

What Type Of Primary Care Services Does The Public Want?

C L K Lam,* FRCGP, FHKAM(Fam Med)

General Practice Unit
Department of Medicine

I J Lauder, PhD

Department of Statistics
The University of Hong Kong

M G Catarivas, MD

Specialist in Family Medicine
Israel

Summary

- Objective** : To find out what type of primary care services the public in Hong Kong wants.
- Design** : Cross sectional population telephone survey.
- Subjects** : 996 Cantonese speaking Chinese adults aged 21 years or above were randomly selected from households in Hong Kong.
- Main outcome measures** : People's preference for the type of practices, doctors, access systems, consultations and other services in primary care.
- Results** : Most people preferred to consult the same doctor close to their homes. Many people wanted doctors to be available in the evenings, weekends and public holidays. More people preferred a walk-in than a telephone appointment system. Most thought it was important for their primary care doctors to have higher medical qualifications. More people preferred male to female doctors. The majority (68%) thought an average consultation should last for more than 5 minutes. Over 90% thought it was important for the doctor to give detailed explanations on their illnesses and treatments. Many wanted primary care practices to provide preventive care. Thirty-seven percent of subjects would consult specialists without referrals. Thirty percent of people agreed that nurses could be responsible for following up chronic diseases but only 16% thought they could treat minor illnesses.
- Conclusion** : The study confirmed that the public wanted accessible, available and comprehensive primary care services provided by doctors with postgraduate higher medical qualifications. Contrary to previous beliefs, most people preferred to consult the same doctor all the time and people wanted explanation as much as medications from doctors. (*HK Pract* 1998; 20:174-186)
- Keywords** : Primary care, patient-centred care, prevention, general practice

*Address for correspondence: Dr Cindy L K Lam, Associate Professor, General Practice Unit, The University of Hong Kong, 3/F, Ap Lei Chau Clinic, 161 Main Street, Ap Lei Chau, Hong Kong.

ORIGINAL ARTICLE

摘要

目 設 對 測 結	量 內 容	的 計 象 容 果	<p>: 了解香港公眾對基礎醫療的要求。</p> <p>: 交錯性電話調查。</p> <p>: 隨機抽樣選擇996名年齡為21歲或以上講廣東話的電話用戶。</p> <p>: 公眾對診所的類別，醫生類型，接觸方式，診斷內容及其對基礎醫療服務的要求。</p> <p>: 絕大部份受訪者喜歡接受住所附近同一醫生診治。很多受訪者希望醫生能提供晚間、周末及公眾假期應診服務。較多受訪者喜歡直接到診症地方而不願選擇電話預約。大部份受訪者希望其就診的醫生有較高醫學資格，而較多受訪者喜歡由男性醫生診治。68%的受訪者認為診症時間應超過5分鐘，90%以上受訪者認為醫生應當針對其疾病及治療作詳細解釋。很多受訪者希望基礎醫療可以提供預防性服務。37%受訪者不經醫生轉介而直接到專科醫生求診，30%受訪者認為護士可以提供慢性疾病的隨診，但只有16%認為護士能夠進行簡單治療。</p>
結	論	論	<p>: 公眾期望基礎醫療能夠提供方便，全面及綜合性的服務，而診治的醫生有較高學歷。與以前觀念相反，多數公眾希望找同一醫生診治並得以有關的解釋。</p>
主 要 詞 彙	彙	彙	<p>: 基礎醫療、以患者為中心的治療、預防、家庭醫學</p>

Introduction

Primary care in Hong Kong is provided in a variety of ways by private general practitioners, government outpatient clinics, company doctors, private specialists, outpatient departments of private and public hospitals and alternative practitioners such as herbalists, bone setters and acupuncturists.¹⁻⁴ Some people even attend the hospital Accident and Emergency Departments for non-emergency primary care. People can change from one doctor to another at any time for the same or different illnesses. It is not uncommon to find patients taking treatments from more than one doctors for the same illness.^{2,4} Doctor-shopping is common and continuity of care seems impossible in our society.^{4,6}

