EDITORIAL

Is good general practice possible in Hong Kong?

There are strong arguments in favour of an efficient and effective form of primary medical care as the basis for national health systems. In countries with health care systems that have a primary care orientation, there are lower costs of care, better levels of health, less use of medications, and higher satisfaction ratings for the health services provided.[1] Studies demonstrate a consistent relationship between the availability of primary health care and improved outcomes such as mortality,[2] life expectancy,[3] and reduced rates of avoidable hospitalisation.[4]

Changing demographic trends, altering patterns of illness, and rising health care costs are all factors which in combination make it likely that primary health care will gain increasing prominence. More patients will be treated outside of the hospital setting, more frail elderly patients will need better-organised systems of community-based care, the management of chronic illness rather than acute care will be of increasing concern, and greater emphasis will be placed on prevention rather than cure.

In the United Kingdom, changing demands and concerns about health care costs have focused attention on the integration of primary, hospital, and community health services together with the development of budget-holding by general practitioners, contracting out of services by hospitals, and systems of shared care. While general practitioners have always been regarded as a key part of the country's National Health Service, they have never before had such a degree of economic power within the system.

In the United States, "managed care" is all the rage,[5] and this attempts, through integrated delivery systems in which family physicians play an essential gatekeeping role, to control the costs of an otherwise overpriced and wasteful system of health care. A recent review of the literature[6] concluded that the move towards managed care has led to lower hospital admission rates and more preventive care, while achieving similar outcomes to traditional fee-for-service systems.

Times and priorities change, and with the same high-technology, specialised care that now dominates modern medical care has come the spectacular increase in costs, which threatens the economies of many countries. Suddenly, the gatekeeper role of family physicians is receiving urgent attention worldwide, and health care systems in which primary care plays a key part are creating a demand for well-trained generalist physicians who can provide comprehensive, coordinated and continuing care in an integrated system that takes advantage of the skills of a variety of providers.

How well-placed is Hong Kong to take advantage of such changing trends in health care—accepting that changing demographic trends and the rising costs of specialist focused care will progress as inexorably here as they have elsewhere? In Hong Kong, is comprehensive, coordinated and continuing primary care provided by well-trained physicians possible? Is it encouraged by the present system or inhibited by it?

Comprehensive care requires primary care providers to recognise a wide range of patient care needs, and to offer a system of services broad enough to meet such needs.[1] For an individual patient this means that a consultation might require attention not only to the presenting problem, but also reference to previous episodes of illness, monitoring of concurrent continuing problems, and consideration of potentially beneficial preventive interventions. It demands knowledge of the patient, an awareness of risk factors in different age groups, and a record system that allows ready retrieval of patient care data.

The ability of a physician to provide comprehensive care depends primarily on appropriate and adequate training. Most medical schools provide little help in this regard, with training programmes which focus on episodic acute care and are concentrated in secondary and tertiary care institutions. For this reason, many countries now demand additional training before a doctor is permitted to enter family practice. In Hong Kong, postgraduate training in family medi-

cine is notable by its absence, despite some worthy efforts on the parts of the Hong Kong College of General Practitioners, the Department of Health, and the academic units of general practice at the University of Hong Kong and the Chinese University of Hong Kong. Nor is there any incentive for doctors to undergo such training, even if it were readily available.

While adequate training is essential, the system of care has a strong influence on the type of care that can be delivered. In the high-volume practices that are characteristic of Hong Kong (often with more than 100 patients to be seen in a day and some four minutes available for each patient)[7] it seems unlikely that comprehensive care can be a priority.

All methods of payment have their disadvantages. Fee-for-service arrangements reward doctors for the number of patients they see, rather than for the type of care they provide. Salaried systems raise concerns that doctors need only meet a particular quota, and that there is no incentive for them to provide a thorough service. In both cases, the worst extreme is one in which quality of care—measured by comprehensiveness—is sacrificed for throughput.

The situation in Hong Kong is compounded by a fee-for-service arrangement which includes the cost of any required medications. The results of such an arrangement would seem to be entirely predictable. For their part, many patients expect to receive medications at each attendance, and the more the better. They may be less than happy with a consultation in which the physician considers psychosocial factors to be more important than biological ones, and when medications might be not only unnecessary, but also counter-productive. Similarly, suggestions that patients should attend for preventive care, for which no medications will be given, might be considered by patients as merely a strategy by the physician to maximise income.

From the doctor's point of view, the most cost-effective consultations are those that involve simple problems that can be treated with inexpensive placebo medications, and there may be a strong temptation to prescribe short courses of multiple medications in an attempt to win the patient's repeat business. Nor is it economic for a private general practitioner to deal with patients with chronic problems which require a constant supply of expensive drugs. Such patients, and their attendant costs, are shifted to the public health system.

There are no simple answers and no ideal ways of paying doctors that do not have both advantages and disadvantages. However, there is increasing recognition that the payment system plays a significant role in determining the quality of care delivered to patients, and composite systems[8] that involve elements of both fee-for-service and salary are receiving increasing attenion. It is hard to see how the perpetuation of a system in which prescribing is so firmly linked to income can be anything but harmful.

