

Chapter 2 ENHANCE PRIMARY CARE

Importance of Primary Care

2.1 Primary healthcare is an integral part both of an economy's health system and of the overall social and economic development of the community. While no uniform and universally applicable definition of primary healthcare exists, primary healthcare is usually taken to mean the first point of contact individuals and the family have with a continuing healthcare process and constitutes the first level of care in the context of the healthcare system. It is the base upon which the rest of the healthcare system is organized. Primary medical care (or primary care in short) refers to the medical part of primary health care which is the first contact of patients with their consulting doctors.

2.2 Studies⁶ including those in advanced OECD economies have shown that stronger primary health care results in better health of the population at lower cost and greater user satisfaction. Evidence also suggests that enhanced primary care can reduce the demand for expensive, specialist-led hospital care, thereby reducing healthcare cost and increasing efficiency of the healthcare system. By providing continuous and comprehensive care as well as serving as a gateway to other parts of the healthcare system, primary care have other benefits such as less hospitalization, less utilization of specialist and emergency services, and less chance of being subjected to inappropriate health interventions. In contrast, frequent direct access to specialists without first using primary care doctors often reduces the appropriateness of care and increases healthcare costs.

Primary Care in Hong Kong

2.3 Currently, primary medical care is predominantly provided by the private sector, by solo practitioners or group practices, mainly on out-patient curative care with some preventive elements. The public sector on the other hand is responsible for general health promotion and education, diseases prevention and control, as well as preventive healthcare services for certain targeted groups (pregnant women, infants and children, students, with partial coverage for women and the elderly) through services offered by the Department of Health (DH). The Hospital Authority (HA) also provides primary curative care through general out-patient clinics (GOPCs) mainly to the low-income, chronically-ill and poor elders.

⁶ See Atun R (2004), *What are the advantages and disadvantages of restructuring a healthcare system to be more focused on primary care services?*, Regional Office for Europe, World Health Organization, for a summary of related findings.

2.4 Primary care is not just about the curing of episodic illnesses, but should provide lifelong (continuous), comprehensive and holistic (whole-person) healthcare to individuals in their home environment. It puts emphasis on preventive care, the promotion and protection of well-being, as well as the improvement in the quality of life through holistic care. This contrasts with the common practice in Hong Kong where most patients seek and private doctors provide mainly curative care on an episodic basis. At present, the offer of comprehensive primary care including preventive care based on the family doctor model is not common.

2.5 Most people in Hong Kong do not have the habit of seeking preventive care and are not provided with very good access to primary preventive care either. The Population Health Survey conducted by DH in 2003-04 shows that only 23% of persons aged 15 and above have regular physical check-ups. Even for those who do go for check-ups, the emphasis is very often on “detection of diseases” rather than comprehensive and holistic assessment or tailored investigations and health advices. While seeking curative care, it is not very common for the public to seek also preventive services as part of the consultation such as screening for risk factors, detection of early symptoms and signs of disease, and corrections of health risks. Health education and promotion is often perceived as the sole responsibility of the government.

2.6 Apart from the lack of emphasis on preventive care, our current primary care also needs strengthening in its role as the gateway for healthcare. As the first contact point, primary care doctors should be responsible for the screening and assessment of medical conditions to see if they could be dealt with in the primary care setting or if further intervention is necessary. If another level of care is deemed necessary, the primary care doctors should serve as the gateway for advising and directing patients for necessary and appropriate healthcare including specialist and in-patient care. Primary care practitioners should also assume the role of managers of care and long-term providers of holistic care to patients, including necessary preventive care, health risk assessment, as well as follow-up care after medical conditions of patients have stabilized and after discharge from hospitals. As most people in Hong Kong do not have a family doctor, they have little access to such a level of care.

Enhance Primary Care

2.7 We have set out in *Building a Healthy Tomorrow* our vision for our future healthcare system featuring a robust primary care system at its foundation –

- (a) A population which is knowledgeable about health and health risk factors, where the general public can and will adopt a healthy lifestyle, and take responsibility for their own health; and a healthcare profession that views health promotion and preventive medicine as priorities, and exercises its practice professionally and ethically.
- (b) A primary medical care system that can provide a good family and community medicine service affordable to all whilst incorporating strong elements of health promotion and preventive care, with standards set for the care of different age groups and health status.

2.8 To strive towards our vision, we have recommended in *Building a Healthy Tomorrow* the following ways to improve the healthcare system –

- (a) Promoting the family doctor concept which emphasizes continuity of care, holistic care and preventive care.**
- (b) Putting greater emphasis on prevention of diseases and illnesses through public education and through family doctors.**
- (c) Encouraging and facilitating medical professionals to collaborate with other professionals to provide co-ordinated services.**

2.9 Our proposals to implement the above recommendations are as follows –

- (a) **Develop basic models for primary care services:** to develop service models with emphasis on preventive care as the basic standard for comprehensive primary care services for different age/gender groups, for reference by both doctors and patients in both the public and private sectors.
- (b) **Establish a family doctor register:** to register private doctors who serve as family doctors and provide comprehensive primary care to patients.
- (c) **Subsidize patients for preventive care:** to subsidize individuals of different target age/gender groups to undertake preventive care with reference to the basic models through family doctors in the private sector, requiring a certain level of co-payment in line with the principle of health as a shared-responsibility and to prevent abuse.