Doctor-shopping is frustrating for doctors and can be harmful to patients.⁷ But why do people doctor-shop? Lo *et al* found that those who were less satisfied with the service

were more likely to doctor-shop.⁶ People are more likely to return to a doctor whose services match with what they want. Although what people want may not always be what they need and vice versa, wants often drive demands ignoring which will result in patient dissatisfaction and complaints. The Ljubljana Charter by the European member of WHO states that 'the citizen's voice and choice should make as significant a contribution to shaping health care services as the decisions taken at other levels....'⁸ It does not mean that all public demands should be blindly met but people's wishes should be addressed in the planning of services and public health education.

It is a common belief that people in Hong Kong shop around for doctors for episodic rapid symptomatic treatment but few are interested in preventive care.^{5,6} Many doctors think that patients always want a large number of medications from each consultation.^{5,9} The doctor is often

pictured as an authoritative person who gives instructions without any need for explanation.^{3,4} Many of these impressions have derived from anecdotal experiences rather than research data. This present study was the first to systematically survey what the public wanted although there were a few local studies on the pattern of service utilization.^{2,4}

The aim of this study was to find out what primary care services the public in Hong Kong wanted in order to separate facts from myths. Four aspects of primary care services were surveyed:

1. access to services,
2. characteristics of doctors,
3. the consultation process, and
4. the range of services.

We hope the information would help health care planners and doctors provide a more patient-centred primary care for the public in Hong Kong.

ORIGINAL ARTICLE

Methods and subjects

A questionnaire was developed after a review of the literature and focus group discussions by four doctors of the General Practice Unit, The University of Hong Kong. It was further revised after a pilot study on 25 subjects by telephone interviews in Cantonese. The final questionnaire that was used in the survey is available from the authors on request. The survey was carried out by telephone in Cantonese by 5 trained interviewers from July to December 1991.

Telephone numbers were randomly sampled from every odd page, third column and first row of the 1991 Chinese Residential Telephone Directories of Hong Kong and Outlying Islands, Kowloon and the New Territories. The telephone number immediately below was used as a replacement if the initial sample was not successful. One person aged 21 years or older was randomly selected from each sampled household, according to a computer-generated Kish selection table, to answer the questionnaire in person. The Kish selection table lists a sample number (to represent the birth order) for each household size.¹⁰ A replacement subject, also selected according to a Kish table, was interviewed if the initial sampled subject refused or was unavailable after three attempts at making contacts.

One thousand six hundred and fifty three telephone numbers were selected, 99 telephone numbers were commercial and there were no contacts from 142 numbers. One thousand four hundred and twelve eligible households were contacted and 996 persons completed the interviews. The

response rate was 70.5%. The age of the respondents ranged from 21 to 88 years with a mean of 35 years. **Table 1** compares the distribution of the sample by gender, age groups, social class by occupations,¹¹ and educational levels to that of the Hong Kong adult population in mid 1991.¹²

The data were analyzed by the SPSS-PC+ (Statistical Packages for Social Science- Personal Computers) programmes.¹³ The effects of age, sex, social class and educational level on the responses were analyzed by logistic regression using SAS (Statistical Analysis System).¹⁴

Table 1: Demography of the study sample compared with the Hong Kong population

	Number (%) of Persons in Sample (N = 996)	Proportion of 1991 Hong Kong population ≥ 21 yrs old (N = 3,960,723)
Gender		
M	492 (49.4%)	50.5%
F	503 (50.5%)	49.5%
Unknown	1 (0.1%)	
Age (yrs old)		
21-39	697 (70%)	53.0%
40-59	240 (24.1%)	28.9%
≥ 60	59 (5.9%)	18.1%
Education		
Nil	20 (2%)	12.8%
Primary	138 (13.9%)	25.2%
Secondary/Matri	692 (69.5%)	50.7%
Tertiary & above	146 (14.6%)	11.3%
Social Class by Occupation		
Professionals	26 (2.6%)	3.7%
Associate professionals/ managerial	205 (20.6%)	19.5%
Skilled workers	556 (55.8%)	57.3%*
Semi-skilled workers	159 (16%)	20.7% } 19.5%#
Unskilled workers	47 (4.7%)	
Unknown	3 (0.3%)	

* Total of all clerks, service workers, shop sales workers, craft and related workers, plant and machine operators and assemblers.

