

Out of Hours

International primary care snapshots:

Israel and China

ISRAEL: CHANGES AND CHALLENGES

For many years community medicine has been the 'stepdaughter' of medicine in Israel since most medical training took place in hospitals, and community medicine was perceived as second best. This has changed dramatically in the past decades.

Since 1995, in accordance with Israeli national health law, all residents of the state of Israel are entitled to receive health care, provided by four health maintenance organisations (HMOs). The service is based on primary care clinics spread across the country. Today there are around 5500 GPs, of which approximately 1600 are board-certified family physicians and employed by the four HMOs.

The training programme in family medicine in Israel began in 1969, and since the early 1990s, there has been a significant increase in the number of physicians specialising in family medicine. Each HMO has at least one department of family medicine responsible for the training programme.

The 4-year internship in family medicine has undergone numerous changes in recent years. The portion of internship in family medicine has been extended at the expense of hospital wards, in order to shift the teaching paradigm to primary care. Board exams were modified to include standard parts enabling more uniform testing and reducing examiner dependent bias.

Moving to the front of the stage

Excellent primary care is the key to good medicine. Changes in the healthcare system led to moving services from hospitals into the community to reduce costs and improve availability, in turn leading to an increment in the exposure of community medicine in medical schools. Yet the vast majority of clinical teaching is still hospital oriented.

Clerkship of family medicine became an integral, mandatory part of medical studies in all medical schools in Israel, and clerkship of exposure to community medicine have been added. The medical school, opened in 2012 at the Safed branch of Bar-Ilan University, includes about one-quarter of all clinical exposure within the framework of primary and secondary health care and community medicine.

The unique medical system in Israel delivered by the four HMOs has also stimulated computerisation of the systems



The annual meeting of teachers in family medicine of the Family Medicine Department at the Sackler School of Medicine Tel Aviv University, 2012. Photographed by Tikva Mahabad.

in the HMOs and then in the hospitals. Since 2000 HMOs have used a computerised patient records system allowing access to the patient's entire medical history. Lab test results, interpreted imaging studies, and consultation and hospitalisation results are automatically updated onto the medical file.

This computerised system has been the infrastructure for the National Indices programme. The National Quality Index Programme, which began in 2004, has developed 69 quality indicators in six major areas of medicine: diabetes, cardiovascular, asthma, cancer survey, vaccinations, and paediatrics. These are annually assessed across the whole country population and a significant improvement ensued following their introduction. In addition, signs of decline in morbidity rate have been observed. The main programme activities are undertaken by family physicians, and it is worthwhile noting that pay for performance is not a part of this programme.

In mid-2013, the German committee, a public committee headed by the former Health Minister Yael German, was established to promote and strengthen the public health system in Israel. The committee devoted a significant part of its recommendations to bolstering primary care in general, and most specifically in the peripheral areas of the country. This was done with the understanding that strong primary care is the key to promoting better health care equally available to all Israeli citizens. The committee recommended adopting an approach where the primary care physician is the patient's care manager, calling for increasing the availability and accessibility of primary care physicians.

The committee also emphasised the importance of the continuity of patient's care between the hospital and the community, to improve the quality of care. In addition, the committee called for a reduction in the considerable bureaucratic burden currently imposed on family physicians.

Future challenges

Although progress has been made, there still remains much work to be done.

The shortage of physicians in Israel in recent years has created a noticeable challenge in all specialties including family medicine. Currently, there are only around 100 new specialists graduating in family medicine annually, when in real terms, Israel needs at least 250 new family physicians a year (accounting for population growth and physicians' retirement).

The burden of daily work prevents many doctors from engaging in research and also makes it harder to instruct students. Rapid changes in the medical system, an ageing population, the entry of many new technologies, and the rising costs of modern medicine will lead to further changes in health care in the years to come.

We believe the family physician is at the forefront in leading these changes, and we hope, together with our colleagues in other disciplines, to find a way of providing good health care available to all patients, while maintaining the biopsychosocial viewpoint led by family medicine.

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CHINA'S JOURNEY TO PRIMARY CARE

China is the world's most populous country, with a population of over 1.35 billion, and has been shaping its primary care provision during the past several decades.¹ Primary care initially developed rapidly under a planned economy (before the late 1970s), but later, more slowly under a market-oriented profit-seeking economy (after the early 1980s). More recent healthcare reforms^{2,3} aim to use primary care delivered by community health centres (CHCs) to provide more equitable care for the whole population. CHCs are being set up in every neighbourhood within a 15-minute walking distance to ensure primary care is kept close to home. The number of CHCs increased dramatically from 17 128 in 2005 to 33 562 in 2012.⁴ The provision of a six-in-one care package integrating health prevention, protection, treatment, rehabilitation, education, and family planning, are required at all CHCs. Although CHCs in China do not have a gatekeeping function as they do in the UK, the expectation is that they will alleviate over-utilisation of outpatient services at secondary/tertiary hospitals where patients can walk in directly to see a specialist doctor and receive medication prescriptions.

