

Shaping the 'Family Doctor for All' system through the Chronic Disease Co-Care Pilot Scheme

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Introduction

Type 2 diabetes mellitus (DM) and hypertension combined were responsible for over 200 million DALYs (disability-adjusted life years) worldwide, representing the sum of years of life lost to premature mortality plus years lived with disability arising from these two highly prevalent conditions.^{1,2} Population-based preventive measures (eg, promotion of healthy lifestyles and targeted screening of at-risk individuals) followed by early team-based intervention have been effective strategies for reducing the associated morbidity, mortality, and healthcare burden.^{3,4} In countries with mature primary healthcare systems, these services are led by family doctors (ie, general practitioners) who partner with multidisciplinary healthcare teams to provide personalised, continuous, and comprehensive holistic care for all community residents.⁵⁻⁷

Hong Kong has a treatment-oriented healthcare system, in which 90% of hospital-based services are provided by the public sector⁸ and approximately 50% of public general outpatient services are used to manage DM and hypertension.⁹ Population-based preventive care initiatives, such as anti-smoking campaigns, the Colorectal Cancer Screening Programme (CRCSP) and the Vaccination Subsidy Scheme (VSS), have been successful but sporadic; they have limited potential to empower participants to pursue healthy living over life course. There is no structured cardiovascular disease screening programme in the public sector for most at-risk citizens without their own family doctors,¹⁰ except for older adults aged ≥ 65 years. Consequently, the public healthcare system has been heavily strained by the increasing prevalence of chronic diseases such as hypertension and DM, along with complications resulting from delayed diagnosis.

To improve healthcare system sustainability and overall population health, the Government recognises the urgent need to establish a prevention-oriented primary healthcare system. The Primary Healthcare Blueprint, issued in December 2022, highlighted key areas of development needed to address gaps in preventive care, continuity of care, and community participation. An important strategy

is to implement the 'Family Doctor for All' concept by establishing a family doctor registration system: the Primary Care Register (PCR).¹¹ The PCR is intended to build a recognition system for doctors who are committed to providing comprehensive, continuous, and holistic care to patients in the community; such care ranges from preventive services to chronic disease management.

Family doctors in the Primary Care Register

Private doctors have been providing approximately 70% of episodic outpatient care in the community.⁸ However, the health advocacy potential of family doctors was not fully recognised by the public until the expansion of family medicine training in 2004. Beginning in 2013, the Government established a Primary Care Directory (PCD) to recruit primary care doctors (ie, any doctor in the private sector who was committed to providing primary care) for participation in various prevention-based programmes, such as the VSS and the CRCSP. To promote the community participation necessary for desired health improvements, the Government subsidised participants for each consultation conducted within these programmes. Because PCD registration was a prerequisite for receipt of related subsidies, PCD doctors were often engaged by the programme-based funding model. However, this model does not promote continuity of care if participants choose to consult PCD doctors only for specific preventive care services, or if the PCD doctors choose to only provide the specific preventive care services to the scheme participants during consultation.

To encourage community-based management of stable chronic diseases and reduce the service burden within the public healthcare sector, the Hospital Authority (HA) implemented the General Outpatient Clinic Public-Private Partnership Programme as an outsourcing service, beginning in 2014.¹² However, the working relationship was unilateral. As the funder, the HA would purchase doctors' services for specific tasks at prices determined through a bidding process; as service providers, PCD doctors would charge fees based on

the service agreement. Benefits to patients were not considered in this programme. Similarly, doctors' efforts to deliver holistic care beyond the scope of the service agreement were not appreciated or supported. Both models regarded PCD doctors as Government agents for service delivery and contributed to the fragmentation of care. Thus, these models failed to encourage the establishment of long-term doctor-patient partnerships necessary to enhance overall population health through patient-centric care.

In contrast, the planned PCR recognises the robust potential of family doctors. Under the PCR, each citizen will be paired with their preferred family doctor; each paired family doctor will be the only doctor eligible to receive any subsidy allocated to the paired patient, including existing programme-based subsidies (eg, the VSS, the CRCSP, and the General Outpatient Clinic Public-Private Partnership Programme) and any future initiatives to support primary healthcare. In addition to subsidies, efforts to optimise holistic care require community-based multidisciplinary team support for family doctors. Community drug formularies will be established to ensure that family doctors have access to common medications at affordable prices, which will facilitate long-term patient management. Community nurses and allied health professionals at District Health Centres will empower patients in leading healthy lifestyles and managing their own health. To encourage best practices, family doctors who have fulfilled their preventive and chronic disease care obligations, such as the provision of seasonal influenza vaccination, will be rewarded through additional payments.

The Chronic Disease Co-Care Pilot Scheme

The Chronic Disease Co-Care Pilot Scheme (the Scheme) targeting DM and hypertension, which will be launched in November 2023, represents the prototype service model under the planned PCR. People aged ≥ 45 years without a known diagnosis of DM or hypertension will be eligible for enrolment in a subsidised screening programme consisting of laboratory tests and a medical consultation with a paired family doctor registered in the current PCD. Healthy participants will be offered education regarding a healthy lifestyle and the opportunity to undergo repeat screening every 3 years. Participants with prediabetes, DM, and/or hypertension will receive subsidised care, including laboratory investigations for chronic disease monitoring, from their paired family doctor and a multidisciplinary team in the community.

To support PCD doctors in this new role, the Scheme incorporates seven key components that will shape the future primary healthcare system when the Primary Healthcare Commission (PHC)

is established in 2024. These components include: (1) pairing of family doctors with participants; (2) District Health Centres and their services; (3) subsidised multidisciplinary services in the community; (4) protocol-driven bi-directional referral with designated medical specialist clinics under the HA; (5) pay-for-performance incentives for both participants and family doctors; (6) community drug formularies to ensure that family doctors have access to common medications at affordable prices; and (7) uniform data sharing in the Electronic Health Record Sharing System platform with participant consent. An important objective of the Scheme is to attract and build a pool of future PCR family doctors who agree with our vision and are committed to delivering quality primary care for our fellow citizens. The ultimate goals of the Scheme are to shift population-level health-seeking behaviour from treatment-oriented to prevention-focused, to encourage shared responsibility for personal health at an affordable cost, to enable family doctors to maintain continuity of care, and to improve health for all.

Conclusion

The Scheme establishes a new framework for primary healthcare involving family doctors and community services. Upon establishment of the PHC, a quality assurance system will be constructed to guide clinical practice among healthcare professionals via service quality standards and reference frameworks. The PHC will also monitor the performance of subsidised services and drive continuous quality improvement through pay-for-performance incentives. Additional subsidy tiers will be established based on clinical practice complexity and doctors' qualifications. Hopefully, the Scheme will encourage more doctors to enrol in the PCD, and work as Family Doctors to provide continuous, comprehensive, and patient-centric care to all citizens.

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

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