter waiting times. GBA cities collectively host a considerably higher ratio of doctors per elderly resident than Hong Kong. Furthermore, Guangdong's international medical services pilot scheme — operating across 25 designated hospitals with ring-fenced capacity, market-driven pricing, and internationally recognised quality standards — has established a purpose-built channel to attract patients from Hong Kong, Macau, Taiwan, and overseas. The two systems are, in this respect, structurally complementary.

Survey findings reinforce this potential: 87% of respondents expressed interest in accessing healthcare in the GBA, yet two in five find it challenging to do so in practice — pointing to a persistent gap between demand and policy support. Despite a decade of incremental progress,

including the EHCV GBA Pilot Scheme, cross-boundary electronic health records, and two-way ambulance transfer protocols, system-level interoperability and strategic coordination remain underdeveloped.

Drawing on the European Union's cross-border healthcare practice as a reference model, this research recommends that Hong Kong expand its existing strategic purchasing framework to the GBA, beginning with a pilot targeting specialist service where elderly demand is highest and cross-boundary delivery is most clinically feasible — notably ophthalmology, orthopaedics, and diagnostic imaging. Under the proposed model, eligible Hospital Authority patients would opt into a parallel GBA waiting list, with government reimbursement pre-authorised and capped below equivalent local service costs. This approach would relieve domestic capacity pressures, extend meaningful healthcare choice to elderly residents, and support the GBA's ambitions as a regional hub for international medical services — delivering a genuine win for both sides of the boundary.

A2. The perspectives of public governance: how digital inclusiveness programs promote the digital usage among the older adults in Hong Kong?

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Abstract

Hong Kong is a global forerunner in digital capability and readiness, ranking fourth in the World Digital Competitiveness Ranking. It thus provides a critical context for examining digital inequality beyond physical access, particularly at the levels of skills and usage. Although 96.3% and 95.8% of citizens own a smartphone and use the internet respectively, there is a noticeable decline in digital usage among older adults compared with the general population, especially in financial and utility-related activities. Given its high level of digital readiness alongside persistent disparities in usage, Hong Kong offers a valuable setting for investigating how digital inclusion policies foster older adults' digital engagement. This study examines digital inclusion initiatives as institutional interventions that shape older adults' opportunities for skill development and meaningful use, and explores facilitators, barriers, and future directions within broader social and institutional contexts.

This research comprises two interrelated studies. First, a structured policy review was conducted to examine how digital inclusion initiatives in Hong Kong have been designed, governed, and operationalized to enhance older adults' ICT access, literacy, and usage from 2013 to 2025. A total of 39 initiatives were identified. This was followed by in-depth interviews conducted between April and May 2025 with program staff from three organizations that implemented digital inclusion programmes, including digital skills training, digital buddy schemes, and an e-health mobile application for older adults. These interviews examined

perceived effectiveness and implementation processes, capturing interactions across policy, organizational, and service delivery levels.

Among the 39 initiatives reviewed, development can be classified into three phases: early development (2013 to 2016), mid-period development (2017 to 2020), and recent development (2021 to 2025). The early phase focused on improving physical and material access to smart devices and developing basic operational skills. The mid-period phase emphasized the enhancement of operational and formal smartphone skills. The recent phase has shifted towards integrating digital inclusion with healthy ageing, psychological well-being, and social participation.

In addition to the policy review, interview findings indicate that older adults vary widely in digital literacy, device ownership, confidence, cognitive capacity, and motivation to learn. Programmes targeting more educated or experienced older adults encountered fewer barriers, whereas community-based initiatives required greater manpower, patience, and individualized support. This heterogeneity necessitates flexible teaching strategies, such as small-group formats, individualized pacing, and adaptive support. The findings suggest that skill acquisition alone is insufficient without conditions that enable sustained use.

Regarding effective learning and support strategies, programmes led by non-governmental organizations and supported by universities were perceived as more effective than informal family-based support. Structured learning environments provided dedicated time, patient instruction, and psychological safety for older adults to ask questions. Programmes that paired older adults with trained peer volunteers or student “digital buddies” benefited from reduced perceived social distance and increased trust. However, the interviews also emphasized that strong leadership from experienced project officers is essential for supervising volunteers and maintaining programme quality.

A3. Improving Healthcare Financing Policies for Cross-Border Healthcare between Hong Kong and mainland Greater Bay Area cities: a Proposal of a Policy Study Using Mixed Methods and System Dynamics Modelling

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Abstract

Hong Kong’s healthcare system is facing increasing pressure due to rapid population ageing, rising prevalence of chronic diseases, and growing demand for public healthcare services. While the public sector remains highly subsidized, it is constrained by limited capacity, long waiting times, and workforce shortages. In response, cross-border healthcare utilisation within the Greater Bay Area (GBA) has emerged as a potential policy strategy to expand service capacity and improve access. Mainland GBA cities offer relatively lower-cost healthcare

services and substantial medical resources; however, financial barriers remain a major constraint. Current financing arrangements are fragmented, relying heavily on out-of-pocket payments, limited government subsidies such as the Elderly Health Care Voucher Greater Bay Area Pilot Scheme, and restricted insurance coverage.

Despite growing policy interest, there is limited empirical evidence on the expenditure associated with cross-border healthcare utilisation and the resulting economic burden on Hong Kong patients. Furthermore, the effectiveness of existing financing mechanisms in shaping patient behavior and alleviating pressure on the public healthcare system remains unclear. There is also a lack of system-level analysis to assess the long-term impacts of alternative financing policies.

This study aims to develop a comprehensive healthcare financing policy framework to facilitate cross-border healthcare utilisation in the GBA and alleviate pressure on Hong Kong's public healthcare system. It adopts a four-stage mixed-methods design guided by the stages heuristic framework. First, a policy review using document analysis will examine existing cross-border healthcare financing arrangements. Second, a quantitative patient survey will assess healthcare expenditure and economic burden among Hong Kong patients utilizing GBA services. Third, semi-structured interviews with key stakeholders will explore financial barriers and facilitators influencing policy implementation. Finally, System Dynamics (SD) modelling will be used to simulate the long-term impacts of current and alternative financing policies on healthcare utilisation, patient affordability, and system capacity.

By integrating policy analysis, empirical data, and simulation modelling, this study will generate robust evidence on the financial determinants of cross-border healthcare utilisation and evaluate the effectiveness of existing policies. The findings will provide actionable policy recommendations to improve financial protection, enhance cross-border healthcare integration, and support the long-term sustainability of Hong Kong's healthcare system.

A4. Extending Universal Health Coverage into the Workplace: An Operational Navigation Framework for Workforce Well-Being in the Asia-Pacific Region

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Abstract

Workplace well-being research is grounded in rich theoretical traditions, yet it remains limited in offering practical tools that practitioners can readily implement. This conceptual paper introduces the Well-Being Navigation Model (WBNM), an integrative framework that synthesizes six established traditions—tripartite motivation, conservation of resources, flow theory, ecological systems theory, Boyd's OODA strategic adaptation logic, and narrative identity—into a unified operational architecture for workplace behavioral health. Central to the model is the five-phase OODAN loop (Observe–Orient–Decide–Act–Narrate), a recursive

process engine that guides individuals and teams through continuous well-being navigation across nested ecological contexts. Tailored for employee assistance program professionals, coaches, and organizational practitioners, the framework supports a range of applications, including workplace counseling, onboarding, career transitions, return-to-work support, and team development. The paper advances three contributions: first, the systematic integration of six theoretical traditions within a single process architecture; second, the OODAN bridging mechanism, which connects theory to practitioner-guided action; and third, the explicit incorporation of assertion motivation—the drive to maintain and savor existing well-being states—as a complement to approach and avoidance orientations.

A5. Sustainable Financing Strategies for Universal Health Coverage: A Comparative Analysis of Singapore and Hong Kong

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Abstract

Objectives This research compares the sustainable financing strategies for Universal Health Coverage (UHC) in Singapore and Hong Kong. Both high-income Asian cities face similar demographic pressures from ageing populations and rising chronic disease burdens. The objectives are to evaluate how each jurisdiction mobilises resources, pools risks, and purchases services to achieve equitable access, financial protection, and long-term fiscal sustainability while maintaining low overall health expenditure relative to GDP. Particular attention is given to mechanisms that balance individual responsibility, government subsidies, and private sector involvement.

Methodologies A comparative policy analysis was conducted using secondary data from official sources, including Singapore's Ministry of Health annual reports (2025–2026), Hong Kong's Domestic Health Accounts (2023/24), WHO Global Health Expenditure Database, and peer-reviewed literature up to early 2026. Key metrics analysed include total and public health expenditure as a percentage of GDP, out-of-pocket (OOP) spending share, coverage breadth and depth, and recent reform initiatives. Thematic analysis identified strengths in risk-pooling, cost containment, and equity. Quantitative trends were triangulated with qualitative policy descriptions to assess sustainability under projected ageing (Singapore: 25% over 65 by 2030; Hong Kong: 21.8% in 2023, rising rapidly).

