District Health System: Needs and Framework
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The concept of District Health System first emerged in the Working Party of Primary Care Report to Hong Kong Government in 1991. Many recommendations have not been implemented probably due to establishment of Hospital Authority at the same time. Now Hospital Authority has been well established with heavy workload demands and limitation of manpower. It is time to strengthening the primary health care system in Hong Kong which has been operated on ‘lassie faire’ basis. This would only be feasible in the past but would not face the future challenges of triple health burden: resurgence of communicable diseases, early onset of non-communicable diseases, disability caused by mental health illnesses. The 1991 Working Party Report recommended the establishment of Primary Health Care Authority making delivery of primary health care in more structured manner like the Hospital Authority overseeing management of all public hospitals. However nearly 70% of primary medical services is provided in private sector and other services related to primary care are delivered by diverse settings. Moreover long term care needs to move beyond medical model to address the social determinants of health as well as the psycho-social needs, e.g., evidence has been established the link between social capitals and health. The partnership with social services and patient empowerment programmes have shown to achieve better clinical outcomes. Therefore it is more feasible to build up a local primary health care system under the concept of District Health System incorporating and integrating different service providers as well as re-deployment of services and manpower to support the development as outline in Figure 1 with further details in Figure 2.

Another unique feature of District Health System is to introduce case management (Figure 3) so patients would have different levels of management according to their conditions. The introduction of Community Health Practitioners (CHP) working with health and/or social care assistants would also cover the psycho-social needs of patient as well as physical needs. They would also help to minimize the risk of unnecessary hospital and emergency admissions also in the context of social determinants of health leading to a fair society with healthy lives, and building a stronger human and social capitals.

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The District Health System will be under the governance of a District Committee composing representatives from DH, SWD, HA, District Council, professionals (medical and health, social services) connected to the district, academics, community leaders and patient groups. The Committee will hold the service providers accountable and responsible for monitoring and evaluation.

The rationale of District Health System

- The current hospital system would not cope with the ever increasing needs and demands with ageing population, early onset of non-communicable diseases, and increasing burden of mental health problems.
- Expansion of hospital services is expansive requiring expansion of professional staff at graduate level and above as well as high operating costs
- Enhancement of primary care would provide more comprehensive and holistic care with first point of contact in community setting and would enhance quality of life of citizens
- Extra resources will be needed to invest in primary health care so the heavy burden of hospital services would be relieved, soothing the manpower issue. This would minimize medical errors
- In long run, primary health care would shoulder substantial portion of health burden so the hospital services will not need further expansion. Therefore the total health care expenditure would be capped under control without compromising the quality care.
- District Health System provides a system of local governance of primary health care tapping in community resources as well as efficient deployment of manpower by engaging health care personnel at all levels not just doctors, nurses and allied health professionals
- Patients with chronic health problems stable to be managed in community setting will be referred back to primary care physicians in private or public sector. The community health care team will provide supporting services for this group of ‘shared care’ patients including dispensing medication for their chronic conditions as well as co-ordinating assessment requiring laboratory test or imaging.
- It is proposed to commission appropriate health care organization to operate the existing public General Out-patient clinics (GOPC) on block grant from public funding plus fee paid by users at current government rate (those eligible for subsidy will be reimbursed). The clinics will maintain same quota for different categories of patients and manage the patients as usual. GOPC is still public service but is operated by health care organisations instead of HA and under the governance of District Health System for monitoring and evaluation.
- It is proposed to allow users of Maternal and Child Care and Student Health choosing their own family physicians to provide the services and reimbursed. The family physicians would purchase services from community health team if they cannot provide the services in their own clinics. They need to undergo clinical audit of their performance under the scrutiny of District Health Care System

Logistic explanation

- Patients with chronic health problems from in-patient or specialist out-patient clinics would be referred to FM Integrated clinic if conditions are stable. After fine tuning of medication and long term care plan, the patients will be discharged to primary care providers either public and private as ‘shared care’ patients. They can be referred back
to FMIC only if needed for assessment whether they need to be seen by hospital specialists.

- The ‘shared care’ patients will pay usual consultation fee according to the rate stipulated by private primary care physicians and the usual rate of GOPCs if attending public.

- The Community Health Care team will provide intensive co-ordination of other supporting services needed for the patients as well as co-ordinating for supply of medications and arrangement for periodic assessment by laboratory testing and/or imaging.