Elementary occupations and others (12).

ORIGINAL ARTICLE

Results

The majority of the subjects answered all questions. The number of missing responses in any of the questions ranged from 0 to 27 (3%). The total sample of 996 was used as the denominator for the calculation of the percentages of different response choices. Some of the percentages may not add up to 100 as a result of rounding.

Access to primary care services

Seventy-three percent of subjects preferred to attend private general practices, 18% preferred Government outpatient clinics (GOPD), 7% preferred practices appointed by their companies, and 2% preferred outpatient clinics of private hospitals. The most commonly cited reason for the choice of practices was proximity to their homes (30%), other reasons in order of frequency were: recommendation by others (21%), already attended by other family members (12%), suitable budget (12%), minimal waiting time (10%), appointed by the company (6%) and others (9%).

Forty-four percent of people wanted appointments by telephone, 31% preferred to have a disc distribution system as that of the GOPD clinics and 25% of them preferred a queuing system. Fifty-nine percent of people thought that a doctor's appointment should be available within the same day of request, 33% said that an appointment within 2 days was acceptable, 8%

would accept waiting for more than two days for non-emergency consultations.

Forty-one percent of people said that normal surgery opening hours should be 12 hours from morning to evening, 40% said that they should be 4 hours in the morning and 4 hours in the evening, and 18% said that they should be 8 hours from morning to the afternoon. During weekends and public holidays, 36% of people wanted surgeries to remain open, 45% would accept access to their doctors by telephone and 18% said that doctors should not be expected to be available. Sixty-one percent of subjects said that doctors should make home visits when necessary, 20% said that they should not and 19% did not know what they wanted.

When people wished to consult a specialist, 37% would consult a specialist without referral, 30% would ask their primary care doctors to recommend a specialist and 30% would consult their primary care doctors about the need. Three percent of people did not answer this question. Recalling the last specialist consultation, 46% said that they were referred by their primary care doctors and 34% consulted a specialist without any referrals; 20% said that they had never seen a specialist.

Characteristics of doctors

Forty-two percent of people said that they always saw the same doctor, 35% said that they usually preferred to see the same doctor but would see

another if the former was not available, 21% would see any doctor who was available and 2% said that they preferred to see a different doctor each time. Seventy percent of subjects thought it was desirable for them and their family members to have the same primary care doctor, 18% said that it did not matter and 12% said that it was undesirable.

Sixty-eight percent of people said that it was important for primary care doctors to have postgraduate higher medical qualifications, 11% thought it was not important and 21% were not sure. Just over half (51%) said that the gender of the doctor did not matter, 42% preferred male and 7% preferred female doctors. Forty-eight percent of people wanted their doctors to treat them like friends, 38% wanted paternalistic doctors, 10% wanted authoritative doctors and 4% wanted their doctors to do whatever they requested.

The place of graduation of their doctors did not matter to 47% of people but 35% preferred Hong Kong graduates, 15% preferred U.K. graduates and 3% preferred others. Forty-two percent of people preferred their doctors to be between 40 to 50 years old, 27% favoured doctors aged between 30 to 40 years, 25% said that the age did not matter, very few people preferred doctors aged over 50 years (5%) or under 30 years (2%).

