The role of primary care doctors in addressing the health impact of poverty in Hong Kong

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Poverty is acknowledged as one of the most significant health determinants in many high-income countries.[1] Efforts to address poverty have historically been the domain of the social welfare sector. In some countries, including Canada, the United Kingdom and the United States, the health sector has actively engaged in screening for poverty or its manifestations—such as food insecurity, housing issues, and precarious work and livelihoods—and then referring patients to social supports or even directly intervening to address those social needs.[2]

Primary care is particularly well suited to engaging in such interventions. Starfield's seminal definition of primary care as "first-contact, continuous, comprehensive, and coordinated care" encapsulates what is unique about the primary care doctor–patient relationship, making it amenable to incorporating social needs interventions.[3] Moreover, the World Health Organization's definition of primary care as "a whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families and communities" makes this vision explicit.[4]

Whether health professionals can—or even should—do this is contested. Patients may not expect, or even welcome, such interventions from healthcare providers. Providers also run the risk of unfulfilled patient expectations or raising issues that they are not empowered to address, while taking time away from clinical care.[5] However, studies have shown that even when patients did not necessarily want help from their primary care provider, they appreciated being asked and reported greater satisfaction with their care.[6] Moreover, the reasons for primary care providers to address the health impact of poverty are compelling. They directly witness the manifestations of unmet income needs and see in daily practice how such obstacles undermine their efforts to improve patients' health.[7] Thus, there is a clear incentive for them to try to address these needs. From the healthcare providers' perspective, such interventions are supported and have even been shown to positively impact the risk of physician burnout.[8] They have also been associated with reduced utilisation of hospital services.[9]

Interventions used in primary care to address patients' unmet economic needs are wide-ranging. These include screening tools, from simple one-question or 60-second assessments to more complex, multidimensional tools.[2] Family doctors have also successfully implemented social welfare referral and signposting services.[10] Some have gone further by directly intervening, for example, by establishing on-site food banks or medicolegal clinics, or incorporating system navigators into the clinical care team.[2] A 2014 randomised controlled trial evaluating social needs screening tools was the first to demonstrate that in-person navigation is associated with reported reductions in social needs and improved caregiver-reported child health.[11] Interventions targeting income insufficiency have successfully helped patients obtain greater financial support, such as by fully claiming the social welfare benefits to which they are entitled.[12]

Poverty—whether measured by the single dimension of absolute income level or in terms of relative deprivation—adversely affects the health-related quality of life of Hong Kong's poorest residents.[13] According to Hong Kong SAR Government estimates, 23.6% of the population were living below the poverty line (set at half the median income) in 2020—the most recent year for which such data were released—and 17.3% remained below the poverty line even after recurrent cash government interventions.[14] In 2020, the overall older adult population reached 1.30 million, representing nearly one-fifth of the total population. Among those living in poverty, older adults are overrepresented, with one in three living in poverty. Nearly one-quarter of those in poverty in Hong Kong are working poor; among this group, uptake of eligible social welfare provisions is low.

The social deprivation associated with housing unaffordability in Hong Kong has been shown to negatively affect both physical and mental health.[15] Government surveys of self-rated health have demonstrated a direct relationship with income.[16] There is evidence that social deprivation in the Hong

Kong context is significantly associated with poor physical and mental health; it is also independently linked to higher levels of obesity and worse glucose tolerance.[17-19]

Despite the prevalence of poverty and low income in Hong Kong, the health sector has thus far not engaged with this issue in the manner utilised in other countries. Given Hong Kong's persistently high levels of poverty and the low uptake of social welfare provisions—coupled with income-related health inequities, and a public health system that is constantly and increasingly under strain—interventions that address poverty while reducing demand on publicly funded healthcare services could arguably 'kill two birds with one stone'. The use of interventions already being developed and deployed in other countries and described above—screening tools, social welfare referral, and direct interventions—could play a meaningful role in this approach.

Settings where family doctors routinely treat patients in poverty are a logical place to consider beginning this work in Hong Kong. We undertook a qualitative study of doctors working in Hospital Authority General Outpatient Department (GOPD) clinics to better understand their attitudes towards poverty and health, as well as associated interventions. This study was important because research in other settings indicates that such interventions can only be successful when doctors themselves are convinced of the interventions' utility and are willing to incorporate those approaches into clinical practice.[20] To our knowledge, this was the first study in Hong Kong's publicly funded primary care setting to examine doctors' attitudes towards poverty with respect to their professional practice. Ethics approval was obtained from the McMaster Research Ethics Board (Ref: MREB#2140) and all participants provided informed consent. Doctors shared what they consider to be their role in responding to poverty, how they perceive the political, structural, and cultural barriers to addressing it, as well as potential enablers. Their experiences provide insights into the broader role of family doctors in addressing poverty and offer guidance on how this might be achieved in the Hong Kong context.