Results Singapore employs a hybrid multi-payer model anchored in shared responsibility. Government subsidies cover up to 80% of public hospital bills, while compulsory MediSave (individual medical savings accounts), universal MediShield Life insurance (with enhanced chronic and preventive coverage from 2025–2027), and MediFund (last-resort safety net) provide layered protection. Total health expenditure remains low at approximately 4.5–5% of GDP, with OOP share around 31%. Recent enhancements—such as increased MediSave

withdrawal limits for chronic care, CHAS subsidies for primary care, and Pioneer/Merdeka Generation packages—have improved affordability without drawing on past reserves, preserving fiscal prudence.

In contrast, Hong Kong's system is predominantly tax-funded, delivering highly subsidised public care (up to 97% subsidy in hospitals) with minimal user fees. Private insurance via the Voluntary Health Insurance Scheme (VHIS, launched 2019) supplements this, but uptake remains modest. Total current health expenditure reached 8.3% of GDP in 2023/24 (public share 4.3%), higher than Singapore's, driven by hospital-centric secondary/tertiary care (70.7% of spending). Recent reforms include public fee adjustments (2025), price transparency legislation for private providers, and Primary Healthcare Commission initiatives to integrate private GPs and reduce hospital overload. OOP remains low in the public sector, but long waiting times and uneven private uptake challenge equity and efficiency.

Singapore demonstrates superior cost control and efficiency, achieving comparable or better health outcomes (life expectancy >83 years in both) at lower GDP share through mandatory savings and targeted subsidies. Hong Kong excels in immediate accessibility but faces greater fiscal pressure from reliance on general taxation amid slower GDP growth relative to expenditure.

Conclusion Singapore's diversified, responsibility-based financing model offers a more sustainable blueprint for UHC by aligning incentives for cost consciousness and broad risk-pooling. Hong Kong's tax-heavy approach ensures near-universal access but requires stronger mandatory elements, primary-care shifts, and private-sector integration to curb expenditure growth. Both systems illustrate that sustainable UHC in ageing societies demands continuous adaptation—Singapore through incremental enhancements and Hong Kong through deeper structural reforms. Policymakers in similar contexts can draw lessons on balancing equity with fiscal discipline to safeguard UHC for future generations.

Parallel Session B: Research in Healthcare

B1. A qualitative study exploring healthcare practitioners' views on chronic stroke survivors using outdoor exercise facilities and associated spaces in public parks for community-based self-managed physical activity

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Abstract

Background: Stroke survivors tended to go outdoors to alleviate perceived social isolation and

negative emotions, suggesting that the outdoor environment plays a crucial role in their recovery. In recent years, outdoor exercise facilities installed in public leisure spaces have increasingly been recognized as a key element of community-based health interventions for specific populations.

Purposes: This study aims to gain an in-depth understanding of healthcare practitioners' perspectives on the use of outdoor exercise facilities and associated spaces in public parks for self-managed physical activity among chronic stroke survivors.

Methods: We used a descriptive qualitative approach to gain a clear understanding of the phenomenon. Semi-structured interviews were conducted with healthcare professionals across various settings.

Results: Twelve physiotherapists participated in the interview: nine work in community settings, one in primary healthcare, and two in private practice. Centre-based physiotherapists relied on clients to locate outdoor exercise facilities independently. They evaluated the suitability of outdoor exercise equipment by reviewing photos or videos. In contrast, physiotherapists who conduct home visits identified appropriate outdoor facilities near clients' homes and encouraged their use. Outdoor exercise prescriptions from therapists were typically less stringent because intensity is limited by the non-resistance nature of most facilities. Therapists perceived outdoor exercise as beneficial for clients' reintegration into the community because it offers emotional benefits, increases the likelihood that treatment effects carry over and persist, and provides free access. Their main concerns when prescribing outdoor exercise were clients' abilities and whether they would have a companion. If some facilities were not suitable for certain chronic survivors, therapists preferred to advise against their use and suggested alternatives. To support therapists in prescribing outdoor exercise, having a rehabilitation professional recommend the types of equipment to install in parks, along with an information-rich facility location map, would be helpful.

Discussion: This is the first study to investigate healthcare practitioners' experiences and perspectives on recommending outdoor exercise facilities in parks to support chronic stroke survivors' physical activity self-management behaviours. Perspectives from practitioners highlight key considerations for designing community-based, self-managed physical activity programs for stroke survivors. In particular, future research may use a co-design approach, involving caregivers in the design and testing of this program to promote health and reduce disability for chronic stroke survivors.

B2. Prevalence and Severity of Problematic Smartphone Use Among University Students in Hong Kong: A Comparative Psychometric Analysis

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Abstract

Background: The pervasive nature of mobile technology in Hong Kong's high-density urban environment has intensified concerns regarding problematic smartphone use (PSU) within academic settings. While smartphones facilitate essential communication and learning, their excessive use is increasingly linked to behavioral addiction. This study aimed to evaluate the prevalence of smartphone addiction among university students in Hong Kong and determine if their usage patterns significantly deviate from established general population and high-risk regional benchmarks.

Methodology: A cross-sectional survey was conducted among students currently enrolled at a university in Hong Kong (N = 92). Problematic smartphone use was assessed via the Smartphone Addiction Scale – Short Version (SAS-SV), a validated 10-item instrument. Data were analyzed using one-sample t-tests to compare the sample mean against general adult ($\mu = 28.9$) and high-risk student ($\mu = 35.0$) benchmarks. A one-sample Z-test for proportions was employed to evaluate the prevalence of high-risk individuals based on gender-specific cut-offs (males ≥ 31 ; females ≥ 33).

Findings: The sample mean SAS-SV score was 36.16 (SD = 10.1), which was statistically significantly higher than the general adult population mean ($p < 0.01$). Notably, 48.39% of the participants were classified as "high-risk" for smartphone addiction. This prevalence rate was found to be statistically significantly higher than the regional student average of 35% at both the 5% and 1% significance levels ($z = 2.69$, $p = 0.0035$), aligning the sample with the upper percentiles of global problematic use trends.

Conclusion: The findings reveal a high susceptibility to smartphone addiction among the surveyed university students, with nearly half the sample exceeding established clinical thresholds. The significant elevation in scores compared to general adult norms highlights an urgent need for targeted digital well-being interventions within campus health services. Future research should investigate whether specific socio-academic stressors unique to the Hong Kong university environment contribute to these elevated addiction risks.

B3. Barriers and Facilitators to MIND (Mediterranean-DASH Intervention for Neurodegenerative Delay) Diet and Forest Bathing Adherence in Older Adults: Insights from a COM B-Informed Process Evaluation

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Abstract

Background: Cardiovascular disease (CVD) is a major public health burden among

community-dwelling older adults in Hong Kong. Elevated low-density lipoprotein cholesterol level (LDL-C) is the primary modifiable risk factor for CVD. Lifestyle modification has become the cornerstone of preventive management in the community. While the MIND diet and Forest Bathing (FB) have demonstrated benefits for lipid profiles, the factors of influencing adherence remain insufficiently explored. Understanding older adult's perceived barriers, facilitators, and motivations regarding the MIND diet and forest bathing will help co-create contextually appropriate, acceptable and feasible lifestyle support strategies within community primary care services.

Objectives: The qualitative comparative process evaluation embedded within the 12-week randomized control trial (RCT), applies the Capability, Opportunity, Motivation-Behavior (COM-B) Model to identify and compare the behavioral barriers and facilitators of adherence between two intervention arms: MIND diet only and MIND diet combined with Forest Bathing. A key objective is to examine whether Forest Bathing functions as a facilitator for dietary adherence or a participation burden.

Methods: Adults aged 50-75 with elevated LDL-C completed with $\geq 90\%$ of parent trial will be purposively recruited (n=24-36) and assigned to 4-6 semi-structured focus group discussion. Data will undergo matrix-based thematic analysis using NVivo 12, coding will combine and align to COM-B domain with identification of themes. Findings will be mapped into the Behavior Change Wheel (BCW) to translate the insight and develop the behavior change recommendation.

Anticipated Findings: Drawing on the COM-B model and existing literature on intervention adherence, barriers and facilitators are anticipated across three domains: within Capability, the expected factors include health literacy regarding MIND diet and Forest Bathing guidelines and protocols, utilization of structured guidance and tracking tools; Within Opportunity, geographic accessibility in suitable green spaces within urban areas, family or caregiving responsibilities and peers' encouragement and social support; with Motivation, self-empowerment, self-efficacy and motivation to sustain the habits. The directionality of these factors will be determined by thematic analysis compared across the MIND-only and MIND+FB arms.

Implication: The COM-B model outlining of participants' ideas on capability gaps (knowledge and skills), opportunity constraints (resources and environment) and motivational drivers (attitudes and goals). The components directly inform how community programmes should be structured, resources and delivered by the Behavior Change Wheel. Non-pharmacological intervention is significant in primary healthcare settings for community-dwelling older adults with cardiovascular risk. Integrated alongside pharmacological management, MIND diet and Forest Bathing offer a complementary approach that addresses the behavioral determinants of cardiovascular health. Findings will equip healthcare professionals as facilitators, educators and resources allocators, to support clients as active agent to manage their cardiovascular health. By identifying the barriers and facilitators of adherence, this study delivers the evidence base for designing person centered, community delivered lifestyle modification programme with sustainable healthy habit.