The consultation process

The maximum acceptable waiting time before a consultation was 5 minutes for 19%, 10 minutes for 49%,

ORIGINAL ARTICLE

30 minutes for 27% and more than 30 minutes for 4% of subjects. Thirty-two percent of people said that the average duration of a consultation should be up to 5 minutes or less, 44% thought it should be 5 to 10 minutes, 22% thought it should be 11 to 20 minutes and 2% thought it should be more than 20 minutes.

A detailed explanation of their illnesses from their doctors was regarded very important by 57%, moderately important by 34% and not important by 9% of people. Forty-seven percent of people thought a detailed explanation of the management was very important, 45% thought it moderately important and 8% thought it not important. Sixty-six percent of people always expected a prescription from the consultation, 21% usually did, 12% occasionally and 1% rarely or never expected one.

Apart from their illnesses, some people said that they would also consult doctors about their life habits (59%), psychological problems (30%), social problems (21%), marital problems (21%) and other family relationship problems (16%). Over half of the people (52%) said that it was necessary for doctors to know their social background like work and family as well as their medical history, 30% thought it was unnecessary and 18% said that it did not matter.

Range of services and the roles of nurses in primary care

Subjects were asked whether they wanted certain services to be provided

by primary care practices and whether they agreed certain tasks to be the roles of practice nurses. **Table 2** shows the responses of subjects by the type of services and roles.

Nearly one third (31%) of people favoured preventive services to be provided opportunistically during regular consultations, 28% preferred dedicated clinic sessions for them, 25% wanted them to be available both ways and 16% said that they did not know.

Fifty-eight percent of people said that they would change to another

practice if the attitude of the practice nurses or receptionists was poor, 27% said that they would not and 14% were not sure.

Effects of age, social class, educational level and gender

The effects of age, social class, educational level and gender on people's response choices on the type of practices, access systems, access to specialists, preference for the same or different doctors, doctor's gender, doctor's age, doctor's attitude,

Table 2: Range of services and roles of practice nurses in primary care

	Proportion (%) of Subjects (N = 996)			
	Yes	No	Not sure	No answer
Range of services				
a. Immunization	96	3	1	0.2
b. Well-baby check	91	7	2	0.3
c. Cancer screening	75	15	10	0.5
d. Family planning	65	22	13	0.6
e. Health education	47	27	25	0.8
Roles of practice nurses				
a. Assist doctors	98	1	1	0
b. Simple procedures*	97	2	1	0
c. Health education	81	9	11	0
d. Follow up chronic diseases	30	43	27	0.1
e. Treating minor illnesses	16	63	22	0
f. Home visits	22	48	30	0

* Include measuring weight, height, temperature and blood pressure, dressings and giving injections

ORIGINAL ARTICLE

importance of explanation of illness, importance of explanation of management, expectation for a prescription, consulting for psychosocial issues, range of services and roles of practice nurses were analyzed by logistic regression. Those who did not give an answer or did not indicate any preference were excluded from the relevant logistic regression analyses.

Table 3 shows the dependent service

variables that were affected by one or more of the four independent demographic variables at statistically significant levels ($p < 0.05$). The various services were regarded as separate aspects of health care, and univariate analyses in terms of the individual covariates were used.

Fitted logistic models were used to predict the probabilities of response

choices of those variables that were significantly affected by the independent demographic variables. Tables 4 to 7 show the probabilities of response choices predicted by age, social class, educational level and gender, respectively. One can assess the magnitude and direction of the effects of the different demographic variables on response choices from these probabilities.

