6. Development of General Outpatient Clinics as Primary Care Providers: Merits and Shortcomings

As soon as the Japanese surrendered in Hong Kong on 15 August 1945, Dr. Selwyn Selwyn-Clarke, who had been imprisoned by the Japanese during the occupation, immediately left the prison at Stanley and returned to work. He resumed the services of the Medical and Health Department by recalling all previous staff to return to work and reopening as many hospitals and clinics as soon as possible. He was assisted by Professor Gordon King, who was the Dean of the Faculty of Medicine before the war, to rebuild the Department, employing as many medical graduates from the University of Hong Kong as possible and those who had completed their medical degrees in Chinese universities on the mainland during the war.

As discussed in the previous chapter, the government took over the nine Chinese Public Dispensaries (CPDs) to provide outpatient care. These dispensaries delivered general outpatient services and most of them also had midwives attached to them to provide domiciliary deliveries, while some of the dispensaries had a few maternity beds. The buildings of most of the CPDs were in a dilapidated state and had to be repaired. From the mid-1950s to 1980s, government outpatient services greatly expanded. By 1990, the Department of Health was operating sixty-four general outpatient clinics and a number of special outpatient clinics in the region.[1] In addition, mobile dispensaries and floating clinics provided medical services to the outlying islands and remote areas in the New Territories. Other inaccessible areas were visited regularly by the "flying doctor" service[2] with assistance from the Royal Hong Kong Auxiliary Air Force.

In this chapter the work of the government general outpatient clinics (GOPC) and their role as primary care providers will be discussed.

Figure 6.1 Sir P. Selwyn Selwyn-Clarke

Repinted from *Kreol International Magazine*,
https://kreolmagazine.com/culture/history-and-culture/sir-selwyn-selwyn-clarke/#.XdzOhtVS82w.

Sir Percy Selwyn Selwyn-Clarke (1893–1976) was appointed the Director of Medical and Sanitary Services in Hong Kong before the War. After the fall of Hong Kong to the Japanese, he felt that he would help the city more by working with the Japanese. He demanded sanitation workers to continue working without pay and to maintain a clean water supply for the population. He provided medications and food for hospitals, prisoner-of-war camps, and the civilian concentration camp in Stanley through various means. He and his wife Hilda raised funds for supplies. However, these activities finally led to his imprisonment where he suffered grievously.

Work of Government General Outpatient Clinics (GOPC)

Curative Care

General outpatient clinics are the first point of contact for patients when they feel unwell. In general, these clinics, which were free or inexpensive, usually served the poorer Chinese in the community. The bulk of work of a medical officer in a general outpatient clinic was to address the immediate complaint of a patient, give a diagnosis, and provide treatment. Most of the time, the conditions encountered were cough and colds from upper respiratory tract infections, stomach upset or diarrhea from gastrointestinal disturbance, skin problems, and childhood infectious diseases. But at times, the doctor needed to decide whether a sick patient should be sent to hospital for further treatment or be treated as an outpatient. The doctor should know the type of infectious disease (e.g. cholera) currently in the community, send the patient with such a disease to appropriate centers for isolation and treatment, and inform public health authorities for contact tracing. He and his staff also performed vaccinations or inoculations. In fact, doctors in these clinics were primary care doctors and were "gatekeepers" to the hospitals.

Unlike their counterparts in CPDs, there was no need for doctors to identify the cause of death for "dumped" bodies (see Chapter 2), which came under the jurisdiction of pathologists in charge of the mortuaries. Doctors were also spared from the duty of performing birth and death registration, because birth and death registries had been set up after World War II.

Most of the time, the clinics were so heavily over-booked that the doctors had no time for anything else other than addressing the patients' immediate problems. The doctors spent very little time with their patients, less than five minutes each, and sent the patient out with a prescription.[3] They had little time to investigate the patients' other health problems, and to practice preventive medicine other than immunization.