Conclusion: By uncovering the behavioral experience of older adults in the community-based

lifestyle intervention, this study generates the COM-B evidence to guide the strategies of the scalable and person-centered cardiovascular prevention programme and advance the lifestyle modification in primary healthcare practice.

B4. From Bench to Community: Exosome-Based Cancer Immunotherapy in Primary Health Care Models

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Abstract

Cancer remains a major global health challenge, and novel strategies are needed to improve immune modulation and therapeutic delivery. Exosome-based cancer immunotherapy has emerged as a promising cell-free approach with the potential to reshape the tumor immune microenvironment. In this study, we integrated single-cell RNA sequencing, bulk RNA sequencing, immunostaining, and flow cytometry to characterize exosome-mediated immune responses and to evaluate its relevance for primary health care and community-based cancer care models.

Single-cell RNA-seq analysis identified heterogeneous immune and stromal populations with distinct transcriptional responses to exosome exposure. These data revealed activation of antigen presentation, cytotoxic signaling, and interferon-related pathways, along with suppression of immunoregulatory programs in select cell subsets. Bulk RNA-seq further validated these findings, demonstrating coordinated enrichment of immune activation signatures and differential expression of genes associated with T cell function, myeloid activation, and tumor immune remodeling. Immunostaining confirmed spatial changes in the tumor microenvironment, including increased localization of effector immune cells and reduced expression of suppressive markers. Flow cytometry provided quantitative immunophenotyping evidence, showing altered frequencies of T cell subsets, myeloid populations, and activation markers consistent with enhanced antitumor immunity.

Collectively, these multimodal analyses suggest that exosome-based immunotherapy can induce measurable transcriptional, spatial, and phenotypic remodeling of the immune landscape. The findings support the use of exosome-associated biomarkers for monitoring therapeutic response and stratifying patients in decentralized care settings. Importantly, integration of this approach into primary health care and community-based models may improve early detection, treatment follow-up, and equitable access to advanced cancer therapies.

In conclusion, exosome-based cancer immunotherapy represents a scalable and biologically grounded strategy for precision oncology. Multimodal immune profiling strengthens its translational potential and provides a framework for community-centered implementation.

B5. Strengthening Community Emergency Response Capacity through Basic Life Support Training among Civil Defense Volunteers in Rural Thailand

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Abstract

Sudden cardiac arrest remains a major cause of preventable mortality worldwide and requires immediate intervention to improve survival outcomes. In rural and underserved communities, delayed access to emergency medical services underscores the importance of trained community responders capable of providing basic life support (BLS) and cardiopulmonary resuscitation (CPR). However, inadequate knowledge, limited self-efficacy, and insufficient practical experience among community volunteers remain significant barriers to effective prehospital emergency response. This quasi-experimental study evaluated the effects of a community-based CPR training program on knowledge, perceptions, self-efficacy, and training satisfaction among Civil Defense Volunteers in Sakon Nakhon Province, Thailand. A one-group pretest–posttest design was conducted involving 84 participants. Data were collected using demographic surveys, CPR knowledge assessments, perception scales, and satisfaction evaluations. Descriptive statistics and paired t-tests were used for data analysis. Although 81.9% of participants had previously attended CPR training, 89.3% had no real-life CPR experience. Before the intervention, all participants demonstrated low levels of CPR knowledge. Following the training program, 63.1% achieved high knowledge scores and 34.5% demonstrated moderate scores, while only 2.4% remained at a low level. Mean knowledge scores significantly improved after the intervention (mean difference = 1.61, 95% CI: 1.49–1.73, $p < 0.001$). Participants' overall perceptions regarding CPR significantly improved after the training program ($p < 0.001$). Significant improvements were observed in perceived self-efficacy for performing life-saving procedures ($p < 0.001$) and awareness of the likelihood of encountering cardiac emergencies ($p = 0.035$). No significant difference was found regarding the perceived importance of CPR ($p = 0.684$), likely due to high baseline awareness. Overall satisfaction with the training program was rated at a very high level (mean = 44.21 ± 3.85 out of 50). The findings suggest that community-based CPR training can effectively improve knowledge, perceived self-efficacy, and preparedness for emergency response among Civil Defense Volunteers. Integrating regular refresher courses and simulation-based training into community health and disaster preparedness programs may strengthen prehospital emergency response capacity in rural settings.

Parallel Session C: Community-Based Models

C1. Social Prescribing: Expanding UHC Service Coverage through Community-Based Models

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Abstract

Universal Health Coverage (UHC) in the Asia-Pacific region is predominantly evaluated through financial protection indicators, such as insurance coverage and out-of-pocket expenditure. However, this approach risks underrepresenting a critical dimension of UHC: the scope, relevance, and integration of services provided. As health systems face rising burdens of non-communicable diseases and ageing populations, there is a growing need to strengthen service coverage through holistic, community-based models of care.

This paper proposes social prescribing as a strategic intervention to advance UHC by bridging clinical services with the social determinants of health. Embedded within primary healthcare, social prescribing enables providers to connect individuals with non-medical community resources, including social support, lifestyle programmes, and welfare services. Emerging evidence suggests that such approaches can improve health outcomes and reduce avoidable healthcare utilisation, particularly for individuals with complex needs that are not adequately addressed by biomedical models alone.

However, scaling social prescribing raises key policy questions: how cost-effective are these interventions, and which population groups benefit most from specific approaches? Addressing these questions requires robust and context-sensitive data to inform resource allocation and programme design.

To support this, a mixed-methods evaluation framework was developed for the second phase of a local social prescribing programme. The framework integrates literature review and value mapping with stakeholder engagement, involving 23 representatives from health and social care, philanthropy, academia, community NGOs, and experienced link workers. It captures outcomes across seven core domains: general well-being and quality of life, goals and needs attainment, physical health, social health, psychological health, healthcare service utilisation, and self-efficacy.

Healthcare utilisation data, in particular, enables assessment of potential cost savings through reduced hospital admissions and emergency visits. At the same time, segment-specific analysis is essential, as different population groups—such as older adults, individuals with chronic conditions, and socially isolated populations—may respond differently to tailored interventions.

While alignment on core domains supports consistency, evaluation frameworks must remain adaptable to local contexts, cultures, and health system structures. Qualitative methodologies play a complementary role by providing deeper insights into patient experiences,

implementation barriers, and underlying mechanisms of impact.

Internationally validated scales such as the WHOQOL-BREF, UCLA 3-item Loneliness Scale, and PHQ-2 were incorporated to ensure rigour and comparability. Recognising the importance of cultural fit, survey wording was tuned for clarity and accessibility for older Hong Kong participants. In addition, selected locally developed questions were included to better reflect context-specific factors, including traditional Chinese medicine use, thereby improving the accuracy of programme effectiveness assessment.

Quantitative surveys at baseline and end-of-cycle, complemented by qualitative focus groups and interviews, enable both statistical outcome tracking and in-depth exploration of

This paper argues that standardised yet localised evaluation approaches are essential to generate the evidence policymakers need. By addressing cost-effectiveness, target group matching, and service integration, social prescribing offers Asia-Pacific health systems a pathway to more comprehensive UHC service coverage beyond financial protection alone.

C2. "Seeing the Warmth": A Community-Based Photovoice Intervention to Support Caregiver Well-being Within Universal Healthcare Frameworks

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Abstract

Caregivers of children with special educational needs (SEN) face persistent stress, complex care demands, and compromised well-being that often remain unaddressed within existing healthcare systems. Despite growing recognition of caregiver burden as a significant public health concern, many families struggle to access timely and appropriate psychosocial support services. As the Asia-Pacific region advances universal healthcare coverage (UHC), accessible community-based interventions are crucial to bridge service gaps and provide psychosocial support beyond clinical settings. Such interventions are particularly vital for populations facing structural barriers to formal mental health services, including stigma, financial constraints, and limited service availability.

In response to these healthcare needs, Hong Kong Shue Yan University, in collaboration with Yew Chung College of Early Childhood Education, Tung Wah College, Saint Francis University, and the Autism Life Development Association, implemented a community health initiative entitled "Through Their Lens: Caregivers' Stories in Focus" (2025–2026). This multi-institutional partnership reflects the collaborative approach necessary for expanding healthcare access under UHC principles.

Over 30 caregivers participated in structured Photovoice sessions exploring three health-related domains: (1) caregiver burden and stress, (2) mental health-seeking behaviours and coping mechanisms, and (3) mental health-related quality of life. Data collection integrated visual

documentation (participant-produced photographs) and narrative accounts (facilitated group discussions and reflective testimonies). Narrative data underwent thematic analysis to identify patterns in caregivers' healthcare experiences and unmet needs. Visual data were examined for symbolic meaning and alignment with participants' health narratives, enabling cross-method validation and deeper understanding of lived experiences.