Emerging organisational models of community health centres

The diversified local healthcare situations across China have resulted in attempts to build up CHCs under different models of ownership and management.⁵ Approximately 36.5%⁶ of CHCs are government-owned and managed (G-CHCs), independent of the hospital system. The revenues (mainly from medical treatments and drug sales) of G-CHCs are given directly to the local government, whereas the expenditures (mainly on premises, equipments, and staff remuneration) of G-CHCs are reimbursed from the local government budget. Around 35.7%⁶ of CHCs are government-owned but hospital managed (H-CHCs), organised as an affiliated department within the host hospital which is the major funding source of the H-CHCs. In contrast to the G-CHCs, the H-CHCs are not part of the government sector, and revenues are retained and self-managed. Nearly 27.8%⁶ of CHCs are owned and managed by private organisations (P-CHCs), who receive limited funding subsidies from government or hospitals, and are therefore profit-seeking due to financial self-sufficiency. These models⁵ reflect the varying extent of government and hospital involvement, and their roles in delivering primary care. Some evidence has suggested that the G-CHC model could lead to better

patient experiences and high-quality outcomes as it succeeds in distributing health resources fairly, resulting in reduced socioeconomic inequality.⁵

Multimorbidity challenges

The CHCs are expected to serve as the usual source of health care for Chinese citizens. China, like many other countries, is facing a growing health burden of chronic conditions. More than 1 in 10 (11.1%) people of all ages in China have multimorbidity (the presence of two or more chronic conditions from a selection of 40 morbidities), and its prevalence increases significantly with age.⁷ However, patients with multimorbidity tend to seek services directly at secondary outpatient care, and primary care is often not popular as the usual source of care.⁷ This reflects the fact that CHCs in China are not at present able to meet the healthcare needs of patients with multimorbidity in the secondary care-dominant healthcare system. Evidence has shown that the primary care approach could substantially reduce morbidity and mortality from chronic diseases.^{8,9} Nevertheless, there is still a long way to go for CHCs in China. They must be able to create a sufficient amount of qualified generalists coming from a strong and contextualised education and training system.¹⁰ This is so that they can be a first point of contact and regular source of care for patients.

Towards an equitable health care

Unlike the UK, healthcare services in China are not free at point of access. Although a social medical insurance system is in place, items covered are limited in terms of service scope and disease categories, resulting in a weak benefit package.^{1,7} Health care still largely relies on individual out-of-pocket payments, particularly among those who are uninsured.¹¹ This makes it difficult for patients financially, in light of an ageing population and a rapidly-escalating cost particularly in secondary care. Vast regional differences with huge divides in health and wealth requires quality primary care to help drive down healthcare disparities. An expectation has been placed on the G-CHC, — a model of CHCs where the government sector are directly involved in delivering primary care, shown to be more efficient in providing better first-contact care in terms of utilisation and coordination,⁵ and thus may also be better at achieving equitable care.

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REFERENCES

1. Wang HHX, Wang JJ. Developing primary care in China. In: Griffiths SM, Tang JL, Yeoh EK, eds. *Routledge handbook of global public health in Asia*. Oxford: Routledge, 2014: 584–600.
2. Liu Q, Wang B, Kong YY, Cheng KK. China's primary health-care reform. *Lancet* 2011; **377** (9783): 2064–2066.
3. Wang HH, Wong SY, Wong MC, et al. Attributes of primary care in community health centres in China and implications for equitable care: a cross-sectional measurement of patients' experiences. *QJM* 2014 Dec 17. pii: hcu248. [Epub ahead of print].
4. Ministry of Health, P.R.China. *China health statistics yearbook 2012*. Beijing: China Union Medical College Publishing, 2012.
5. Wang HHX, Wong SY, Wong MC, et al. Patients' experiences in different models of community health centers in southern China. *Ann Fam Med* 2013; **11**(6): 517–526.
6. Anonymous. *Research on health services of primary health care facilities in China*: Centre for Health Statistics and Information, Ministry of Health, P.R.China, 2009.
7. Wang HHX, Wang JJ, Wong SY, et al. Epidemiology of multimorbidity in China and implications for the healthcare system: cross-sectional survey among 162 464 community household residents in southern China. *BMC Med* 2014; **12**(1): 188.
8. Rasella D, Harhay MO, Pamponet ML, et al. Impact of primary health care on mortality from heart and cerebrovascular diseases in Brazil: a nationwide analysis of longitudinal data. *BMJ* 2014; **349**: g4014.
9. Wang HHX, Wang JJ. Effects of community-based general practitioners-led care for 12 864 patients with hypertension: study of cardiovascular risk intervention — hypertension (SCRI-HTN) in China. *Eur Heart J* 2012; **33** (suppl 1): 762–763.
10. Wang HHX, Wang JJ, Zhou ZH, et al. General practice education and training in southern China: recent development and ongoing challenges under the healthcare reform. *Malaysian Family Physician* 2013; **8**(3): 2–10.
11. Wang HHX, Wang JJ, Lawson KD, et al. Relationships of multimorbidity and income with hospital admissions in 3 health care systems. *Ann Fam Med* 2015; **13**(2): 164–167.