- (d) **Improve public primary care:** to enhance public primary care services for the low-income families and under-privileged groups through exploring various models of public primary care, including purchase of general out-patient services from the private sector, and to provide more comprehensive public primary care by incorporating elements of preventive care alongside curative services provided by general out-patient clinics (GOPCs). Primary care and community-based healthcare should be appropriately interfaced and integrated with other social services for the under-privileged and the elderly.
- (e) **Strengthen public health functions:** to continue to strengthen public health education, healthy lifestyle promotion and disease prevention provided by the Department of Health (DH). DH should also strengthen its role in the development and standard-setting of primary care services to ensure the quality and standards of such services.

2.10 These recommendations are elaborated in the following paragraphs.

Develop Basic Models for Primary Care Services

2.11 To promote primary care especially preventive care, we propose to develop in conjunction with the medical profession basic models of primary care services for different age/gender groups. The basic models, with emphasis on preventive care, should aim at providing the public as well as the healthcare professions a reference on what a comprehensive range of primary care services should cover. Through developing and promoting the basic models among the public and healthcare providers, coupled with other reforms to the service delivery model for primary care, we hope to bring about a paradigm shift that would put a much greater emphasis on preventive care.

2.12 The basic models should cover essential elements of primary care including assessment of health risks, surveillance and screening of health problems, health education and healthy lifestyle promotion, primary prevention and curative services. More specifically, we believe that the basic models should be developed on the basis of the following guiding principles –

- (a) **Life-course approach:** the models should cover every stage during the lifespan from first born to old age, and devise appropriate primary care services including preventive care for each stage of life.

- (b) **Holistic health:** the models should take into account not only physical health, but also psychosocial, emotional, behavioural, developmental and functional health.
- (c) **Essential:** the models should include services essential not only for prolonging life but also for functional independence, with the aim of attaining optimal health outcomes and ensuring a healthy life with quality.
- (d) **Evidence-based:** services included in the models should be based on empirical evidence (local and/or international data) on their efficacy, efficiency and cost-effectiveness.
- (e) **Need- and risk-based:** services in the models should be provided based on professional assessment of need having regard to risks, and intervention including screening tests must be preceded by assessment.

2.13 The basic models of primary care services should be supported by specific clinical protocols developed for use by healthcare professionals involved in delivering primary care. These clinical protocols would cover services included in the models, referral of patients for appropriate healthcare in other parts of the healthcare system or with other healthcare professionals, as well as follow-up of patients post-discharge or after specialist or other referred healthcare. Involvement of the healthcare professionals in the development of these protocols is essential. We therefore intend to engage the medical profession and other healthcare professions in developing the basic models and the clinical protocols for primary care services.

Establish a Family Doctor Register

2.14 Family doctors can come from diverse backgrounds. A family doctor can be a general practitioner, a family medicine specialist, or any other specialist. To help the public identify those who are practicing as family doctors from those who would like to pursue a practice in other specialty areas, and to provide patients with adequate information that will facilitate them to choose the provider, we propose to establish a **family doctor register** with the following features –

- (a) **Information for patients:** the register should contain relevant information about the family doctors such as their qualifications, training they have undergone, their experience, as well as any other information that may be relevant to the services they offer, e.g. addresses, opening hours, availability of service outside normal hours, contact arrangements in case

of emergency, availability of and form of backup arrangements in case of absence. Such a register would not only facilitate individuals in choosing their primary care providers who can serve them as family doctors, but also provide the public with a concrete idea of a family doctor practice.

- (b) **Training and qualification requirements:** initially all registered medical practitioners who are practicing in Hong Kong and providing family doctor service or willing to provide family doctor service may register as family doctors. For the future, we believe it is imperative that registered family doctors should undergo continued professional training and medical education, especially in the field of family medicine. We therefore recommend that appropriate training requirements and qualification milestones for registered family doctors to remain on the register be set in order to promote the continuous enhancement of quality of primary care.
- (c) **Accessibility and back-up arrangements:** family doctors should be encouraged to provide patients with out-of-hours access especially in cases of urgency. To ensure uninterrupted access to family doctor service by patients, private doctors should be encouraged to provide mutual support in service provision, and doctors who register as solo practitioners should be required to make back-up arrangements in the event that they take absence from practice.
- (d) **Sharing health records:** to enhance continuity and integration of care, especially between family doctors, specialists and hospitals in the referral of patients, family doctors should share their patients records with relevant parties subject to their patients' consent, and should make use of the future electronic health records (eHR) sharing infrastructure to be developed (see Chapter 4).

2.15 We propose that the establishment of a family doctor register be further developed through a working group with the involvement of the medical professions in the public and private sectors as well as other stakeholders.