Patients attending these clinics often had to wait for several hours just to spend three to five minutes with a doctor, and many had to make two trips to the clinic: one in the early morning to obtain a "visit ticket," and another during consultation hours to receive care. Some enterprising individuals attempted to make money out of selling their "visit tickets" to those who did not have time to stand in line.[4] As evidenced by the

problem of overcrowding of clinics, medical care was "free" only in a technical sense, as patients paid dearly in the less tangible currencies of wasted time, inconvenience, and stress. Evening clinics and clinics during Sundays and public holidays were held regularly, but they nonetheless failed to relieve the congestion in the daytime clinics.[5]

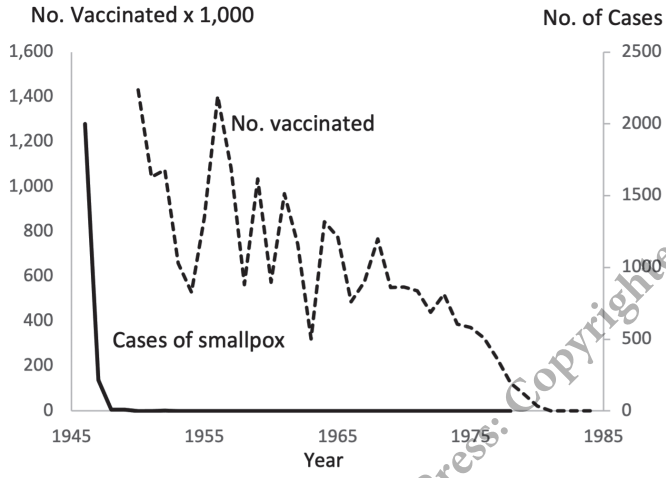
In 1954, doctors in some of the major clinics worked shifts between 9 am and 12 midnight. In most major clinics, such as Sai Ying Pun Clinic and Violet Peel Health Centre, the volume of patients passing through was incredibly high, about half a million in attendance that year.[6] The remarkable expansion of the outpatient services from the 1960s to 1980s only marginally reduced the workload of doctors and the waiting time of the patients because of the concurrent rapid population growth during this period (almost one million per decade in three successive decades from 1950).[7]

Control and Prevention of Infectious Diseases

Other than clinical activities, government general outpatient services performed the work of prevention and control of infectious disease epidemics and conducted health education. Immunization against infectious diseases was and still is one of their vital functions. One of the most pertinent historical examples of CPDs/outpatient services managing an infectious disease is that of the twentieth-century smallpox epidemic. The smallpox vaccination program was part of the duties of the CPDs since their founding in 1905, and was effective in preventing severe epidemics. Around thirty years later, the arrival of refugees from Mainland China in 1937 brought a smallpox epidemic to Hong Kong. Responding to this increase in morbidity and mortality rates, in 1938, CPDs carried out smallpox campaigns in the form of education and vaccination. Altogether, 1.1 million people were vaccinated, resulting in only 198 cases in 1939 in contrast to 2,327 cases in the previous year.[8]

In 1946, shortly after World War II, almost 2,000 people were infected with smallpox,[9] catalyzing a huge anti-smallpox campaign starting in 1947 when about one and a half million people were vaccinated. The vaccination program continued every year until 1979, with over one million people vaccinated annually for several years in the beginning.[10] As a result, there were no cases of smallpox reported after 1951 (Figure 6.2). Hong Kong was declared free of smallpox by the WHO in 1979, a testament to the efficacy and importance of vaccinations.[11]

Figure 6.2 Number of people vaccinated and number of cases of smallpox, 1946 to 1985

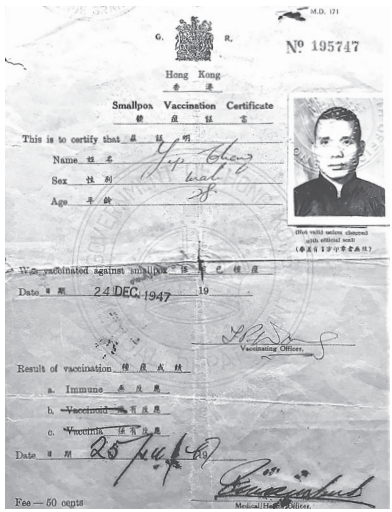


Source: Hong Kong Medical and Health Department Annual Reports for the years 1946 to 1985