Comprehensive care demands integration, and the acknowledgement of the important roles that other health care workers can provide. For example, practice nurses[9,10] can provide effective care in minor illnesses, in the monitoring of chronic conditions, and in the provision of preventive care and health education. Community nursing services[11] can help family physicians to look after the frail elderly in their own homes, and allow the early discharge of patients who would otherwise need prolonged hospitalisation.

Different forms of practice organisation can contribute to comprehensive primary care, but at present there seems little to encourage innovation, and primary care in Hong Kong relies almost entirely on doctors working alone.

In the private sector there are difficulties regarding the payment of other health personnel, and the typical solo practice arrangement does not allow for much flexibility. Group practice arrangements that enable cost-sharing and the deployment of a variety of health care workers, are the exception rather than the rule. In the public sector, where the potential exists for the more creative use of different talents, the difficulties seem to relate to issues of organisation, and role descriptions that may be rigid and outdated.

To be effective, primary care needs to be comprehensive. In addition, for it to be efficient, it needs to be coordinated. The coordination of care—particularly of complex patients—is of critical importance in ensuring that the patient receives maximal care at the cost of minimal iatrogenic complications. It demands that at all times, the family physician has access to current and comprehensive notes on the patient. Only with an adequate record system can the physician keep track of the patient's movements through the medical system, the investigations that have been performed, and the drugs that have been prescribed.

It also demands effective links between generalists and specialists, in a referral system in which both sides understand and value the roles that each can play. As much as medical organisations in Hong Kong might

advocate a "seamless web of care", anecdotal evidence would indicate that this is not the case. Specialists complain about inappropriate referrals, with patients arriving in their clinics with little or no background information, and in turn general practitioners claim that specialists provide no useful feedback as a result of their referral, often taking over the care of the patient altogether.

These difficulties often seem to be compounded by the lack of a clear and functional distinction between family physicians and consultants. The efforts of the Academy of Medicine, and recent moves towards the rediscovery of the concept of "shared care",[12] seem to indicate that unsatisfactory difficulties in the present system are becoming apparent, and are receiving attention.

Coordination is a role that requires the investment of resources and time, but again is not well compensated in a system that rewards high-volume episodic care. Coordination is encouraged and facilitated by a doctor-patient relationship that is continuous. Continuous care is measured[1] by the degree to which both physician and patient agree on their mutual association, and the extent to which patients relate to a particular family physician over time.

In a system that seems neither to value nor encourage comprehensive and coordinated care, there is little reason to expect that the importance of continuity is appreciated by either physicians or patients, and indeed this appears to be the case. A recent report[13] estimated the prevalence of "doctor shopping" in government outpatient departments to be approximately 40%. Anecdotal evidence from the private sector indicates that the situation is little different there.

Why is "doctor shopping" so prevalent? Lo et al have suggested that fault lies on both sides.[13] Patients have high expectations of the efficacy of Western-style medicine, anticipate rapid resolution of symptoms, and have a low threshold for seeking care elsewhere if their symptoms do not resolve. Physicians pay little attention to patients' expectations, and do not appear to either value or encourage continuity of care. Waiting times are often long, appointment systems are rare, and little effort seems to be made to identify and deal with sources of patient dissatisfaction.

If primary care really is the bedrock of an efficient and effective health care system, it is hard to escape the conclusion that in Hong Kong, the health care edifice is built on shifting sand.

There is no lack of goodwill, and no lack of honest effort made by many general practitioners to provide the best care possible. The Hong Kong College of General Practitioners has taken a leading role in raising standards of primary health care, the university general practice units are working hard to emphasise the role of primary care in the medical schools, and the Department of Health is paying increasing attention to the importance of adequate record systems and the appropriate training of its medical staff.

However, the fact remains that with the best will in the world, it is hard to provide high-quality primary medical care in a practice and professional environment that encourages volume and expediency.

It is not possible to develop the skills required to provide comprehensive family medicine when training is inadequate, nor is it possible to deliver such care in high-volume solo practice settings. The payment systems of these practices encourage inappropriate and unnecessary prescribing, and the potential contributions of other health care professionals are not recognised or utilised.

It is difficult to provide coordinated care when effective information systems are undeveloped, consultant roles are ill-defined, and there is a lack of understanding and respect between the different levels of health care.

Continuity of care is not enhanced by a system in which the achievement of income, or the filling of quotas, takes precedence over the development of helpful long term doctor-patient relationships.

Many other countries have faced similar challenges, and have redeveloped a primary care sector that plays a central role in the provision of health care services. What factors encourage such change?

Governments have to accept that attention to primary care—although it demands the commitment of additional funds—will lead to eventual cost savings. No government has been able to sustain the costs that result from a health service that is dominated by hospital-based care.

Specialists have to realise that family physicians are better as allies than as rivals, and that an effective system of family medicine encourages the use of specialist expertise in situations in which it is most helpful to the patient and most satisfying to the specialist. Specialists can play an essential role in the training of

family physicians, but also have much to learn from their generalist colleagues.

Family physicians have to take responsibility for changing things, rather than just accepting them the way they are. They have to accept that comprehensive, coordinated and continuing care is important, to seek out ways to provide it within the present system, and to encourage changes in the system when necessary.

The health care system in Hong Kong is out of step with developments elsewhere, and its economic power has allowed it to ignore the lessons of others. This situation is unlikely to last forever, and if ignored, the crunch when it comes will be all the more severe.

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