Table 3: Effects of age, social class, educational level and gender on the choice of services tested by logistic regression

Dependent service variables	Significance level (p value)			
	Age	Social class	Education	Gender
Type of practice#	<0.001	0.003	<0.001	0.03
Same/different doctor#	N.S.	0.02	N.S.	N.S.
Registration system#	N.S.	0.004	<0.001	N.S.
Access to specialist#	N.S.	0.03	<0.001	N.S.
Gender of doctor*	N.S.	N.S.	N.S.	<0.001
Explanation of illness#	0.007	N.S.	N.S.	N.S.
Advice on life styles*	0.04	N.S.	0.03	N.S.
Advice on marital problems*	0.01	N.S.	0.003	N.S.
Advice on family relationship*	0.007	N.S.	N.S.	N.S.
Advice on social problems*	0.01	N.S.	N.S.	N.S.
Nurse follow up chronic diseases*	N.S.	0.02	0.02	N.S.
Nurse treating minor illnesses*	0.03	N.S.	N.S.	N.S.

Statistical Notes

1. All dependent variables have categorical responses. Binary logistic regression analyses were used for those variables that have two categories (marked by *); polychotomous logistic regression analyses were used for those variables that have more than two responses (marked by #).

2. Independent variables: age is continuous, social class has 5 categories, education has 6 categories, and gender is binary.

N.S. = Not significant

ORIGINAL ARTICLE

The age effect on the importance of explanation about the illness was mainly a difference between very important and moderately important; very few people, young or old, thought explanation was not important (Table 4). Social class and educational level were strongly correlated independent variables ($p < 0.01$), thus the effects of social class and educational level produced broadly similar outcomes (Tables 5 and 6). Females were more likely than males to use public clinics and prefer female doctors (Table 7).

Discussion

A response rate of 70.5% was comparable to those of other local telephone surveys.^{3,4,9} The sample size of 996 subjects gave a standard error of 3%. The study sample had relatively more female, younger and better educated people than the 1991 Hong Kong general population. Similar sampling bias was also observed in other telephone surveys.^{4,9} The elderly, who are on average less educated, are less accessible by telephone because some of them are institutionalized and others may have communication problems. The bias from the exclusion of non-Cantonese speaking individuals and people without telephones, e.g. boat people, was negligible because they make up only a small proportion of the population.

The survey was carried out one year after the formation of the Hospital Authority and the publication of the Primary Care Working Party Report

Table 4: Probabilities of response choices of services predicted by age

Affected services	Age (years)	
	30	60
Type of practice		
Private	0.75	0.60
Public	0.25	0.40
Explanation of illness		
Very important	0.55	0.70
Moderately important	0.35	0.22
Usually unimportant	0.06	0.03
Not important at all	0.04	0.05
Seeking advice on life styles	0.88	0.58
Seeking advice on marital problems	0.27	0.18
Seeking advice on relationship problems	0.22	0.13
Seeking advice on social problems	0.28	0.18
Agreeing to nurses treating minor illnesses	0.18	0.26

Table 5: Probabilities of response choices of services predicted by social class

Affected services	Social class by occupation	
	Professional	Unskilled
Type of practice		
Private	0.80	0.60
Public	0.20	0.40
Choice of doctor		
Always the same	0.33	0.50
Usually the same	0.46	0.25
Whoever is available	0.17	0.24
Different each time	0.04	0.01
Access system		
Appointment	0.57	0.33
Disc system	0.27	0.33
Queuing	0.16	0.33
Access to specialist		
Self-refer	0.44	0.30
Ask G.P. to refer	0.34	0.26
Consult G.P. on the need	0.22	0.44
Agreeing to nurses following up chronic diseases	0.30	0.53

(Continued on page 182)

ORIGINAL ARTICLE

Table 6: Probabilities of response choices of services predicted by educational level

Affected services	Educational level	
	Tertiary	Nil
Type of practice		
Private	0.80	0.60
Public	0.20	0.40
Access system		
Appointment	0.54	0.34
Disc system	0.31	0.30
Queuing	0.15	0.36
Access to specialists		
Self-refer	0.42	0.32
Ask G.P. to refer	0.40	0.22
Let G.P. decide on need	0.18	0.46
Seeking advice on life styles	0.70	0.56
Seeking advice on marital problems	0.36	0.17
Agreeing to nurses following up chronic diseases	0.33	0.51

