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Incentives and barriers to adopting the family doctor model in Hong Kong: an in-depth qualitative study of the views, knowledge, and attitudes of patients

Key Messages

1. Many patients regard family doctors as a 'luxury item', some of whom continue to attend the public health care system for their chronic diseases even if they have a family doctor.
2. Cost, quality, perceived need, and choice are important barriers to adopting the family doctor model.
3. Incentives include financial subsidies and a long-term therapeutic relationship with a doctor.
4. If findings of this study are representative, successful implementation of a family doctor system in Hong Kong for chronic disease management seems unlikely, unless these barriers are addressed.

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Introduction

Effective primary health care is essential for a high-quality, equitable, and cost-effective health care system.[1] The increasing prevalence of chronic health conditions and the ageing of the population are important drivers for the development of more effective primary care services.

In Hong Kong, recent health care reform proposals by the government emphasise the need for an effective primary care system, especially for chronic disease and preventive care. The family doctor model has been put forward as a possible solution.[2]

The aim of the present study was to explore the incentives and barriers to adopting the family doctor model in Hong Kong from the viewpoint of patients with chronic disease. We focused on patients with chronic diseases, because of their significant need and demand on health care services.

Methods

This study was conducted from June 2007 to July 2008 using qualitative methodology and one-to-one interviews. Interviews from 28 patients with a range of chronic conditions were taped and transcribed verbatim. The patients were classified as having a family doctor (n=10), having a regular doctor but not a family doctor (n=10), and having no regular doctor (n=8). To ensure maximum variation in terms of age group, gender, socioeconomic status, and type of chronic disease, the sample was selected purposively.

Results

Knowledge and understanding of the family doctor model

Patients' descriptions of a family doctor generally matched most of the key concepts of a family physician, ie first contact for care, continuous, comprehensive, coordinated, and orientated to patients (patient-centred). Some believed that a family doctor is a regular doctor attending the whole family and having a close relationship with them, almost like a 'family member'.

Those having a family doctor considered that such a model was appropriate, irrespective of age and type of condition. They were mainly in the higher socioeconomic brackets in terms of educational level and income (Table). Many of those who had no family (or regular) doctor considered such a doctor to be a 'luxury item' for the better off.

Most respondents viewed the family doctor model as only possible in the private sector. This was largely because of perceived pressure on the public system. Patient knowledge was very limited regarding available training or qualifications in family medicine, and the concept of a family doctor was not

solely limited to general practitioners or family physicians. For example, most respondents believed that traditional Chinese medicine practitioners also had the potential to become family doctors.

Views on public and private primary care

Most respondents (irrespective of having a family doctor or not) attended the public health care system (specialist or general out-patient clinics) for management of their chronic diseases. Reasons for this included issues related to cost, consistency, informational continuity, duration of prescriptions, quality, trust, access to specialists and allied health professionals (in-house referrals), and access to tests and investigations. Nonetheless, the public health care system was criticised for problems related to access, waiting times, a lack of interpersonal continuity, short consultations, and poor attitude of doctors. Thus 'being in the public health care system' was often seen as the 'least bad option'. Other factors that conspired to keep patients in the public health care system included recommendations by their private doctors, and ongoing internal referrals with no effective linkage to the private sector.

Table. Patient characteristics

Variable	No. of patients		
	With family doctor (n=10)	With regular doctor but not family doctor (n=10)	With no regular doctor (n=8)
Income (HK$ per month)			
<5000	0	0	1
5000-10000	1	2	2
10000-20000	1	3	3
20000-30000	4	0	1
30000-40000	2	1	0
>40000	0	3	0
Refused to answer	2	1	1
Education			
None	0	0	1
Primary	1	3	3
Secondary	3	2	4
Tertiary	6	4	0
Age (years)			
21-30	3	1	0
31-40	0	2	0
41-50	3	4	2
51-60	2	1	1
61-70	1	1	2
71-80	1	1	3
Male:female ratio	1:1	1:1	1:3
Marital status			
Single	2	1	0
Married	7	7	3
Divorced	1	2	1
Widowed	0	0	4
Chronic disease*			
Musculoskeletal problem	3	6	3
Heart disease	2	1	1
Diabetes	1	1	1
Hyperthyroidism	0	2	0
Hypertension	4	2	4
Respiratory problems	4	1	0
Minor stroke	2	0	2

* Some have more than one co-morbidity (range, 1-4)

Private primary care was generally regarded as being mainly for acute illnesses, rather than chronic diseases. Many patients voiced concerns about health care reforms by the government, and public-private partnerships between the Hospital Authority and private general practitioners.

