ASIA PACIFIC Family Medicine

Return to Table of Contents

Asia Pacific Journal of Family Medicine Volume 5 Issue 2

REGIONAL ROUND-UP

Primary care in the Asia Pacific: Making it survive

Introduction

Thomas Bodenheimer, giving a perspective on primary care in America in the New England Journal of Medicine in August this year said that the American College of Physicians recently warned that “primary care, the backbone of the nation’s health care system, is at grave risk of collapse’.[1] This is a message that is applicable to countries around the globe. Primary care in the Asia Pacific is no exception.

Should primary care survive?

This is an important question to ask of ourselves and others. Employers and insurers, public and private, may reap a return on investment by fostering a more effective primary care sector that will reduce health care costs.[1] The public will benefit from microsystem improvement by having more meaningful interpersonal relationships with their primary care providers.

Even organ specialists might recognize that they would suffer if primary care were to disappear. They will be forced to have to take on the tasks to co-ordinate care and confront psychosocial issues in patients with multiple acute and chronic conditions, rather than focusing on diagnosing and managing specific diseases within their scope of expertise.[1]

Formula for survival

Primary care should therefore try to survive. The formula to make it survive has to be a macro and micro set of strategies. It has to be from a patient, a professional, and also a systems perspective. Bohenheimer observes that fixing primary care requires actions on the part of primary care practices (microsystem improvement) and the larger health care system (macrosystem reform).

Microsystem improvement

Microsystem improvement is the capacity-building of each practitioner in his ability to communicate, explain, and convince the patient of the need for paying for performance so that the provider can begin to have the time and resources to deliver what the patients need to be kept in better health. Vocational training regarding the know-how of good care, safe care and mindset change of being able to make a difference, is needed.

Macrosystem reform

Macrosystem reform is more tricky, but necessary. The standard of health care delivered is precisely what the system allows practitioners to do. Reform is needed to promote the preventive focus, the concept of unity for

health, and safe outcomes.

What Asia Pacific countries can do?

There are many things that Asia Pacific countries can do to make primary care survive and even thrive. What will happen will of course depend on the prevailing leadership.

Evidence is necessary and that means research

Barbara Starfield showed that countries with greater emphasis on primary care spent less on health care and have better outcomes. In her cross-sectional study of 10 industrialized countries in the later 1980s and early 1990s, concluded that there was general concordance for primary care, the health indicators, and the satisfaction-expense ratio in nine of the 10 countries. Ratings for the US were low on all three measures. West Germany also had low ratings. In contrast, Canada, Sweden, and the Netherlands had generally high ratings for all three measures. The lack of concordance in the ratings in the UK may be a result of relatively low expenditures for other social services and public education in that country.

Starting with prevention

Into the 21st century, it is necessary for Asia Pacific countries to continue to demonstrate that the presence of primary care will make a difference. Such information will strengthen the belief about cost effectiveness of primary care to patients, politicians, and practitioners themselves. This can be patient education programs like stopping smoking, targeting blood pressure control, or or avoiding complications via diabetes control. Even people with one stroke, one heart attack, or an admission for poorly controlled asthma, can be helped to prevent future episodes. The list of preventive care, primary or even tertiary, can go on.

Documentation of such interventions will prove beyond doubt the importance of prevention and reduction of health care costs. This is where practice-based research projects come in. And one can collaborate across countries to document such interventions. We can work collaboratively on case control studies on prevention in primary care – one arm documenting the outcome of usual care, and the other arm documenting primary care interventions in preventive care.

In rich and poor countries alike in the Asia Pacific region, prevention can be made to work to show the difference between its use and its non-use. And paramedical staff can provide the manpower substitution if there are no doctors.

The starting point will be the convergence of belief in the four Ps (patients, profession, politicians and policy makers and the press); that prevention is cost-effective but also requires resources and commitment to be ploughed into it to achieve results. All need to believe that prevention can be more effective and cost-saving than care after the disease has struck. We must see how to make the first step.

Towards unity for health

Health care today is fragmented into silos: the hospital, the community hospital, the primary care clinic, and the nursing home. Primary care doctors can begin the initiative to link the different sectors together through the spread of the vision of unity for health. Easier said than done, but we can always take the first step to link people and facilities together.

Developing family medicine capability

Family medicine is the discipline that promotes personal, primary, continuing, comprehensive care of the individual in the context of family and community. Much thought, experience and paradigm have gone into the discipline to help its practitioners practice more effective primary care and beyond. Isn’t experience enough? Experience is important but not enough. We need to recognize that family medicine capability = GP experience + vocational training. Countries in the Asia Pacific region are now developing vocational training programmes for GPs to build capacity to be FPs (family physicians). Primary care survival will be more assured if its practitioners have a means to build capacity to treat more than cough and cold.

Working towards paying for performance

Paying for performance in the long run will be the way to go to sustain primary care and keep it alive. The patient needs to be convinced that paying the primary care doctor his due consultation fee keeps him alive. More importantly, it also keeps the patient alive by saving him from complications of chronic diseases, and also prevents many diseases from even occurring. The money he or she pays the primary care doctor may be more than before, but think of the savings from prevented morbidity and mortality. Employers, governments, and insurance funders need to recognize the long-term savings and be generous enough to pay primary care providers for their performance in keeping patients in total good health.

Conclusion

Primary care should be able to survive so long as every primary care practitioner is committed to keep the patient alive and thriving. This requires attention to the set of strategies in microsystem improvement and macrosystem reform. For a start, primary care providers can consider: starting with prevention, towards unity for health, developing family medicine capability, and working towards paying for performance. There is also a need to undertake relevant research to provide evidence in support of strategies of improvement.

Associate Professor Goh Lee Gan
Regional President
WONCA Asia Pacific Region

References

1 Bohenheimer T. Primary care – will it survive? N Engl J Med 2006; 355: 861–4.
2 Starfield B. Primary care and health. A cross-national comparison. JAMA 1991; 266: 2268–71.

^top