

Strengthening attributes of primary care to improve patients' experiences and population health: from rural village clinics to urban health centres

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Primary care is an integrated model of care underpinned by the discipline of general practice (GP), aiming to optimise population health and reduce disparities across the population. The key attributes of primary care—first contact, continuity, coordination, comprehensiveness, and community orientation and family centeredness—enable a high-value service delivery to address the wider determinants of health.¹ In recent years, primary care transformation has taken place across the globe. In Scotland, for example, ‘GP clusters’ have been introduced to provide a more holistic, values-based approach to health and social care integration. It aims to provide a mechanism for a focus on quality improvement to encourage primary care to adjust clinical foci to local aims and needs, alongside the expansion of multidisciplinary teams to address workload and population health inequalities.² In Hong Kong, strategies to foster continuity of care have been developed, such as the Elderly Health Care Voucher Scheme to encourage a regular source of care best suited to people’s needs, the integration of the medical workforce in Community Health Centres, which is particularly important for patients with multiple healthcare needs, and the expansion of the Electronic Health Records Sharing System to enable smooth information transfer of patient records to achieve coordinated care.³ In mainland China, the ‘family doctor teams’ which are built on the national basic public health service package have been gradually translated into routine primary care practice.⁴ A typical team consists of one GP clinician and healthcare personnel including public health doctors, nurses, and if available and suitable, pharmacists and social workers. The teams are featured by a continuous relationship between service providers and service users, thereby

enhancing the provision of a core set of preventive care including health assessment, health-promoting interventions, health advice, and when necessary, home visits. Health issues related to the efficiency of care, control of chronic diseases, and quality of services from users’ perspectives have gained increasing attention.⁵

In this issue of the *Hong Kong Medical Journal*, Shi et al⁶ explore the utilisation pattern of village clinics in rural areas and investigate the clinical competence of rural primary care providers through a survey study conducted in Southwestern China. Significant gaps were identified in service provision between ethnic groups, which may be explained by the suboptimal clinical competence of ethnic minority providers. The study carries implications for upscaling system-level inputs to enhance the clinical capacity of rural primary care personnel through government-level actions to ensure adequate in-service training and professional development in remote and deprived areas. It also provides impetus for developing integrated competency-based GP training systems for village clinicians, which could then be translated into improved accessibility to and process of primary care, thereby leading to sustainable health promotion and disease prevention.

Nevertheless, multisectoral efforts to strengthen capacity building in rural primary care would also require attention paid to address barriers to strong motivation and active commitment to the provision of care in rural practice given the possible existence of clinical inertia and workload-related factors. A recent multicentre study conducted among rural primary care physicians across four provinces in China demonstrated physician-level challenges to the attainment of the target frequency of follow-up care for hypertension and diabetes—

the two most common long-term conditions in the community.⁷ Ethnic minorities, or those who live in rural areas of high socio-economic deprivation, tend to encounter greater physician-level barriers to optimal care such as inadequate healthcare capacity and limited availability of qualified professionals. This may be due to insufficient clinical resources and the physician's inherent pursuit of advanced medical technology, higher remuneration, and better career prospect in more affluent areas. Meanwhile, individual-level barriers such as financial burden, lack of social support, fearful emotions, negative health beliefs, underestimation of concomitant risks, and unfavourable cultural preferences may also inhibit the routine utilisation of healthcare services in low-income areas. In real-world settings, longitudinal observations manifest difficulties in maintaining long-term improvement of clinical parameters in chronically ill patients in the absence of actively provided and continuous health education support.⁸ Previous investigations conducted in eastern, central, and western rural China have highlighted the importance of effective provider-patient communication, which is, however, relatively poor during clinical encounters in rural primary care practice.⁹ These barriers may act together, rather than in isolation, to hinder the personalisation and prioritisation of care, resulting in exacerbated health and social disparities in areas of high socio-economic deprivation.¹⁰

From the perspective of health services research, the physician-patient encounter is a reflection of the care process, which takes into account patient needs and health expectations. A recent multi-centre primary care assessment demonstrated significant associations between improvement in patients' experiences and reduced treatment burden.⁴ Structural efforts to improve the process of care emphasise the need to strengthen capacity building within, with and around primary care multidisciplinary teams in joint decision-making and problem-solving.¹¹ Such approaches carry the potential to enable a combination of care regimes based on effective health education to ensure patient engagement across the care continuum, leading to improved patient experiences and population health.¹²

International consensus has been reached on the contribution of high-quality primary care to better population health outcomes in a cost-effective manner. This offers improvements in health equity, greater efficiency in chronic disease management, avoidance of preventable hospitalisation and emergency room visits, and better quality of life. Nowadays, primary care plays a central role in delivering both patient-centred and population-oriented services for long-term conditions, for instance, the screening for diabetes.¹³ Of equal

importance is eye health for those diagnosed with diabetes to prevent vision loss. Similarly, promoting and improving eye health also requires systematic actions to address a wide range of protective and risk factors at all stages of life, starting from as early as the preconception and prenatal stage, through infancy and early childhood to adolescence, and into adulthood and older age. To further this objective, the World Health Organization is calling for increased emphasis on reorienting the model of care towards an integrated, people-centred approach for eye health based on strong primary care.¹⁴