Attitudes towards health and self-care

Respondents generally considered health as an absence of symptoms, pain, and disease. Many reported that a healthy person has no need to see a doctor, and there was little mention of preventive public health measures. Self-care was a common theme and mostly referred to diet and exercise. It also included massage, Tai Chi, herbal remedies, dietary supplements and vitamins, and traditional 'food therapies' such as certain types of soups.

Barriers and incentives to adopting the family doctor model

The five main barriers to the adoption of the family doctor model were cost, perceived need of a family doctor, choice of doctors, doctor-patient relationships, and quality issues.

Regarding costs, some patients felt that 'good things can't be cheap', ie high quality family medicine had to be expensive.

Regarding perceived need of a family doctor, many who had no family doctor considered having one as unnecessary (irrespective of financial issues). Conversely, others perceived the need for family doctors. The need was related to perceptions of risk and concurrent diseases and to a large extent current or past experience of having a family doctor, but could also be 'created' through the media and social network.

Regarding choice of doctors, respondents strongly defended their right to choose a doctor (or doctors), in order to find the 'right match'. 'Doctor shopping' was regarded as a way to assert choice in order to find a good doctor. A potential barrier to the adoption of the family doctor model was the concern that the government might limit choice (imposing restrictions). Despite provision of financial incentives or subsidies for the adoption of a family doctor model, many also wanted reassurance that the 'right to choose' would not be diminished.

Regarding the doctor-patient relationship, an enduring therapeutic relationship was associated with numerous potential advantages, such as effectiveness, efficiency, holistic support, empathy, respect, trust, confidence, health promotion, and self-care support. Nonetheless, many felt that a therapeutic relationship with a family doctor took a long time to develop. Thus, the relationship had to be nurtured over a period of years, irrespective of the doctor's training, qualifications or certificates. Respect and trust had to be earned through contact and experience, and the patient's judgement of the doctor's skills by their own personal evaluation of honesty, integrity, and effectiveness of care.

Regarding quality, many patients were concerned that private family doctors were not adequately trained or skilled to deal with chronic diseases. Some felt that only specialists could look after specific chronic conditions, and therefore family doctors had to be specialists in the patient's particular disease. Qualifications and certificates were rarely used by patients as criteria on which to judge whether a doctor was suitably qualified to deal with chronic diseases. The issue of trust was not simply related to knowledge, it was also closely related to perceptions of the doctor's ethics and values.

Discussion

That most respondents had some knowledge of the concept of a family doctor is in agreement with a recent survey of over 1000 members of the public by the Hong Kong College of Family Physicians.[3] The survey found that over 90% of respondents had heard of the term family doctor, and that cost was the most important issue influencing choice of service. Moreover, only a few felt that private doctors were capable of dealing with chronic illness, which was in line with our own findings.

Almost all respondents (irrespective of having a family doctor or not) attended the public health care system for ongoing management of their chronic diseases. Many factors seemed to conspire to keep patients in the public health care system, both from within and without the system. Nonetheless, for most respondents, the public health care system was regarded as the appropriate setting for chronic disease management. Thus 'shifting the balance of care' from the public to the private health care system, or even to a more 'shared-care' system between public and private providers (as suggested in the recent consultation document on health care reforms in Hong Kong[2]) is unlikely to be straightforward.

Three quarters of all patients were interested in knowing more about their diseases.[4] In the present study, the patients generally expressed a keen interest in knowing more about their health problems. In this respect, they tended not to enquire and seek explanations about their diseases from the doctors in public clinics, owing to the limited time available in the consultation, and possibly because when patients are paying they feel more able to assert their 'purchasing power' and demand more from the consultation.

Regarding barriers to adopting the family doctor model, cost, perceived need, choice, relationship, and quality were important. Incentives included the perceived benefits of a long-term therapeutic relationship with a family doctor, and the possibility of government financial subsidies. That respondents knew little about the Hong Kong College of Family Physicians, nor how to find a qualified family doctor reflects both the limited number of fully qualified family physicians in Hong Kong, and the lack of such information available to the public.

One limitation of qualitative research is that definitive statements on the generalisability of findings and transferability to whole populations cannot be made. Thus, in drawing conclusions, caution is warranted and further quantitative research of a large patient sample would be helpful.

In conclusion, according to patients with chronic diseases, there are major barriers to the implementation and adoption of the family doctor model in Hong Kong. Unless they are addressed, effective implementation of a comprehensive family doctor system for chronic disease management in Hong Kong is likely to be difficult.

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