Subsidize Patients for Preventive Care

2.16 To encourage the provision and uptake of comprehensive and quality primary care, the Government is prepared to consider providing subsidies for individuals to receive preventive care in the form of primary care voucher. The

provision of subsidization through primary care voucher should be considered on the basis of the following principles –

- (a) **Protocol-based:** the preventive care services to be subsidized must be based on clinical protocols for different age and gender groups and should be provided on the basis of need and risk assessment. The clinical protocols to be developed under the basic models for primary care will be the reference.
- (b) **Age/gender/disease group-based:** as individuals of different age, gender or disease groups may require different types and levels of preventive care, the subsidy levels should be set differently for individual groups, e.g. the level for the elderly should generally be higher.
- (c) **Through family doctors:** the provision of comprehensive primary care requires a long-term continuous relationship between a patient and his family doctor. The subsidized preventive care should therefore be obtained through family doctors on the family doctor register.
- (d) **Co-payment required:** the subsidy is not intended to subsidize the full cost of preventive care, and a certain level of co-payment should be required to encourage appropriate and judicious use of preventive care services and to reflect that health is a shared-responsibility.
- (e) **Secondary prevention:** the subsidy should also cover secondary prevention which includes post-discharge care since this is also an important part of preventive care, especially in maintaining the health of patients with chronic diseases as well as minimizing their risk of suffering from other complications and their need for re-admission to hospitals.
- (f) **Not for curative care:** the subsidy is not intended to cover curative services for episodic illnesses. An appropriate monitoring mechanism will need to be put in place (e.g. through the introduction of an electronic health record (eHR) system, see Chapter 4) to ensure that the subsidy is directed towards preventive services.
- (g) **Initial health assessment and screening:** in principle the subsidy should cover initial health assessment and screening. Further investigation or treatment of health problems should generally be paid for through the patient's own means.

2.17 We will further develop the concept of a primary care voucher scheme and the implementation details in the light of the experience of different pilots to test the feasibility of such a scheme.

Improve Public Primary Care Services

2.18 Over the past few years, the services of GOPCs have been gradually enhanced with initiatives such as introducing elements of family medicine with the setting up of family medicine specialist clinics alongside certain GOPCs. We reaffirm the current policy that the **general out-patient services of HA should continue to be made available to the low-income families and under-privileged groups to provide a safety net of primary care services** for these groups. To provide more comprehensive and holistic primary care services to these target groups, who may not be able to afford the co-payment required in the use of the proposed government subsidy to purchase preventive care services in the private sector, we see a need to enhance primary care provided by the public sector.

2.19 To this end, we propose the following –

- (a) **Explore future public primary care models:** we will explore with HA and DH the future service delivery model for public primary care services for the target groups, having regard to the basic models of primary care services. In particular, we recognize that public-private partnership including purchase of primary care services from the private sector would offer opportunities for providing comprehensive primary care services to the target groups in an even more accessible setting, thereby improving the quality and enhancing the efficiency of publicly-funded primary care services. The further development of electronic health record sharing should facilitate better integration and collaboration of the public and private sectors in providing primary care services. We propose that such opportunities be explored as far as possible.
- (b) **Incorporate preventive care in public primary care:** we propose that public primary care services provided by HA and DH should be enhanced and better integrated. In particular, preventive care services should be incorporated alongside existing curative care services in GOPCs, having regard to the basic models of primary care services. The aim is to make available the range of preventive care in the basic models to the target groups of GOPCs who may not be able to afford preventive care with family doctors in the private sector. To avoid double benefits, those receiving preventive care services at GOPCs would not be eligible for the

subsidy for preventive care services with private family doctors and vice versa.

- (c) **Examine interface of primary care with social services for the under-privileged and the elderly:** primary care and community-based healthcare provided by the public sector form an important component in the whole spectrum of social services offered to the under-privileged and elderly population. We propose that the Government should take the lead in facilitating the establishment of necessary liaison networks between the relevant institutions and professionals at the district level, for the purpose of ensuring that primary care services and community-based healthcare services are appropriately interfaced and integrated with other social services provided to the under-privileged and the elderly population.

Strengthen Public Health Functions

2.20 To complement other proposals for enhancing primary care, we see a need to strengthen existing public health functions –

- (a) **Enhance public health education:** public health education is an essential complement to enhancing primary care for the population. The Central Health Education Unit of the Department of Health has played a key role in formulating the direction of, and providing resources for, public health education. Such public health education functions should continue to be led and co-ordinated by the Government, with the engagement and co-operation of the private healthcare sector especially the family doctors.
- (b) **Public health promotion through community involvement:** through the Department of Health, the Government should continue to strengthen the promotion of healthy lifestyles and the prevention of diseases. There should be greater involvement of healthcare professionals in the private sector, especially family doctors who would have a much more direct and continuous relationship with individual patients, as well as other non-government organizations in the community which would also have their established networks within the local community.
- (c) **Strengthen DH's role in primary care:** to facilitate the development of the primary care services in the private sector, as well as to ensure the quality and standards of such services, the Department of Health should focus on devising appropriate standards and protocols for various primary care services, and to promote and monitor the application of such standards

and protocols in the private sector. With the reform recommended for primary care, DH as the public health authority should increasingly focus on developing and setting standards for primary care services.