The health promotion effectiveness of Photovoice is understood through two frameworks relevant to UHC implementation. Common Factors Theory (Rosenzweig, 1936) demonstrates how peer support, empathic validation, collective meaning-making, and hope cultivation generate health benefits complementary to formal healthcare services. Third Place Theory (Oldenburg, 1989) positions Photovoice sessions and the subsequent public exhibition (April 2026) as accessible community health spaces bridging home-based care and institutional services—fostering social connectedness, identity validation, and public health awareness.

This presentation examines how participatory action research (PAR) approaches can function as low-cost, scalable interventions that strengthen caregiver resilience and address psychosocial dimensions of health—critical considerations for achieving comprehensive and equitable universal healthcare coverage in the Asia-Pacific context. Findings demonstrate the potential for integrating community-based participatory methods into broader healthcare service delivery models.

C3. A Novel Community-Based Multi-Organ EIT Framework for High-Throughput Population Health Screening

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Abstract

Chronic kidney disease (CKD) and fatty liver disease (FLD) are highly prevalent yet underdiagnosed conditions that impose a substantial public health burden. Conventional screening relies on laboratory testing or specialized imaging, which limits accessibility and

scalability in community settings. To address this, we previously developed machine-learning pipelines to predict elastography-based controlled attenuation parameter (CAP) ($R^2=0.67$, $p<0.001$) and blood serum-based estimated glomerular filtration rate (eGFR) ($R^2=0.58$, $p<0.001$) values for liver and kidney health, respectively, from portable electrical impedance tomography (EIT) measurements (VitoCheck®, E-SENSE Innovation & Technology). These models enabled the successful classification of FLD (sensitivity: 88%, specificity: 92%) and CKD (sensitivity: 99%, specificity: 100%) using clinical benchmarks. To validate this approach in large-scale deployments, we assessed non-invasive liver and kidney health through a series of community-based health screening events in collaboration with the Hong Kong Young Women's Christian Association, HKU School of Professional and Continuing Education, and the Hong Kong Housing Society. Nearly 800 individuals (25th percentile: 66.0 years old, median: 73.0 years old) participated in an initial EIT scan of the liver and kidney, with almost 250 individuals returning after two months for follow-up scans of both organs (>2000 total EIT scans). At each timepoint, participants provided self-reported medical history, family medical history, and various lifestyle factors.

The majority of screened individuals exhibited elevated risk of liver steatosis ($>70\%$ mild, moderate, or severe) or reduced kidney function ($>90\%$ mild, moderate, or severe). In fact, we observed a significant association between CAP and eGFR scores ($p<0.001$). This aligns with established metabolic links between FLD and CKD risk, and highlights the need for multi-organ health screening. Furthermore, we found that diabetes mellitus and hypertension were both significantly (both $p<0.01$) associated with reduced kidney function and elevated liver steatosis, which is consistent with their established roles as major risk factors for multi-organ dysfunction. Moreover, across CAP or eGFR scores, we identified significant differences (Kruskal-Wallis test) and trends (Cusick's test) associated with various lifestyle factors such as weekly exercise, daily water intake, daily sleep duration, and hypertension stage. These results highlight lifestyle factors that can meaningfully impact liver and kidney health, and which can be modified to improve organ-specific health. Interestingly, when examining changes in these lifestyle factors across the longitudinal cohort, we found significant trends (both, $p < 0.05$) for CAP and eGFR scores associated with changes in daily water intake. In both cases, this trend suggests that compared to baseline, increasing daily water intake improved liver and kidney health, and decreasing daily water intake reduced liver and kidney health.

These findings demonstrate a clear link between FLD and CKD risk that is driven by shared metabolic conditions like diabetes and hypertension. In addition, simple lifestyle adjustments, such as optimizing daily water intake, offer a practical and modifiable strategy to protect multi-organ health. Finally, this work showcases the unique power of longitudinal EIT measurements to capture both metabolic shifts and behavioral trends, which positions this technology as a scalable solution for community-based screening and long-term health tracking.

C4. From Pilots to Policy: Institutionalising Social Prescribing in Hong Kong's Primary Care System

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Abstract

As healthcare systems confront ageing populations, rising chronic disease burdens, and growing psychosocial distress, there is increasing recognition that many drivers of poor health lie beyond the reach of conventional medical care. In Hong Kong, ongoing healthcare reforms have emphasised preventive care, community-based services, and medical-social collaboration as part of a broader transition toward a primary care-led, person-centred system. The city's five-year strategic development agenda has further reinforced priorities related to healthcare sustainability, population well-being, and long-term public service resilience.

Within this policy landscape, social prescribing, the practice of linking patients to non-clinical community resources through a trained Link Worker, has begun to emerge through diverse NGO-led initiatives addressing loneliness, anxiety, social isolation, and other socially determined health needs. However, despite growing momentum, most social prescribing programmes in Hong Kong remain fragmented, grant-dependent, and institutionally peripheral to the formal healthcare system.

This paper argues that the central developmental challenge for social prescribing in Hong Kong has shifted from programme experimentation to institutionalisation. Drawing on Hong Kong primary care policy analysis, comparative evidence from overseas, and qualitative findings from stakeholder engagement with policymakers, NGO practitioners, and clinical leads, the paper examines the structural conditions required for social prescribing to transition from scattered pilots into sustainable health system infrastructure.

The analysis identifies four interdependent institutional gaps that impede scale and integration: fragmented financing arrangements that leave programmes perpetually dependent on short-term philanthropic cycles; the absence of a shared governance architecture linking community, clinical, and government stakeholders; a lack of workforce standardisation for Link Workers; and isolated evaluation practices that prevent cumulative evidence generation. Together, these barriers produce what the paper terms “permanent project-based delivery,” a structural condition in which promising preventive care innovations fail to achieve systemic reach.

To address these challenges, the paper proposes a “middle-out” institutional framework that avoids both rigid top-down mandates and uncoordinated bottom-up fragmentation. Concrete proposals include blended public–philanthropic financing mechanisms; common referral and data-sharing protocols across primary care and community settings; minimum competency frameworks for Link Workers; and shared outcome indicators that enable system-level evidence generation. International comparative insights offer transferable lessons on governance design and cross-sectoral financing relevant to Hong Kong's context and to other

Asian healthcare systems navigating similar transitions.

By repositioning social prescribing as strategic preventive infrastructure, rather than isolated community programming, this paper contributes to policy debates on sustainable healthcare financing, primary care governance, and the institutional future of community-based care in Hong Kong and the broader region.

C5. A Comparative Study of the Effectiveness of Live and Digital Music Therapy for Individuals Experiencing Emotional Distress in District Health Centres (DHCs)

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Abstract

Music therapy refers to the clinical and evidence-based use of music interventions to accomplish individualized therapeutic goals within a professional therapeutic relationship. Although it is not a universal remedy for all mental health conditions, it has been widely recognized as an effective and engaging approach for alleviating symptoms associated with depression, anxiety, and related psychological difficulties. An expanding body of scholarly literature, including systematic reviews and meta-analyses, has demonstrated its efficacy in the treatment of anxiety disorders. In the present study, music therapy is conceptualized as an intervention delivered through both live and digital musical activities. These two modalities have become increasingly significant in contemporary practice. Live music therapy is already implemented in Hong Kong hospitals, including Queen Mary Hospital and Hong Kong Children's Hospital, as well as in non-governmental organizations, to support individuals experiencing anxiety, depression, dementia, and pain. Digital music therapy gained particular importance during the COVID-19 pandemic in maintaining continuity of care and may further promote self-expression through digital music creation tools, irrespective of participants' prior musical experience. Both live and digital music therapy may be delivered through District Health Centres (DHCs) within the community-based primary healthcare system as modalities of preventive care or complementary therapeutic intervention.

The study will be conducted in two phases and will involve two target populations: young people and older adults experiencing emotional distress. A music therapist will provide peer debriefing and evaluate each phase of the intervention. In the first phase, the therapist and participant will jointly determine the participant's preferred musical style and repertoire, after which the music will be performed live. This session will subsequently include discussion of emotions, memories, and personal concerns in order to facilitate therapeutic progress, with lyric analysis incorporated as an additional means of processing difficult emotions. The second phase will follow the same procedure, except that the music intervention will be delivered digitally. Data will be collected and analyzed through a mixed-methods design integrating

closed-ended quantitative instruments, such as questionnaires, with open-ended qualitative approaches, such as focus groups. This methodological design is intended to enhance reliability and validity, address the limitations inherent in a single-method approach, enable triangulation of findings, and provide both breadth and depth of understanding. The study further seeks to support the early identification of mental health needs, facilitate timely professional intervention, and generate policy recommendations for relevant stakeholders and the HKSAR Government to strengthen preventive mental health care in Hong Kong.

Parallel Session D: Student Presentations I

D1. Design of a DNA Probe-Based Biosensor for Antimicrobial Resistance Detection

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Abstract

Antimicrobial resistance (AMR) poses a serious threat to global health, creating an urgent need for rapid, sensitive, and affordable diagnostic tools. Conventional culture-based methods and molecular assays are often time-consuming, resource-intensive, or limited in point-of-care applicability. To address these challenges, we proposed to design a DNA probe-based biosensor for the detection of antimicrobial resistance markers with high specificity and rapid turnaround.

