COMMENTARY

Estate doctors and policy on family medicine

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Estate doctors were dismayed by the Hong Kong Council of Social Service's publication of a survey of patients leaving clinics after consultations. The data, however, show high levels of satisfaction from patients who consulted estate doctors, and most people (and their families) attended one doctor by choice, contrary to widespread perception of 'doctor shopping' in Hong Kong. Aspects of care in Hong Kong could be improved and include short consultation times, limited discussion, and frequent usage of short courses of medication. There is segregation of care: estate doctors see more working-age people and their families, while out-patient departments see older and unemployed people. The report concluded that further development of family medicine is needed in Hong Kong—a conclusion that the Estate Doctors Association shares. The survey demonstrates again some underlying problems of primary medical care in Hong Kong—problems which are largely related to the expectations and learned habits among both doctors and patients, and which must change for Hong Kong health care to reach the level expected in a modern, developed society.

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In February 1998, the press widely publicised the results of a survey undertaken by the Hong Kong Council of Social Service, in which patients of estate doctors were interviewed outside clinics after their consultations. Some doctors reacted very negatively to this survey, annoyed that this was done without their knowledge. Most of us would feel threatened by such covert surveillance of our work.

The authors of the survey concluded that greater development of family medicine is needed in Hong Kong. Although the full copy of the survey is not yet available, the preliminary report[1] is very interesting to the newcomer. While there may be a small overlap in the sampling of doctors, the report adds to the morbidity studies performed by the Hong Kong College of Family Physicians[2] and those conducted in general out-patient clinics (GOPCs),[3] to reflect the third major component of out-patient care in Hong Kong—the estate doctors.

The fees that estate doctors charge are $150 on average (compared with the $37 fee of GOPCs), so as one might expect, half their patient population are working and aged between 20 and 44 years. The median patient salary ($12 300) is higher than the median Hong Kong income ($10 000). However, estate doctors see approximately one third fewer of the very young or those aged >45 years, than do doctors in GOPCs.

Ninety percent of patients visited a doctor in their own estate or close by, and the two most important reasons for doing so were the perceived medical quality and convenience. Price and recommendations by others were less frequently given as reasons. Only 3.6% of patients would go to any doctor anywhere, and 56.5% said that their whole family usually goes to the same doctor.

Upper respiratory tract disease was the predominant reason for seeing an estate doctor—73.1%, compared with 33.8% in GOPCs. Few attended for chronic disease, quite unlike the GOPCs, where 26.7% of patients present with cardiovascular disease and 8.8% with endocrine disorders (mostly diabetes). Medication was given by estate doctors to 99.0% of patients, and 83.4% of patients received medication for 2 days only; 2.3% received medication for 5 days or more.

These data show that patients are appropriately responding to economic incentives: those with chronic disease go to GOPCs where the care and particularly

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the drugs, are subsidised, while those who are working have money but limited time, perceive they have acute illnesses, and consult estate doctors. Despite the widespread perception that Hong Kong patients 'shop around', few of this sample said they do, and the majority of those questioned value what they perceive as the quality and continuity of medical care that they receive.

According to the patients, doctors asked about daily life in 38.3% of consultations and gave advice on health in 42.4% and advice to have a regular check-up in 9.3%. The median and modal consultation duration was estimated to be 5 to 6 minutes; 47% of consultations took this time, while 17.6% took longer. While only 26.3% of the 401 patients questioned who had respiratory illness felt that the doctor explained the cause of their illness, 41.7% of those with other types of illness said that the doctors did so. The authors concluded that most doctors are not aware of preventive care, and do not give enough health education information to their patients. They recommended that estate doctors should use opportunities in their consultations to advocate preventive care and assess the health risk of their patients.

Overall, the authors recommended that Hong Kong policy should support and develop primary health care by training more family doctors, encouraging the development of good communication between doctors and patients, and reducing hospitalisation rates through preventive medicine. These are desirable goals, but not all of them follow directly from the data.

The Estate Doctors Association responded to the report by supporting the call for further policy change to develop family medicine and emphasising that the Association has promoted this concept by working with a variety of organisations.[4] However, they also noted that preventive medicine and patient education take time and cost money. While they support such communication, they rightly pointed out the difficulty of doing so in the consultation time they have available, and suggested that it must be even more difficult for doctors in GOPCs, who have only 2.7 minutes available per consultation.[4]

International change

The survey reflects an increasing international trend, whereby organisations with a consumer interest evaluate health services and find gaps—mostly where doctors had already expected them. Doctors and medical organisations tend to perceive this as criticism and react defensively; yet, all of us are pleased when consumer organisations undertake reviews of motor car reliability or advise which electronic goods to buy, adding to and sometimes contradicting information provided by the vendors. If increased information is good for us when we are consumers, we cannot be surprised that consumer organisations take an interest in the product we sell—medical care. So we should stand back and recognise that the consumers and ourselves are generally on the same side. Both groups want high-quality health care.

The great problem for primary care doctors worldwide (whether they are called family physicians or general practitioners) is that most work in situations that simply do not permit provision of service according to their ideals. No matter how well trained doctors are, they can only provide the care that is possible in their circumstances. The issue is how to provide the best care possible, given the limited resources that are available. This issue is just as relevant in the private sector as it is in the public sector, since the majority of private patients who consult estate doctors do not have unlimited time or the capacity to pay the price needed to obtain the highest quality health care.