Local experiences have demonstrated the crucial role of well-trained primary care physicians in infectious disease control, performance measurement, and emergency response as an integral part of the surveillance system in dealing with outbreaks of severe acute respiratory syndrome (SARS), H1N1 influenza, and coronavirus disease 2019 (COVID-19).^{15,16} So-called 'long covid' poses additional challenges for delivering tailored health and educational services to children and families.¹⁷ In response to the ever-increasing healthcare need due to complex conditions and circumstances, more work is needed in the study of digital technologies for health, lifestyle management strategies from the perspective of complementary and alternative medicine,¹⁸ and research instruments that capture key attributes of primary care to monitor the extent to which equitable care is achieved.¹⁹ Meanwhile, endeavours to promote workforce wellbeing and prevent primary care practitioners from stress, burnout, and depression are of vital importance.²⁰ Empirical evidence from studies on innovative models of service delivery in real-world settings would better inform policy decisions and prioritisations to meet the health aims and move the health system towards a more people-centred approach of service delivery over time in areas of different socio-economic status.

Author contributions

All authors contributed to the editorial, approved the final version for publication, and take responsibility for its accuracy and integrity.

Conflicts of interest

All authors have declared no conflict of interest.

References

1. World Health Organization and United Nations Children's Fund (UNICEF). Operational Framework for Primary Health Care: Transforming Vision into Action. Geneva: World Health Organization; 2020.
2. Stewart E, Donaghy E, Guthrie B, et al. Transforming primary care in Scotland: a critical policy analysis. *Br J Gen Pract* 2022;72:292-4.
3. Ho MK. Strengthening primary care in Hong Kong: fostering continuity of care from a health system

- perspective. *Hong Kong Med J* 2020;26:543-5.
4. Hu XJ, Wang HH, Li YT, et al. Healthcare needs, experiences and treatment burden in primary care patients with multimorbidity: an evaluation of process of care from patients' perspectives. *Health Expect* 2022;25:203-13.
 5. Wong MC, Huang J, Xu W, et al. Research for health issues in mainland China—a growing need unaddressed. *Hong Kong Med J* 2020;26:4-5.
 6. Shi Y, Song S, Peng L, et al. Utilisation of village clinics in Southwestern China: evidence from Yunnan Province. *Hong Kong Med J* 2022;28:306-14.
 7. Wang Y, Hu XJ, Wang HH, et al. Follow-up care delivery in community-based hypertension and type 2 diabetes management: a multi-centre, survey study among rural primary care physicians in China. *BMC Fam Pract* 2021;22:224.
 8. Hu XJ, Wu HF, Li YT, et al. Influence of health education on clinical parameters in type 2 diabetic subjects with and without hypertension: a longitudinal, comparative analysis in routine primary care settings. *Diabetes Res Clin Pract* 2020;170:108539.
 9. Zhou Q, An Q, Wang N, et al. Communication skills of providers at primary healthcare facilities in rural China. *Hong Kong Med J* 2020;26:208-15.
 10. Wang HH, Mercer SW. Understanding barriers to adherence to optimal treatment of elevated blood pressure and hypertension—insights from primary care. *JAMA Netw Open* 2021;4:e2138651.
 11. Wang HH. Taking a multidisciplinary team approach to better healthcare outcomes for society. *Hong Kong Med J* 2020;26:551-2.
 12. Wang HH, Li YT, Wong MC. Leveraging the power of health communication: messaging matters not only in clinical practice but also in public health. *Hong Kong Med J* 2022;28:103-5.
 13. Wong MC, Huang J, Kong AP. Diabetes screening revisited: issues related to implementation. *Hong Kong Med J* 2020;26:283-5.
 14. World Health Organization. *World Report on Vision*. Geneva: World Health Organization; 2019.
 15. Poon PK, Wong SY. Primary care doctors and the control of COVID-19. *Hong Kong Med J* 2021;27:86-7.
 16. Yu EY, Leung WL, Wong SY, Liu KS, Wan EY; HKCFP Executive and Research Committee. How are family doctors serving the Hong Kong community during the COVID-19 outbreak? A survey of HKCFP members. *Hong Kong Med J* 2020;26:176-83.
 17. Tse WW, Kwan MY. Impacts of the COVID-19 pandemic on the physical and mental health of children. *Hong Kong Med J* 2021;27:175-6.
 18. Wang Y, Wu XY, Wang HH, et al. Body constitution and unhealthy lifestyles in a primary care population at high cardiovascular risk: new insights for health management. *Int J Gen Med* 2021;14:6991-7001.
 19. Wang HH, Wong SY, Wong MC. Attributes of primary care in community health centres in China and implications for equitable care: a cross-sectional measurement of patients' experiences. *QJM* 2015;108:549-60.
 20. Kwan KY, Chan LW, Cheng PW, Leung GK, Lau CS. Burnout and well-being in young doctors in Hong Kong: a territory-wide cross-sectional survey. *Hong Kong Med J* 2021;27:330-7.