The biosensor will be developed using a sequence-specific DNA probe capable of recognizing a conserved resistance-associated nucleic acid target. Optimization with probe immobilization will improve hybridization efficiency, surface stability, and signal generation. Upon target binding, the biosensor could produce a measurable response that correlated with the presence of antimicrobial resistance sequences. The analytical performance of the platform will be evaluated in terms of sensitivity, specificity, reproducibility, and detection time. We expect the biosensor will demonstrate a strong resolution to discriminate between complementary and non-complementary sequences, indicating robust sequence selectivity. In addition, the platform will have potential for detecting low-abundance targets, supporting its utility for early AMR surveillance. To assess practical applicability, the biosensor will be tested under conditions relevant to environmental samples. The resultant assay could be adapted for rapid screening of resistance markers in diverse settings including Hong Kong based water systems.

In conclusion, our proposed DNA probe-based biosensor would represent a promising tool for AMR detection. By enabling rapid and specific identification of resistance-associated genetic markers, this platform may support timely clinical decision-making, infection control, and AMR surveillance. Further optimization and validation in real-world samples will strengthen its translational potential for diagnostic and public health applications.

D2. Artificial Intelligence Analytics for Early Detection of Asymptomatic Ischaemic Stroke in Elderly Populations: A Critical Literature Review

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Abstract

Background: Silent brain infarctions appear on roughly one in five MRI scans of healthy elderly adults, and on up to half in selected clinical series. They double the risk of subsequent symptomatic stroke and of dementia. Despite this, current American Heart Association and American Stroke Association guidance does not endorse population screening: no diagnostic pathway has yet combined acceptable accuracy with randomised evidence of downstream benefit. This review asks whether artificial intelligence can change that calculation for elderly populations, and whether existing systems are likely to generalise to East Asian and Hong Kong stroke epidemiology, where intracranial atherosclerosis predominates over the extracranial pattern more common in Western training cohorts.

Methods: A structured search of PubMed, IEEE Xplore, Scopus, and Google Scholar identified peer-reviewed English-language work published between January 2020 and March 2026, with citation chaining used to recover seminal earlier sources on screening theory and silent stroke epidemiology. Inclusion required quantitative AI performance reporting in populations potentially relevant to elderly silent stroke detection, or authoritative reviews and guideline statements bearing on screening policy. Two studies that addressed silent stroke detection most directly were assessed qualitatively against QUADAS-2 domains. Two analytical frameworks structure the synthesis. Wilson and Jungner's screening criteria set out approximately ten evaluation points, including the requirement for an accepted treatment, a positive cost-effectiveness case, and continuity of case-finding. Discrimination and calibration are then treated separately: AUC measures how well a model distinguishes positives from negatives, while calibration measures how closely predicted probabilities match observed event rates. AI is therefore evaluated as a screening-programme proposal, not only as a diagnostic test.

Results: A retinal-photograph deep-learning system was trained on 895,640 images and validated on 213,762 across multiethnic datasets spanning six countries, with a silent infarct detection AUC of 0.797 (95 per cent CI 0.500 to 0.995). An AI-enabled electrocardiogram analysis of 930 stroke patients failed to differentiate embolic stroke of unknown source from other causes; a secondary analysis showed that the algorithm did stratify the likelihood of monitoring-detected atrial fibrillation. Beyond these two, the wider acute-stroke AI literature is large but indirectly relevant. Three linked gaps recur: external validation in older adults is sparse, calibration is rarely reported, and no randomised trial has shown that AI-enabled detection improves elderly outcomes, including in Hong Kong-relevant subtypes.

Conclusions: Deep learning has narrowed the accuracy gap, but not the benefit gap. Elderly-

subgroup validation, calibration reporting, and randomised evidence of clinical impact are all still missing. Wilson and Jungner's criteria are met on test quality, but unmet on accepted treatment and cost-effectiveness. Five integrated recommendations follow: a Bayesian adaptive platform trial with hard clinical endpoints, an international validation registry with mandatory age stratification, participatory design with cognitively vulnerable populations, age-stratified post-market surveillance, and competing-risk health economics. These five depend on each other; partial implementation will produce partial answers.

D3. Enhancing Community Emergency Response through Robotic AED Delivery and Smart Network Integration

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Abstract

Out-of-hospital cardiac arrest (OHCA) remains a critical public health challenge, with survival rates varying dramatically across the Asia-Pacific region. In Hong Kong, approximately 6,000 OHCA cases occur annually, yet the survival-to-discharge rate stands at only 2.3%, significantly lagging behind other developed Asian cities (Yeung et al., 2017). A principal contributor to this disparity is the delayed access to automated external defibrillators (AEDs): bystander defibrillation rates in Hong Kong remain as low as 1.4% (Leung et al., 2017), and over 77% of the public report not knowing the location of the nearest AED (Leung et al., 2016). This study proposes a community-based emergency response model that integrates autonomous mobile robot (AMR) delivery systems with smart digital alert networks to enhance AED accessibility and reduce time to defibrillation.

The proposed model comprises three interconnected components: (a) an AMR system capable of autonomously navigating urban community environments to deliver AEDs directly to emergency locations via optimised path-planning algorithms; (b) a digital dispatch platform that integrates emergency call data, real-time geolocation, and community responder networks—drawing on systems such as GoodSAM (Smith et al., 2017), PulsePoint (PulsePoint Foundation, 2024), and Singapore's myResponder (Singapore Civil Defence Force, 2023)—to simultaneously notify trained community responders upon activation; and (c) a data-driven AED placement and fleet optimisation strategy informed by historical OHCA incidence data. The study adopts a design-based research approach, combining engineering prototyping with scenario-based simulation to evaluate system feasibility, projected response time, and operational constraints in a dense urban setting modelled on Hong Kong.

Preliminary evidence supports the viability of each component. Drone-based AED delivery studies in Sweden demonstrated a 92% successful delivery rate and arrived before ambulances in 64–67% of cases, with a median time benefit of approximately 3 minutes (Claesson et al., 2022; Claesson et al., 2023). In hospital logistics, AMRs have achieved 32–36% reductions in

delivery time compared with manual transport (Li et al., 2026). Community volunteer responder systems have been shown to increase bystander defibrillation rates threefold (Gregers et al., 2023) and improve survival outcomes (Nielsen et al., 2022). However, no existing model has integrated ground-based robotic delivery with community alert networks for OHCA response.

This research contributes to the discourse on universal health coverage by proposing a scalable, technology-enabled solution that strengthens primary health care capacity at the community level. By addressing the critical gap between OHCA onset and defibrillation, the proposed model demonstrates how interdisciplinary collaboration across healthcare, engineering, and digital infrastructure can foster more responsive, inclusive, and resilient community-based care models across the Asia-Pacific.

D4. Evaluating the Clinical Utility of Artificial Intelligence in Brain Tumour Diagnosis

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Abstract

Brain tumours represent one of the most diagnostically complex malignancies in modern oncology, with over 300,000 new cases reported globally each year and particularly high mortality rates for aggressive subtypes such as high-grade gliomas. Conventional diagnosis relies heavily on radiological interpretation of magnetic resonance imaging (MRI) and computed tomography (CT), yet substantial inter-observer variability among radiologists, overlap with non-neoplastic conditions and subtle imaging features frequently contribute to diagnostic delays and errors. Artificial intelligence (AI), particularly deep learning approaches such as convolutional neural networks, has emerged as a potentially transformative technology in neuroradiology, with diagnostic accuracy that rivals and occasionally surpasses experienced radiologists in controlled research settings. This literature review critically evaluates the clinical utility of AI in brain tumour diagnosis by synthesising evidence from studies published between 2019 and 2026, identified through structured searches of PubMed, the PolyU library and Google Scholar. The review examines diagnostic performance metrics, AI capabilities across the diagnostic pathway (detection, segmentation, classification and grading), comparative studies with radiologists, workflow and regulatory barriers and emerging human–AI collaboration models.

Findings indicate that AI systems consistently achieve high sensitivity and specificity, with pooled values exceeding 85% across multiple techniques and AUC values above 93% for distinguishing low-grade from high-grade gliomas. AI further offers precise tumour segmentation, improved consistency in feature interpretation and the ability to predict

molecular markers directly from imaging data. However, meaningful gaps persist between laboratory performance and real-world clinical effectiveness. External validation studies report measurably lower performance than internal benchmarks, with scanner heterogeneity, single-institution training data and limited prospective validation identified as key contributors to domain shift. Additional barriers include integration with existing PACS and RIS infrastructure, alert fatigue, automation bias, evolving regulatory frameworks and unresolved questions around informed consent and liability.

The review concludes that AI should be positioned as a complementary tool that augments rather than replaces radiologist expertise, with the greatest near-term value in high-volume, well-defined tasks such as tumour detection, segmentation and volumetric monitoring. Evidence-based recommendations include adopting a stepwise implementation framework progressing through research, production and feedback maturity levels, prioritising prospective multi-institutional validation, advancing standardised evaluation frameworks such as AI-RANO and designing human–AI collaboration models that preserve clinical oversight while leveraging AI's strengths in speed, consistency and pattern recognition.

