# Evolving health policy for primary care in the Asia Pacific region

Most countries experience major challenges to their health systems. The factors behind this global trend are increasing health costs and diminished returns on healthcare investment for ageing populations. Where the primary healthcare function is formally structured in the health system, and professionals are educated for their specific tasks, the performance of the system is improved: better primary health care leads to better population health at lower healthcare costs.[1] This makes strengthening primary health care a global strategy to secure sustainable care.[2] The value of international collaboration in implementing primary healthcare policy was exemplified by the I LIVE PC conference in 2011 in Washington.[3] A critical feature of this is the modification and adaptation of general principles to the prevailing local conditions: primary health care must be built up from the community level where it has to operate.[4] For this, a good understanding of the existing health system is important in initiating reforms. There is growing insight in primary health care in Europe and North America,[3,5] but data are scarce for many countries or regions.[4] To address this, the World Organization of Family Doctors (WONCA) took the initiative to document how primary care is organised around the world, and created dialogues on how the values of primary care can be addressed within the constraints of different healthcare systems.[6] A plenary symposium at the 2015 WONCA Asia Pacific regional conference in Taipei, Taiwan, offered an opportunity to compare the health systems of six member organisations of WONCA — China (Shanghai region), China (Hong Kong), Japan, Republic of Korea (South Korea), Singapore, and Taiwan — and document their experiences in the implementation of policy. The six presentations were structured on the format and method developed by the WONCA Working Party on Research.[6] The discussions that followed focused on five aspects of policy implementation: the strengths and weakness of each system; priorities for change; the available capacity in the system to address and process major changes; setting-specific and joint Asia Pacific regional needs to support this process of change; and priorities in international collaboration to support change.

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### China — Shanghai

Healthcare reform in Shanghai is driven by a floating and increasingly ageing population.[7] There is poor referral between primary, secondary, and tertiary care, resulting in disordered medical consultations. The current challenges include how to provide high-quality primary care. More than 200 community health centres have been set up; the priorities for change include improving the quality and quantity of primary healthcare providers and establishing effective two-way referral systems. A healthcare system oriented to primary care should be implemented by government reform.

### China — Hong Kong

Although Hong Kong has some of the best public health outcomes in the world, there is poor integration between primary and secondary care, as well as between private and public care, resulting in duplication of resources and doctor-shopping. Within primary care, the current challenges include differing standards of care provision and fragmented primary care.[8] The priorities for change include realigning the hospital-oriented healthcare system to a patient-focused healthcare system centred on primary care. This will require the government to put primary care at the centre of health system reform.

### Japan

Despite having universal health insurance coverage since 1961, Japan is an example of a society that is underserved by an ill-defined primary care system with fragmentation and hospital centralism.[9] Faced with a rapidly ageing population and growing social security expenditures, Japan needs major reforms to reduce waste and enhance cost-effectiveness. A national system to accredit training programmes, including for general practice, has finally been introduced. A nationwide database project with international collaboration has been initiated to prospectively show the content and quality of general practice, to be ensured by standardised professional development.

### Republic of Korea

Healthcare coverage in South Korea consists of National Health Insurance and Medical Aid. There is a very weak gatekeeper system, and fee-for-service is the main payment method. The easy accessibility to any specialty and the low medical costs are major benefits for patients. Over-consumption and excessively high frequency of specialist consultation are major problems for the medical system.[10] The government and the primary care group seek to strengthen primary care but this is opposed by the medical society governed by the specialist group.

### Singapore

Ranked by Bloomberg as the most efficient healthcare system in the world in 2014, Singapore's system has primary care as its foundation. However, not having a fixed primary care doctor and doctor-shopping have resulted in fragmented patient care. With an ageing population and an increased chronic disease burden,[11] priorities for change include patient 'empanelment' to clinical practices and teams of healthcare professionals, new care delivery, and payment models that better support chronic disease management. The government's continued support for greater collaboration between public and private primary care clinics[12] is imperative to ensure sharing of limited resources.

### Taiwan

Taiwan's National Health Insurance has a high coverage rate, easy access, and high patient satisfaction, and it provides consistent healthcare quality. The current challenges include frequent ambulatory care visits and medical resources being wasted because of no strict referral system and only limited financial incentives for patients to choose primary care visits.[13] The priorities for change include improving the quality of primary care and shifting from hospital-oriented health care to community primary care. Integrated primary care, including a family doctor

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programme (community medical group), has been initiated to solve these problems.

The presentations referred to many problems and uncertainties encountered when improving local health systems. This came forward in particular in the experiences in mainland China, where the recent decision to promote primary health care highlighted the need to build the family medicine workforce more or less from scratch. WONCA's mission has for long been to help countries build primary care and family medicine leadership in their local context through the establishment of national colleges and academies of family physicians.[14] It currently, has member organisations in 131 countries (http://www.globalfamilydoctor.com/).

Referred to at the same time was a next phase in primary care development. Their experiences were based on strong societal and economic development, with substantial improvements in population health and in general high levels of (technical) health care for populations covered by health insurance. From here, the challenges were not only in changing existing structures but also building where there had been nothing before.

An emphasis on provider-driven (instrumental) interventions led to poor integration between professionals. Where there was integration this was vertical,[14] leading to stand-alone disease-centred care. This lack of integration led to duplicated care, over-use of facilities, and wasting of precious resources that threatened the sustainability of the health system. A common feature was the absence of a primary healthcare function in the system to coordinate and horizontally integrate the care provision towards the needs and priorities of individuals and communities. With no restrictions to practise in the community, every specialist can claim 'primary health care'. This leads to variation in the quality of care and makes a primary healthcare function in the health system a priority. For primary health care to be able to lead, it is essential to introduce professional training in primary health care — including in family medicine — as the mandatory condition to practise in the community.

To move to primary health care, stakeholders near to policymakers, notably patients and community leaders, must work in a relation of trust with family physicians and other primary healthcare professionals.

Shanghai and Singapore's community-based structure of health care is strong, and could be reinforced by introducing 'panels': individuals registered with a family practice to contract all their health care. Most countries could learn from how both Singapore and Hong Kong have built on their SARS experiences by creating facilities in polyclinics and community health centres to assess at-risk patients in isolation.

The workshop highlighted the need for better integration of care between different providers as well as with social services. Many countries share this need and this may emphasise the importance of horizontal integration based on a generalist primary care function.[15] This is directly related to the second need the workshop highlighted. To deliver its potential the generalist primary care function has to be built on competent professionals. Strengthening the primary care workforce through education and training directed at the core values of primary care[14] is again an issue for many countries. The workshop brought together in a pragmatic way experiences of only six WONCA member organisations and a more comprehensive review, including countries from other regions, may have presented other needs and priorities. This should therefore encourage a further international collaboration to review the implementation of primary healthcare policy. To secure access to high-quality health care for all, *every* health system will have to provide strong primary health care as its basis. Learning from others in implementing primary healthcare policy through international sharing of experiences — their challenges, failures, and successes — will continue to support this.

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