Table 7: Probabilities of response choices of services predicted by gender

Affected services	Gender	
	Male	Female
Type of practice		
Private	0.70	0.60
Public	0.30	0.40
Gender of doctor		
Male	0.95	0.75
Female	0.05	0.25

did? Many subjects said that they would see another doctor when their usual doctor was not available. People's perceived need for early medical attention seemed to outweigh their loyalty to doctors. It is normal for patients to be worried and lose trust in the doctor when symptoms persist unless they have been informed that it will take a few days before the illness will get better. People may be more prepared to 'wait and see' if they were better educated on the natural course of common illnesses.

Over 90% of subjects thought detailed explanations of their illnesses and management were important, but Wong *et al* found that the nature of the illness was explained in only 49% and treatment was explained in only 26% of all consultations.³ Patients have a right to know more about their illnesses and treatment¹⁵ and such knowledge has been shown to improve clinical outcome.¹⁶ The Medical Protection Society points out that 'Many claims could be avoided if practitioners took time and trouble to..... explain things and listen to them (patients) and, where appropriate, their relatives'.¹⁷ Only 66% of people always expected a prescription from a consultation but drugs were prescribed in nearly 100% of consultations.^{9,18} It is time doctors start explaining more and prescribing less.

which were the most major changes in our health care system in the last decade. There have been few changes in the health care system since the time of our data collection. We therefore believe that our results are applicable to the present situation even though the data were collected a few years ago.

Seventy-seven percent of people said that they always or usually preferred to consult the same doctor but earlier studies showed that the prevalence of doctor-shopping was as high as 40%.^{4,6} Why was there a discrepancy between what people said they preferred and what they actually

One of the reasons given by doctors for not explaining more to patients is the lack of time in the consultation. How long should a consultation last? Sixty-eight percent of subjects thought that an average consultation should last for more than 5 minutes. This was consistent with

ORIGINAL ARTICLE

findings from other studies that more patients complained of 'too little time' when consultations were scheduled at five-minutes intervals than when they were scheduled at 10 or 15 minutes' intervals,¹⁹ and doctors explained significantly more when consultations were scheduled at longer intervals.²⁰

Most people wanted their primary care doctors to have postgraduate higher medical qualifications which implied that they expected doctors to undergo further training and education after graduation from medical schools. The public's expectation is consistent with the international trend that undergraduate medical education mainly prepares doctors for post-graduate vocational training which is essential before any independent medical practice.²¹ It may be time for the Hong Kong Medical Council to consider such quality assurance of the health care services for our public.

Many subjects said that they wanted primary care to provide preventive services but earlier studies showed that few people had ever received them.²²⁻²⁵ A recent morbidity survey in Hong Kong showed that preventive care made up as little as 1.3% of all the reasons for consultations²² while the 1991/92 survey in the U.K found that it accounted for 11% of the consultations.²⁶ Thirty-seven percent of women attending a GOPD clinic had ever had their breasts examined by a doctor;²⁴ 33% of women attending a private practice and 17% of women attending GOPD clinics had ever had a cervical smear test;^{23,25} very few patients had received any advice about life styles from doctors.²³

Cost is the greatest barrier to the provision of preventive care in the private system while that for the GOPD is workload. The Government has set up some special preventive centres, e.g. the well women centres, to overcome some of these barriers, but the effectiveness is limited by the Inverse Care Law: those who are at risk are the least motivated to consult and the worried-well tend to abuse the service.²⁷ Since over 90% of the population would consult their primary care doctors at least once a year for illnesses, it is easier to reach the target population and follow up abnormal results by integrating preventive and curative care.^{28,29} The Government can consider contracting with private primary care doctors in the provision of preventive care to the public, this has been found to be successful in Ireland.³⁰

The public recognized the provision of health education and home visits as appropriate roles of practice nurses. These duties should be taken into account in the training and job description of primary care nurses. On the other hand, most subjects did not agree with nurses following up chronic diseases or treating minor illnesses on their own. Poor patient-acceptance may be an obstacle in the use of 'nurse practitioners' to do the work that is traditionally done by doctors.³¹

Professionals and the more educated were more likely than the working class and uneducated to consult specialists without referrals. This is another illustration of the Inverse Care Law.²⁷ The rich and educated tend to use more specialist

services than they may need because they can afford to by-pass the gate-keepers; the poor often have to wait for a long time before they can see the public specialists that they need.