D5. Decentralized but Politicized: Primary Health Care and Community-Based Models for Universal Health Coverage in the Asia-Pacific

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Abstract

Background: Universal Health Coverage (UHC), a goal that is set by many countries to achieve a holistic healthcare system. In this journey, decentralized and community-based models have been widely promoted as a key pathway in the Asia-Pacific. However, these models often face obstacles that are rarely discussed in black and white policy documents. This paper examines a crucial but overlooked contradiction: decentralized primary health care (PHC) is expected while frequent intensifying political approach is instilled, prompting distorted resource allocation with weak local accountability. In this way, stagnant process on attaining UHC is paved.

Objective and methods: This study aims to: (1) analyze the prevalence of politicized primary health care system in Asia-Pacific; (2) identify the contradictions between the rationale of the community-based models and the actual practice; (3) suggest ways for improving the phenomenon by migrating the contradictions to practical and public-centered solutions. This paper adopts a narrative approach where case studies from Asia-Pacific countries and cities are included, for instance Indonesia, India, Korea, Bangladesh, and Thailand. Data sources include PubMed Central, The Lancet, World Health Organization, and official websites of the mentioned countries.

Findings: This analysis reveals a persistent “politicized contradiction” across Asia-Pacific PHC systems. Ranging from partisan competition to professional autonomy to governance weakness, these diverse underlying causes paving the way to this controversy issue: Decentralized but Politicized Primary Health Care and Community-Based Models.

First and foremost, in **Indonesia**, clientelism directs PHC resources to politically loyal districts over medical need. In such case, inadequate and unequal resources distribution in PHC was resulted, showing the local National Health Insurance (JNK) system is greatly affected by the political dynamics. Regarding **India**, partisan transition trigger shutdowns of community clinics, treating health infrastructure as political tools for gaining more votes in the election cycle. Being religious-centered, the PHC system of India is also vulnerable to symbolic politicization, for example the people who are higher-class in the caste system, are served with better PHC than that of the normal ones. In **South Korea**, professional politicization was illustrated. A significant disparity in service access and over-commercialization was prompted owing to conflicts between the government and healthcare professionals, and thus community-healthcare services are hindered. **Bangladesh** exemplifies governance failure: the promised healthcare agenda went vanished. Moreover, sufficient government accountability is failed to maintain, and hence political interests are more favorable than that of the patient welfare. Last but not least, **Thailand**. Its PHC system demonstrates a strategic governance: the UHC scheme which is introduced in 2002. However, under a politically unstable environment, subsequent instability on fiscal supply and professional healthcare trainings are the concerns. This lies a paradox of a so-called successful universal health system continuously undermined by the political instability.

Conclusion and Policy Implications: These contradictions cannot be resolved by simple recentralization. This paper proposes three policy implementations. Firstly, legally mandated minimum PHC budgets could be introduced. Secondly, career-track community health worker (CHW) schemes that bypass local political patronage. Thirdly, countervailing community power. The establishment of independent health councils which are elected by households — not appointed by local elites. As a result, a communication bridge that focusing on PHC could be established, and thus political contradiction could be alleviated.

D6. Critical Evaluation of Omega-3 Supplementation for Brain Development in Young Children: Evidence Synthesis and Implications for the Hong Kong Context

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Abstract

Background: Omega-3 supplements containing docosahexaenoic acid (DHA) are commonly recommended for children's brain development, and many Hong Kong parents regularly give their young children dietary supplements. DHA accounts for around 15% of fatty acids in the human frontal cortex and is involved in neurogenesis and synaptic plasticity during early life. Whether oral supplementation adds measurable cognitive benefit beyond an adequate diet is unclear, and the evidence has not been synthesised for the Hong Kong dietary context.

Methods: A comprehensive review of peer-reviewed literature published between 2009 and 2023 was conducted. Key sources included two Cochrane systematic reviews, major randomised controlled trials (RCTs) in preterm and healthy paediatric cohorts, and a meta-analysis addressing attention-deficit/hyperactivity disorder (ADHD). International dietary guidelines were evaluated alongside local epidemiological data on paediatric seafood consumption and supplement toxicological reports. Cognitive outcomes were assessed using standardised instruments, including the Bayley Scales of Infant and Toddler Development (Bayley-III) and the Wechsler Preschool and Primary Scale of Intelligence (WPPSI).

Results: Synthesised evidence indicates no significant cognitive benefit of routine supplementation in healthy, well-nourished paediatric populations. The DOMInO trial of maternal DHA supplementation during pregnancy ($n = 2,399$) reported no difference in offspring Bayley-III cognitive composite scores at 18 months (adjusted mean difference 0.01; 95% CI -1.36 to 1.37 ; $p = 0.99$), consistent with a Cochrane review of 15 RCTs of long-chain polyunsaturated fatty acid (LCPUFA)-supplemented formula in term infants ($n = 1,889$). Conversely, measurable benefit followed a saturation-threshold pattern, confined to populations with low baseline status or specific clinical indications. Neonatal DHA supplementation (60 mg/kg/day) modestly improved full-scale IQ in preterm infants (born <29 weeks' gestation) at age five (adjusted difference 3.45 points; 95% CI 0.38 to 6.53 ; $p = 0.03$) (Gould et al., 2022), and supplementation reduced clinical symptoms in children with ADHD (Hedges' $g = 0.38$; $p < 0.0001$). On safety, a meta-analysis of 90 predominantly adult RCTs reported higher odds of mild adverse events — diarrhoea (OR = 1.26), dysgeusia (OR = 3.48), and bleeding tendency (OR = 1.26) — with no serious adverse events. Product quality is a further local concern: in 2022, testing of 25 fish-oil products detected the genotoxic carcinogen glycidol in 14 (one exceeding the EU limit) and the contaminant 3-MCPD in 24 (three exceeding the EU limit). These concerns are heightened in Hong Kong, where children aged 6 to 17 already consume around 32 g of fish daily and per-capita seafood intake is more than three times the global average.

Conclusions: The evidence does not justify routine omega-3 supplementation in healthy young children in Hong Kong, where dietary fish intake is already high. Cognitive benefit depends on baseline nutritional status and is largely limited to preterm infants and children with diagnosed clinical conditions such as ADHD. Two to three weekly servings of low-mercury oily fish represent a safer, more cost-effective nutritional strategy. Targeted supplementation should be reserved for specific clinical indications under medical supervision.

D7. The healthcare needs of Gen Z living in Hong Kong and underlying reasons for accessing cross-border healthcare services in the Greater Bay Area in the post-pandemic era

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Abstract

Background: The post-pandemic healthcare landscape in Hong Kong has been marked by sustained system pressure, particularly prolonged waiting times for public specialist services. While cross-border healthcare initiatives within the Greater Bay Area (GBA) have been widely discussed in relation to older adults, limited empirical attention has been paid to Generation Z (Gen Z). This study examined the healthcare experiences, decision-making drivers, and policy expectations of Gen Z residents in Hong Kong regarding cross-border medical service utilization in the post-pandemic era.

Methodology: A mixed-methods design was adopted, combining a structured questionnaire survey with a targeted literature review. The survey collected responses from 100 Gen Z participants born between 1997 and 2012, capturing healthcare utilization patterns in Hong Kong and mainland GBA cities. Survey domains included service type, waiting time, costs, willingness to seek cross-border care, and perceived policy gaps. Secondary sources comprised government statistics, policy documents, and academic literature relevant to cross-border healthcare governance.

Results: Results indicate that excessively long waiting times for specialist services in Hong Kong are the most influential driver of cross-border healthcare seeking. Approximately 56% of respondents identified local waiting times as their primary reason for seeking care in the GBA. In contrast, approximately 90% of respondents who used mainland services reported same-day consultations, including specialist care and diagnostic testing. Cost considerations reinforced this pattern, as approximately 75% of respondents reported total cross-border medical expenditures below HKD500, inclusive of transportation. The most frequently desired measures were an officially accredited list of mainland medical institutions (28%), cross-border medical subsidies (25%), and secure electronic sharing of medical records (20%).

Conclusions and Implications: This study concludes that cross-border healthcare functions as a pragmatic extension of Hong Kong's health system for Gen Z rather than a marginal alternative. Policy implications include prioritizing data interoperability, improving institutional transparency, and designing age-inclusive cross-border healthcare policies to align healthcare provision with the expectations of youth.

D8. Integrating Zoonotic Surveillance into Primary Healthcare: Mitigating Climate-Driven Rat Hepatitis E Risks in Community Settings in Hong Kong

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Abstract

Climate change poses significant public health threats because by amplifying the spread of infectious diseases, specifically Rat Hepatitis E Virus (rHEV). In Hong Kong, rHEV has one of the highest documented prevalence rates and spillover risks, commonly affecting immunocompromised individuals. With Hong Kong's ageing population and rising chronic disease burden, the issue has brought attention to protecting the vulnerable populations.