- The ‘shared care’ patients will be better managed in community and hospital admission and/or emergency attendance will be minimized. This would be incentive for primary care physicians in public sector as patients might not need to consult so frequently. For private primary care physicians, this will allow shared care patients with lower health care expenditure so more patients will opt to have continuing care by their usual family doctors. Otherwise this group of patients will stay in public setting.

- One might raise concerns that patients initially managed well by their own private primary care physicians (also in GOPCs) for their chronic health conditions would request to be seen by specialists in hospital so they would become ‘shared care’ patients taking advantage of this new system without the actual needs.

- If patients request referral or referral from Accident and Emergency rooms, they will be seen at FMIC. Only those referred to Specialist Out-patient or inpatient will become ‘shared care’ if they are referred back to FMIC then back to primary care. If FMIC manages to stabilise their conditions, they will be referred back to primary care physicians in private or public and they will continue their care as usual not as ‘shared care’ patients.

- The District Health System has 3 key functions:
  - To enable more patients with chronic health problems to be managed in primary care with structured and holistic care involving different levels of health care personnel also addressing the social determinants of health and psycho-social perspectives
  - To provide greater support to primary care physicians (public and private) so they would manage more patients with chronic health problems effectively and efficiently
  - To integrate other preventive care such as student health, maternal and child health into primary care system
Routine referral and referring back

Cases of chronic diseases with complex needs and multiple inputs

**Community Health Care Team**
Consists of nurses, physiotherapy, occupational therapists, counsellors, pharmacists, community health practitioners re-deployed from HA or Department of Health supported by Community Health Practitioner and health and/or social care assistants

- Multi-disciplinary assessment to unfold the unmet complex bio and psycho-social needs of patients
- Co-ordination of related allied health services including pharmacist review of medication
- Enhancement of knowledge and skills in self-care and self-management

**Acute Hospital Care by HA**
Patients with conditions clinically stable for discharge but require further inputs from multi-disciplinary services for different needs to be well maintained in home environment

**Condition stable**

**Unstable condition needs intensive treatment in Hospital**

**Patient centred Care by Primary Care Physicians in the community as Centre of Care in Community**

**Services by Maternal and Child Health Centre, Student Health Services, Elderly Health Services, other preventive services by Government**

**Other community health services such as elderly home, nursing home, nursery, community centres, youth centres**

Community Health Care Team consists of multi-disciplinary health professionals including nurses, allied health professionals such as physiotherapists, occupational therapists, pharmacists, social workers, counsellors, clinical psychologists, dieticians, nutritionist, assisted by community health practitioners (CHP) and health and/or social care assistants.

Each patient will be assigned to one health professional depending on his/her condition to design long term management plan and co-ordination of care to support primary care physicians to rehabilitate the patients’ physical as well as psycho-social perspectives. The goal is to prevent hospital admission and emergency attendance and maintenance pf physical and psycho-social well-being for patients, carers and family members.

Case manager will pass the cases to case co-ordinator, CHP together with health and/or social care assistants to make use of community resources to prevent hospital and emergency admission by monitoring of risk factors in the context of social determinants of health beyond medical risk factors.

Supporting Primary Care Physicians to supplement primary prevention i.e. enhancing skills to expose to protective factors for positive health and well-being and minimizing exposure to risk factors, secondary prevention – provide screening services that cannot be performed in primary care physicians’ clinics, tertiary prevention-assist primary care physicians to manage any complications arises.
Designation of professional staff as Case Manager depending on the clinical condition and co-morbidity, e.g., diabetic patient requiring weight loss will benefit from dietitian or physiotherapist depending on priority for diet intervention or exercise; if patient has poor drug compliance, pharmacist would be case manager; if patient has difficulty with injection/general personal health, nurse would be case manager; if patient has issue with self-efficacy or self-confidence, social worker would be the case manager.

- Assessment of case to identify different needs of patients
- Identification of needs for inputs from different professional disciplines
- Convene a meeting for case management plan and estimate the time schedule
- Supervise the Community Health Practitioner (CHP) for logistic arrangement of care plan
- Liaison person for any problems and also with referring health sector (hospital/primary care).

Re-assessment whether target goals have been achieved for stabilisation of clinical conditions
- If not, what are the current needs and which discipline(s) would help further?
- If stable, consider long term day to day care plan with CHP.

Day to Day Co-ordination and monitoring by CHP

Conditions become unstable