The effect of social class on doctor-shopping was not straight forward, people from the working class were more likely than professionals to see the same doctor always but they were also more likely to see whoever doctor was available. Therefore, it is inappropriate to generalise. Hedley *et al* found that age had a positive effect on the use of the same doctor but they did not find any effect from social class.⁴

It was a bit surprising to find that more people preferred male to female doctors. The nature of the consultation was not specified in the survey and the results might not apply to consultations for gynaecological problems. It would be interesting to have further studies on the factors and reasons of preference for the doctor's gender.

Conclusions

Our study confirmed that the public wanted accessible, available and comprehensive primary care services preferably provided by doctors with postgraduate higher medical qualifications. The public expressed a lot of interest in preventive services. Contrary to our common belief, most people actually wanted to see the same doctor if he/she was available. The other unexpected finding was the low proportion of people preferring authoritative or female doctors. An

(Continued on page 185)

ORIGINAL ARTICLE

Key messages

1. The public's opinion should make a significant contribution to making primary health care services more effective and satisfying for patients.
2. Most people wanted to consult the same doctor if the doctor was available.
3. The public thought it was important for primary care doctors to have postgraduate higher medical qualifications.
4. Patients expected detailed explanation on their illnesses and management but not necessarily medications from a consultation.
5. The public expressed a lot of interest in the incorporation of preventive care into primary care services.

important message for doctors is that the majority of patients wanted detailed explanations on their illnesses and treatments but many did not always expect a prescription from the consultation.

The expectation for immediate access to services and instantaneous cure might be the driving force of doctor-shopping. More public education on the natural course of illnesses may be a better way of correcting inappropriate illness behaviour than unlimited supply of services.

Our findings have provided some insight into the gaps between what the public wants and what our existing system provides. We need to find ways to encourage continuing rather than episodic care, reward with explanation rather than symptomatic treatment, and promote preventive as well as curative care. The Government has a pivotal role to play in this by setting a clear policy on what and how primary care services including

prevention should be provided and funded for our population. The Government has invited a consultant to review our health care system in 1998, we hope that the public's wishes will be taken into consideration in the planning of our future primary care services so that they will be more effective and patient-centred.

Acknowledgements

This study was funded by a research grant from the Committee of Research and Conference Grants (CRCG), The University of Hong Kong. We would like to thank Dr. Clarke Munro and Dr. Alywin W.T. Chan for their contribution in the planning of the study. Thanks also go to Mr. Nam Tat for his assistance in data analysis. ■