The study aims to: (1) examine how the climate change variables affect the urban rat populations and the transmission risk of rHEV in Hong Kong; (2) evaluate the current epidemiology of rHEV in Hong Kong; (3) investigate the effectiveness of existing rodent pests' surveillance and control strategies; (4) propose recommendations on reducing the rat populations and rHEV transmission risk will also be suggested according to climate change conditions.

This study synthesizes and compares existing literatures on the effects of rising temperatures, the Urban Heat Island (UHI) effect and extreme precipitation and typhoons on rodent population dynamics. Furthermore, Hong Kong's rodent surveillance control and management strategies are compared with those of New York and Singapore. The analysis shows that increased temperatures and the UHI effect are positively associated with the acceleration of rodent population growth, especially when paired with industrialization and urbanization. The breeding periods of the rodents will be extended, and microclimates will be stabilized due to the thermal retention in the urban infrastructure of Hong Kong. Conversely, extreme rainfall and typhoons reveal conflicting impacts on rodents. While it could provide more food resources and trigger a "flushing effect", it could also potentially destroy the living environment of the rodents. This exacerbates the contact between humans and rodents, posing risks of rHEV infections for vulnerable populations.

Hong Kong's current rodent surveillance system is inadequate and lacks climate-induced effects. Recently introduced methods use thermal imaging cameras and artificial intelligence to calculate Rodent Absence Rate (RAR). However, the high RAR does not provide conclusive results of the actual rodent infestation numbers. Therefore, the necessity of a robust rodent control surveillance system is important to ensure public health safety. Recommendations on adopting an interdisciplinary surveillance and integrated framework through One Health approach, drainage and flood management, and education campaigns. Early detection and a more robust surveillance system not only allow for early prevention and proactive intervention but also yield financial gains. By raising the public's awareness on the effects of climate change

on rodent populations, people could be more self-sufficient and will be more willing to practice good hygiene, preventing prospective outbreaks.

Parallel Session E: Student Presentations II

E1. Applying GIS to recognize Healthcare Service Gaps in society and enhance strategies of Market Penetration

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Abstract

In the recent past, the life expectancy in Hong Kong has been consistently raised for 21.83% over 53 years. The study aims to use Geographic Information System (GIS) & Spatial Big Data to examine the accessibility to clinic in real world to alleviate the pressure on health facilities. It works out network analysis to calculate the real distance including stairs and footbridge instead of using Euclidean distance, in order to show the impact of micro-topography between the distance affect the convenience of the citizens. In previous study indicates that within 15 minutes, over 90% of HK citizen can reach to a private clinic from their home while only 56% of people can reach to public healthcare services, which government may grossly underestimated the accessibility and needs of people with reduced mobility.

To identify the demanding focus on locating for a new clinic, Two-Step Floating Catchment Area (2SFCA) method can be applied to calculate provider-to-population ratio for the healthcare venue as well as accessibility score for the residential area. High Score indicates clinics can accommodate with the service demand of near residential area, while low score indicates clinics are unable to manage the service demand of that area. This spatial model can provide evidence for prioritise the new clinic location and for better resources allocation.

The data collection of catchment area with micro-topography can present a more authentic representation of health service coverage and cater the needs of citizens. This structure of assigning equal resources may further extent as a planning model of other dense urban areas, such as for Primary Healthcare Commission to arrange and formulate the places of service point to address the ageing population issue by minimizing localized healthcare pressure in elderly dense region such as Sham Shui Po and Wong Tai Sin plus allowing people with other special needs could be more approachable to the location.

E2. Navigating Care Across Borders: Intergenerational Care Strategies Among Hong Kong Families During the COVID-19 Pandemic

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Abstract

This study examines how cross-border ties links on the lived experiences of Hong Kong families with older parents ageing in the mainland Greater Bay Area (GBA) during the COVID-19 pandemic, especially amid unprecedented cross-border travel bans. Through 23 qualitative in-depth interviews with Hong Kong older parents living in the GBA and their adult children in Hong Kong, the study identifies shifting strategies for families to provide care and maintain connection during crisis.

Framed by the intergenerational solidarity-conflict model, findings indicate that cross-border restrictions and health concerns affected traditional modes of care and connections among these Hong Kong families. Although long-term living arrangements rarely changed, the suspension of short-term visits and face-to-face interaction restricted access to direct emotional and instrumental support. People coped by relying more on information and communication technologies (ICTs) to maintain emotional support and feel present even when instrumental care was impossible. Additionally, findings also demonstrate a recalibration of filial expectations. Older parents lowered expectation for physical and financial support, emphasizing their self-reliance, whereas adult children increased emotional support and digital demonstrations of filial piety.

This study highlights how cross-border ties both limit and maintain intergenerational solidarity during the crisis. It concludes with policy implications for tailoring cross-border welfare, enhancing digital inclusion among older people, and supporting families navigating care and connection across borders under crisis conditions.

E3. Feasibility of Continuous Glucose Monitoring (CGM) Adoption in Non-Diabetic Populations for Preventive Health in Hong Kong

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Abstract

Hong Kong faces a growing metabolic health crisis. With adult diabetes prevalence at 8.2% and an estimated one in three prediabetic individuals unaware of their condition, the healthcare burden on the public system is projected to intensify as the population ages. Continuous glucose monitoring (CGM) — a wearable sensor that provides real-time glucose readings — has gained global traction as a preventive wellness tool for non-diabetic populations, following the U.S. FDA's clearance of the first over-the-counter CGM in 2024. Yet no published study has systematically examined whether CGM adoption is feasible for non-diabetic adults within Hong Kong's specific regulatory, economic, and cultural context. This study addresses that gap.

Using a feasibility study design based entirely on secondary data, this research applies the Health Belief Model (HBM) as its analytical framework to evaluate the prospects of preventive CGM uptake in Hong Kong. The study draws on official Hong Kong government and clinical sources, international market reports, and company disclosures. Industry-level analysis covers global and Asia-Pacific CGM market trajectories, while a company-level comparison focuses on the two leading suppliers — Dexcom and Abbott — across pricing, regulatory classification, and suitability for non-diabetic use. SWOT and PESTLE analyses contextualise the broader environment.

The findings reveal a pattern of conditional feasibility. On the motivational side of HBM, Hong Kong scores favourably: perceived susceptibility is high given the city's prediabetes prevalence figures and a documented 90% lifetime diabetes risk among young prediabetics, and self-efficacy is supported by the local population's strong digital literacy. However, perceived barriers — particularly sensor costs of HKD 250–600 per unit relative to median household income, the Pharmacy and Poisons Board's classification of CGM as a restricted medical device, and the absence of any public subsidy for non-diabetic preventive use — currently outweigh the perceived benefits for most potential users. The international clinical evidence is also more cautious than market data suggest: while short-term glucose awareness and modest dietary changes have been observed, long-term behavioural effects in non-diabetic populations remain unestablished.

Rather than recommending full-scale rollout, this study argues for a conditional-feasibility position and proposes three targeted interventions: a small evaluated pilot through the Chronic Disease Co-care Pilot Scheme targeting 300–500 prediabetic adults aged 30–50; negotiated tiered pricing with Dexcom and Abbott distributed through private insurers; and HBM-informed public education campaigns framed around Hong Kong-specific risk data and the success of the local Jockey Club CGM programme.

This study contributes to evidence-based health policy in Hong Kong by offering the first integrated framework combining market analysis, company assessment, and behavioural modelling for preventive CGM. Its findings are directly relevant to discussions of sustainable healthcare financing and community-based preventive care models in an ageing, high-density urban population.

E4. The Effectiveness of Social Prescribing and Time Banking Intervention on Improving Mental Health of Stroke Patient Caregivers

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Abstract

Background: Stroke caregivers experience substantial psychological burdens, including depression, anxiety, and social isolation, which can adversely affect both caregiver well-being and patient outcome. Although social prescribing and time banking have individually demonstrated benefits in improving mental health and social participation, limited empirical evidence exists on their integrated application for stroke caregivers.

Objectives: This study aims to evaluate the effectiveness of a hybrid intervention combining social prescribing and time banking in improving the mental health of stroke caregivers in Hong Kong.

Hypothesis to be tested: It is hypothesized that caregivers receiving the combined intervention will demonstrate significantly better mental health outcomes compared with those receiving usual care.

Design and Subjects: A randomized controlled trial (RCT) will be conducted, recruiting 400 primary caregivers of stroke survivors from community centers and related organizations. Participants will be randomly assigned to intervention or control groups.

Intervention and Measures: The intervention is expected to significantly reduce psychological distress, including depression, anxiety, and loneliness, with projected reductions exceeding 30% in key outcomes, alongside improvements in life satisfaction and caregiver burden.

Data Analysis: Quantitative data will be analyzed by *t*-tests or non-parametric analysis.

Expected Results: The intervention is anticipated to yield significant improvements in caregiver well-being, including a reduction in loneliness of more than 30%, enhanced life satisfaction, and significant decreases in symptoms of depression and anxiety.