In addition, both doctors and patients learn and become accustomed to particular styles of health care that are favoured by the systems in which they work. Generally, individuals make what appear to them to be the best decisions at an individual level and according to their knowledge. Thus, in any system or organisation where many individuals make similar problematic decisions, we must analyse the system to understand its effects, rather than simply blame individuals. Solutions must come through changing those systems.

Underlying problems in health care in Hong Kong

Hong Kong prides itself upon its free-market approach to business and to health care, but the medical market place is far from free. It is limited by a series of rules that directly affect the practice of medicine, and reinforce how both doctors and patients have learned to behave.

While the most expensive component of health care in Hong Kong is admission to hospital, there are major problems in the ambulatory care sector that need addressing and which affect the hospitals' effectiveness. Current policy favours caring for patients with chronic disease and those who need chronic medication, in either hospital out-patient departments or GOPCs. The subsidised drugs would otherwise cost

a great deal for individuals. Many cannot afford them, but others who could may prefer to avoid private prescription costs. In private practice, many patients are insured by companies that pay minimal fees for both the consultation and 2 or 3 days of medication.

These systems teach patients to expect prescribed medication for no extra charge. Low fees and pressure of numbers lead to fast throughput and little communication. This has a corrupting influence on both sides: patients demand medication to get value for the money they have paid—and indeed many assert that it is their right—while doctors feel obliged to prescribe placebos or unnecessary medications. Even specialists in hospital out-patient departments complain that when patients come for something else, they very often finish a consultation by asking for a cough medicine. Both in hospitals and GOPCs, many doctors stop arguing because it takes too much time and effort, and acquiesce, so that the average prescription issued (at public expense) contains items that doctors know to be useless.

Doctors in private practice have difficulty providing and charging for high-quality, longer consultations with perhaps less drug use, unless patients perceive this is appropriate. Under these circumstances, doctors need to see many patients to cover their overhead costs and to make a living. Few can look after patients with more complex conditions because medications cost their patients so much more than in the public sector. In addition, they cannot give adequate time and attention to the somatisers who may have underlying social and emotional problems.

The survey shows that many patients in Hong Kong go to their private doctors for management of minor diseases. Patients have become accustomed to—and expect to get—very short courses of medication. Doctors provide very short consultations, although they know that they cannot explain, educate, and communicate with patients as effectively as they would like to. Attendances are mostly for self-limiting diseases that mostly need neither medication nor even a doctor's attention. In other countries, these problems would mostly be self-medicated, and doctors might advise patients but would not prescribe, for example, cough mixtures or decongestants. But what we see in Hong Kong is learned behaviour on the part of both doctor and patient—that is, their rational response to the system.

Although the Hong Kong College of Family Physicians educates doctors, through continuing medical education and its journal, that upper respiratory tract infections should not be treated so intensively, they are fighting an uphill battle. While the ingredients in the medications prescribed may usually be cheap, the work of dispensing them is not. Recent dispensing disasters show that prescribing these medications has considerable potential for harm.

The current mode of practice in Hong Kong is reminiscent of Britain or Australia 40 years ago; however, action has been taken in those countries. Doctors and government authorities have combined to reduce and eliminate the subsidised provision of drugs to treat minor symptoms. Even when doctors recommend the use of symptomatic medications, patients must buy them over the counter, so that public funds are expended on important life-saving medications.

Policy change

A great anxiety for many doctors in private practice is that if they cease prescribing short courses of medications to patients with minor acute problems, patients would not return to them often enough and would simply go to pharmacies for these medications. Then, there would not be enough work for the doctors. This is an understandable fear. Yet at the same time, far too many patients crowd the out-patient departments. Some way must be found to transfer that work outwards so that patients obtain the skilled professional attention and time that they need. If hospitals and GOPCs stopped prescribing unnecessary drugs, it would not only reduce the drug budget, but it would change patients' perception of the value of going to these institutions. More might then attend private doctors, who could then better use their high-level skills and knowledge, while the remaining patients attending out-patient departments could be seen promptly and for enough time to provide high-quality consultations.

In both public and private sectors, a further useful change would be to separate the charges for consultations and drugs, so that more patients would learn to value the consultation for itself, not merely as a trivial preliminary step to the prescription. This change also occurred long ago in comparable countries—that is, separating the responsibility for prescribing from the dispensing function. This approach reduces the conflict of interest that inevitably occurs when the two fees are amalgamated, and allows doctors to negotiate with patients about the duration and real cost of an appropriate course of treatment, rather than the current practice of providing 2 days of drugs.

Clearly, all those concerned need to consider changes in policy and behaviour here in Hong Kong. A well-functioning health care system requires that the incentives for both doctors and patients should be directed as far as possible towards high-quality care. Ultimately, careful changes must be made in the way health care is funded and subsidised through the public system, which will have major effects on patient behaviour and expectation, and which will also provide the lead for both doctors and patients in the private sector.

The Hong Kong Council of Social Service is right to bring this problem to public attention. They are right to call for the development of high-quality primary health care and family doctor services in this community. We all support the same goals, and should therefore work together to develop policy choices that will assist their development. Family medicine cannot develop without the right conditions set by the policy framework and supported by government, patients, and doctors.

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