References

1. Lam CLK. The health care delivery system of Hong Kong. *WONCA News* 1992;18:12-15.

2. Lee RPL. Perceptions and uses of Chinese medicine among the Chinese in Hong Kong. *Culture, Medicine and Psychiatry* 1980;4:345-375.
3. Wong TW, Wong SL, Donnan SPB. Traditional Chinese medicine and Western medicine in Hong Kong: a comparison of the consultation processes and side effects. *J H K Med Assoc*. 1993;45:278-284.
4. Hedley AJ, Cheng KK, Pei GK, et al. *Surveys on health and medical care in Hong Kong: 2. General population- health problems, choices of care and patterns of utilization in a well population telephone survey*. Hong Kong: Department of Community Medicine, University of Hong Kong & Department of Health, Hong Kong Government, 1990.
5. Dixon AS. Is good general practice possible in Hong Kong? *HKMJ* 1995;1:190-193.
6. Lo AY, Hedley AJ, Pei GK, et al. Doctor-shopping in Hong Kong: implications for quality of care. *Int J Qual Health Care* 1994; 6:371-381.
7. Chan C. Doctor shopping can be fatal. *HK Pract* 1993;15:2645-2647.
8. Anonymous. The Ljubljana Charter on reforming health care. *BMJ* 1996;312:1664-1665.
9. Lam CLK, Catarivas MG, Lauder IJ. A pill for every ill. *Family Practice* 1995;12:171-175.
10. Aday LA. *Deciding who will be in the sample*. In: Aday LA. *Designing and conducting health surveys*. San Francisco: Jossey-Bass, 1989:92-111.
11. General Registrar Office. *Registrar General's Classification of Occupation*. London: HMSO, 1966.
12. Census & Statistics Department, Hong Kong. *Hong Kong 1991 population census - Main report*. Hong Kong: Government Printer, 1993.

ORIGINAL ARTICLE

13. Norusis MJ. *SPSS/PC+ for the IBM PC/XT/AT*. Chicago: SPSS Inc, 1986.
14. SAS Institute Inc. *SAS User's Guide*, Vol. 1 & 2. North Carolina: Gary, 1988.
15. General Medical Council. *Good medical practice- Guidance from the General Medical Council*. London: GMC, 1995.
16. Kaplan SH, Greenfield S, Ware JE. Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Medical Care* 1989; 27 (3 Supplement): S110-127.
17. Medical Protection Society. *Information for members - Guidance for good practice*. London: The Medical Protection Society.
18. Hedley AJ, Cheng KK, Pei GK, et al. *Surveys on health and medical care in Hong Kong: 1. GOPD - Health problems, patterns of utilization, medical work and outcomes in patients attending general outpatient department*. Hong Kong: Department of Community Medicine, University of Hong Kong & Department of Health, Hong Kong Government, 1990.
19. Ridsdale L, Carruthers M, Morris R, et al. Study of the effect of time availability on the consultation. *J R Coll Gen Pract* 1989;39:488-491.
20. Baker R. Characteristics of practices, general practitioners and patients related to levels of patients' satisfaction with consultations. *Br J Gen Pract* 1996;46:601-605.
21. General Medical Council. *Tomorrow's doctors - recommendations on undergraduate medical education*. London: GMC, 1993.
22. Lee A, Chan KKC, Wun YT, et al. A morbidity survey in Hong Kong, 1994. *HK Pract* 1995;17:246-255.
23. Pei GK, Hedley AJ, Cheng KK, et al. Preventive health measures and counseling in the Government Outpatient Department Clinics. *HK Pract* 1991;13:1838-1853.
24. Lam CLK, Ho LWC, Douglas SL, et al. Mammography screening in general practice - a pilot study. *HK Pract* 1996;18:315-320.
25. Ip KK. The practice of breast self-examination (BSE) among local working women. *HK Pract* 1994;16:351-356.
26. McCormick A, Fleming D, Charlton J. *Morbidity statistics from general practice - fourth national study 1991-92*. Office of Population Censuses and Surveys Series MB5 no. 5. London: HMSO, 1995.
27. Hart JT. The inverse care law. *Lancet* 1971;1: 405-412.
28. Bindman AB, Grumbach K, Osmond D, et al. Primary care and receipt of preventive services. *J Gen Intern Med* 1996;11:269-276.
29. RCGP. *Combined reports on prevention*. London: RCGP, 1984:3-8.
30. Meagan G. *An ounce of prevention...* Forum 1996;12:39.
31. Lam CLK. The nurse practitioner. *HK Pract* 1992;14:1879-1880.



NEXT ISSUE

1. Seasonal Variation Of Morbidity In Hong Kong
2. Recent Advances In The Management Of Nasopharyngeal Carcinoma
3. Common Breast Conditions: When To Refer And What Will The Specialist Do?