Conclusion: This study will provide important empirical evidence on the feasibility and effectiveness of an integrated social prescribing and time banking model. The findings are expected to inform community-based caregiver support strategies, contribute to policy development, and advance innovative approaches to caregiver mental health in Hong Kong.

E5. Breathe Easy, Sleep Deep: HLZ Earbuds as a Non-Invasive Method to Monitor Breathing while Sleeping

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Abstract

Sleeping is a fundamental biological process where humans are in a state of both reduced mental and physical activity which helps restore cognitive function, repairs tissues, balances hormones, and strengthens the immune system. While sleeping, it is important to measure

oxygen saturation levels to make sure we are breathing properly as certain positions can hinder airflow and reduce our body's amount of oxygen intake. Effects of reduced oxygen intake can lead to hypoxia, which causes an increase in cardiovascular load, especially in those with pre-existing heart problems, raising health risks.

Many devices aim to help monitor oxygen saturation (SpO₂) levels, such as the Oura Ring, which monitor overnight SpO₂ levels. However, these devices are unable to monitor sleeping position data, which is essential to monitor as for example, sleeping on one's back may worsen breathing difficulties during sleep. This is due to the finger being unable to accurately determine body position at a given time due to unconscious movement. However, the ear – another available site for monitoring – allows for monitoring of sleeping position by gauging head movement.

Currently on the market, the Hera Leto Zzzbuds (HLZ) is an extensive piece of earbud technology which tracks vital patient data such as head position, SpO₂ levels, heart rate, sleep stage and respiratory rate. Being able to monitor sleeping positions helps with positional therapy, alerting users if they are sleeping on their back. This could be helpful in identifying possible patterns of oxygen desaturation and correlating them with sleeping positions. As a non-invasive therapeutic method, HLZ could possibly help avoid intrusive treatments when dealing with breathing problems. Given the fact that the HLZ are earphones, they are able to play white noise, which research suggests helps individuals fall asleep faster.

The HLZ is unique in that it is able to monitor SpO₂ levels and sleeping positions without disrupting the individual. This defining feature separates the HLZ from other products on the market, such as the Oura Ring, which only measure SpO₂ levels, while positional therapy belts are bulky, interfering with the sleep quality. Being able to combine the two features into wearable earbuds allows for possible correlations between sleeping position and oxygen saturation levels. Furthermore, the HLZ is being used by the Hospital Authority to monitor sleeping conditions and position in users.

Thus, the HLZ has the potential to be deployed within primary health care and community-based models, allowing sleep breathing and oxygen level monitoring to be done in the user's home, rather than frequent hospital checkups.

E6. A Systems-Informed Framework for Integrating Obesity and Lifestyle-Related NCD Prevention into Universal Health Coverage: Insights from Nepal

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Abstract

Background: Countries across the Asia-Pacific region are advancing universal health coverage (UHC) while experiencing a rapid rise in obesity and lifestyle-related noncommunicable

diseases (NCDs). In Nepal, this trend is occurring alongside persistent undernutrition, creating a double burden of malnutrition shaped by urbanization, changing food environments, and socioeconomic transitions. Despite policy progress, current health system responses remain fragmented and predominantly treatment-oriented, with limited integration of prevention and insufficient alignment with the complex, multi-level determinants of obesity and malnutrition.

Objective: This study develops and proposes a systems-informed framework for integrating obesity and lifestyle-related NCD prevention into UHC in Nepal.

Methods: A systems thinking approach was applied using a causal loop system map of obesity in Nepal, synthesizing evidence on multi-level determinants across food environments, socioeconomic conditions, social and cultural norms, psychosocial factors, and structural drivers. The analysis identified key feedback loops and behavioral pathways linking ultra-processed food consumption, physical inactivity, and psychosocial influences to health outcomes. These system insights were subsequently translated into a structured, policy-oriented framework aligned with UHC intervention pathways.

Results: The system map demonstrates that obesity in Nepal is driven by interconnected feedback loops, particularly those reinforcing ultra-processed food consumption and poor diet quality, within a broader context of urbanization, remittance-driven dietary transitions, food insecurity, and evolving social norms. Behavioral pathways including diet, physical activity, and psychosocial influences such as time poverty and stress mediate these drivers and contribute to a double burden of malnutrition, encompassing both undernutrition and rising overweight/obesity and NCD risk. Current UHC responses remain insufficiently aligned with these system dynamics, with a predominant focus on downstream treatment.

Building on these findings, the proposed framework synthesizes system-level determinants into actionable domains and identifies key UHC entry points. These include strengthening primary healthcare for prevention and early detection, integrating nutrition and NCD services across the life course, expanding health promotion and behavior change interventions, and leveraging Nepal's Female Community Health Volunteer (FCHV) network. The framework further highlights critical system enablers, including governance and regulatory action on food environments, fiscal sustainability through earmarked taxation and reduced long-term curative costs, data and surveillance systems, and multisectoral coordination addressing upstream determinants.

Conclusion: Addressing obesity and lifestyle-related NCDs within UHC requires a shift from fragmented, disease-specific approaches to integrated, system-oriented strategies that simultaneously address the drivers of both undernutrition and overnutrition. By translating complex system dynamics into policy-relevant action, the proposed framework positions UHC as a central platform for coordinated prevention and management, supporting both improved population health and long-term health system sustainability.

E7. Debunking the midlife metabolism ‘crashes’: Evidence-Based Interventions for Weight Management- after 30

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Abstract

Weight gain in middle age is a prevalent health concern, with over 60% of Hong Kong adults aged 45-54 being overweight or obese. A widely held belief attributes this trend to an inevitable "metabolic crash" after the age of 30. This paper aims to critically evaluate this claim by highlighting that midlife weight management depends not on combating a predetermined biological metabolic slowdown, but on implementing targeted, evidence-based behavioral and dietary interventions.

This paper synthesizes findings from historical and recent metabolic research. Early cross-sectional studies suggested a metabolic decline with age, but these often neglected to account for changes in body composition, such as the gradual loss of muscle mass. In contrast, the landmark 2021 study by Pontzer et al., which used the gold-standard doubly labeled water (DLW) method across 6,400 individuals, provides definitive evidence. The study revealed that, after adjusting for body size, human metabolism remains remarkably stable from ages 20 to 60. The perceived slowdown is not a crash in metabolic rate but is linked to factors such as sarcopenia (age-related muscle loss of 1-3% per decade) and hormonal shifts.

While metabolism itself does not decline, other factors significantly contribute to weight gain after 30. These include hormonal changes, such as reduced estrogen in women during menopause and a gradual testosterone decline in men, both of which can lead to reduced muscle mass and increased fat storage. Furthermore, lifestyle factors prevalent in modern society, including sedentary behavior, chronic stress, and poor dietary habits, play a crucial role. Genetic predispositions, like the FTO and MC4R genes, can also influence an individual's susceptibility to weight gain.

Recognizing that the "metabolic crash" is a myth shifts the paradigm from biological defeat to proactive health management. Consequently, this paper emphasizes evidence-based strategies crucial for counteracting midlife weight gain. Key interventions include prioritizing progressive resistance training to combat sarcopenia and preserve metabolically active lean mass, alongside adopting a balanced, high-protein diet to support muscle protein synthesis and improve satiety. Furthermore, addressing environmental and behavioral triggers—such as chronic stress and sedentary habits—is essential. By focusing on these actionable, evidence-based strategies, individuals and healthcare professionals can effectively manage body weight and mitigate the risks of associated chronic diseases throughout middle age and beyond.

E8. Exploring University Support for International Student Wellbeing in Australian Universities: A Scoping Review

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Abstract

Background: International University students experience unique challenges in Australia; their wellbeing is lower than that of their domestic peers. Universities play a crucial role in supporting students' wellbeing. Existing literature identifies various factors to improve students' wellbeing. Self-Determination Theory (SDT) as framework of autonomy, relatedness, competence in understanding psychological need and motivation. The PERMA model highlights the importance of positive emotion, engagement, relationships, meaning, and accomplishment in nurturing student wellbeing. The scantness of research on university support and how these wellbeing programs are implemented for international students remains limited.

Objectives: This scoping review aimed to map the research regarding the support of Australian universities for international students' wellbeing.

Methods: Adhering to Arksey and O'Malley framework and PRISMA-ScR checklist, a systematic search was performed across three databases, including Scopus, ERIC and PsycINFO. Peer-reviewed studies published in English between 2000 and 2025 were included. The included studies were selected based on the focus of international student wellbeing in Australian universities.

Results: A total of 13 studies met the inclusion criteria. The university wellbeing interventions were categorised into peer-based interventions, basic needs & material wellbeing support, animal-assisted program and mental health and psychoeducational program. Thematic analysis through PERMA model such as positive emotion, engagement, relationships show as anchor for these interventions. Peer connection is the main theme across most interventions, with the exception of mental health interventions.

Conclusion: Evidence shows a diverse range of university-based interventions to support international students' wellbeing in Australia. Integrating academic team involvement, peer-led initiative and social connection across international and domestic students enhances international students' wellbeing in Australia.