Three main considerations emerged from this research to inform whether interventions addressing primary care patients' unmet income needs could be applied in Hong Kong. First, GOPD doctors encounter patients experiencing poverty. They reported that within the first few moments of a 6-minute consultation, they can observe tell-tale signs of poverty in a patient's dress, demeanour, facial expression, and mood. Such patients often present with chronic illnesses and mental health–related issues. They frequently report being under stress and show signs of depression and anxiety, which are attributed to low income, limited agency in work, and overcrowded and/or substandard living conditions. Another common sign is poor treatment adherence and self-management of chronic conditions—often because patients cannot afford necessary supplies and find it hard to make lifestyle changes like eating healthier and exercising. For a patient working 60 hours a week across two jobs, there may quite literally be no time to exercise. For someone living in subdivided housing, there may not even be cooking facilities.

Second, it is important to understand the barriers to engaging in such interventions. Family doctors working in GOPD clinics face considerable practical, cultural, and systemic obstacles. Many are hesitant to screen for poverty because they worry about identifying problems they are unable to resolve, which they may view as unethical. Another factor is cultural stigma, as traditional Chinese values favour self-reliance, and seeking social welfare may be considered shameful. This cultural context influences the doctor-patient encounter, reinforcing the power distance between the two and tempering expectations of doctors—even in clinical care. A lack of doctors' lived experience with poverty can make it harder to express empathy, and these knowledge gaps are rarely addressed in medical training.

There are also physical and organisational constraints. For example, the GOPD clinic waiting area is often overcrowded, with insufficient space for all patients to sit. All consultation rooms are in constant use. Creating space for private intervention, such as poverty screening, could be challenging. A typical doctor working in a GOPD clinic routinely sees 30 to 40 patients in a single half-day session, with just 6 minutes per consultation, leaving little room for social needs screening.

Nonetheless, the doctors described informal efforts to help. For GOPD clinics attached to a hospital, doctors may refer patients to medical social workers or compile resource lists of non-governmental organisations to share with patients who require support.

Third, practical change could empower doctors to better address poverty. The most obvious enabler is more time—even a few additional minutes per patient could allow doctors to explore the patient's social needs. Alternatively, screening can be conducted by nurses and other clinical staff. Existing poverty screening tools could be adapted for use in Hong Kong, though this would require training and adequate resources. To foster empathy, experiential learning could help medical students understand poverty's real-world impact and other social issues. Importantly, this work could be done outside GOPD clinics—particularly in District Health Centres, which are designed to support medical-social collaboration.

In terms of public policy that could better support such efforts in Hong Kong, it remains unclear how two intertwined societal forces—growing rates of poverty, especially among older adults in a rapidly ageing population, and increasing demand on health services that threatens to become unsustainable—will evolve. Arguably, the government cannot ignore these issues indefinitely; this may gradually open a policy window for interventions to address poverty and improve population health.

Practical barriers to health sector engagement in addressing poverty in Hong Kong should not be underestimated. Favourable public policy is undoubtedly important, but doctors can—and do—work within real-life limitations to help their patients address unmet economic needs. Many income-related interventions in primary care that are now highly developed, widely used, and incorporated into standard care in other countries began as small-scale, experimental, and opportunistic efforts. They did not start with broad consensus. Rather, they were driven by a small group of health practitioners who sought to address what they considered fundamental barriers to effectively treating their patients.[7] These interventions were proven to be effective, gradually gaining both momentum and credibility. It is worth noting that the early stages of many behavioural health interventions, such as smoking cessation that currently dominates health promotion and medical-social integration discourse in Hong Kong, started small and gained wider support over time.

Various pilot studies to test poverty screening tools and interventions are already underway in Hong Kong. These studies represent a sign that advancing the concept of medical-social integration—and addressing the health impact of unmet income needs directly where they are encountered, in primary care—is an idea whose time has come in Hong Kong.

Author contributions

Concept or design: All authors.
Acquisition of data: JE Parry.
Analysis or interpretation of data: JE Parry.
Drafting of the manuscript: JE Parry.
Critical revision of the manuscript for important intellectual content: All authors.

All authors had full access to the data, contributed to the study, approved the final version for publication, and take responsibility for its accuracy and integrity.

Conflicts of interest

All authors have disclosed no conflicts of interest.

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