An exceptionally virulent epidemic of cholera occurred in 1937 that killed 774 of the 1401 affected patients.[12] Recognizing the seriousness of the problem, the government was much more alert in 1938 when streams of refugees from China arrived, some carrying the disease. In addition to extensive campaigns on the prevention of the deadly disease, anti-cholera inoculation was carried out by staff in all hospitals, dispensaries, and clinics in Hong Kong. In the end, the total number of deaths was 363 out of the 547 affected, considerably less than the previous year.[13]

The outbreak of cholera of 1961 also illustrates how the epidemic could be controlled efficiently by

Figure 6.3 Smallpox vaccination certificate issued by the Medical and Health Department Hong Kong in 1947. Note while the vaccination was free, the fee for the certificate was 50 cents (left bottom)



Photograph courtesy of Mr. Keith Poon

preventive measures. During the first week of August 1961, rumors reached Hong Kong that there had been a recent outbreak of cholera in southern Guangdong. The Medical and Health Department responded to these rumors by immediately increasing the production of the cholera vaccine, mobilizing equipment and staff to open cholera treatment units, and designating a number of inoculation and quarantine centers. The first case occurred in Hong Kong on 15 August and was confirmed by a bacteriological investigation. At the same time, intensive public education in the prevention of the disease was carried out through the media. Anti-cholera inoculation was carried out mostly in these government dispensaries and in a number of other stations that were convenient for people, similar to smallpox campaigns. The response to the campaign was tremendous. People lined up in long queues outside every clinic and inoculation station (Figure 6.4). They all knew about the horrors of cholera and the high mortality from past experience. By 25 August, over 1.5 million persons had been inoculated, approximately half of the population of Hong Kong at that time. With such vigorous measures, the epidemic ended with only 129 cases.[14]

Figure 6.4 Long queue alongside and in front of the old Wan Chai Post Office for anti-cholera inoculation in a nearby dispensary

Reproduced by permission from Hong Kong Medical and Health Department Annual Report 1961–62, opposite 52.

The government outpatient clinics were vital in the control of any infectious disease epidemic. In those days, enteric fever, typhoid, and paratyphoid, were not uncommon. When T.A.B. vaccines (against typhoid-paratyphoid A and B) became available, inoculation was offered to the public throughout the year,[15] but the campaign was intensified during May, June, and July of 1961. Intensive health education was also given at that time on personal hygiene in an effort to decrease the spread of disease through techniques like handwashing and covering the mouth when sneezing or coughing.

Health Education

Health education was always an important part of the work of Medical and Health Department, and it was carried out through various channels including talks given by doctors, nurses, and midwives in the outpatient clinics and health visitors going into homes of patients (Figure 6.5). Health education was also delivered through the media, newspapers, radio, and television, and health information, printed on leaflets, pamphlets, or booklets, was given out during health exhibitions. At times, special campaigns were organized for selected experts to give lectures, with teams going to schools and public places to give talks and demonstrations. In government dispensaries and clinics, health education was delivered on a variety of topics. In maternal and child health centers, health education was given on hygiene, how to care for newborn babies, the importance of breast feeding, and immunization. In tuberculosis clinics, the significance of taking all the medications regularly, completing the course of treatment, how to avoid infecting others, and side effects of the medications were taught, while in venereal diseases clinics, patients were given sex education, which included how to avoid getting infected.

Outpatient Work in Remote Areas: Vans, Boats, and Helicopters

The early days of development of the New Territories were characterized by a lack of accessibility to medical care, largely due to the absence of public transportation. Therefore, the government sent mobile dispensaries to bring medical officers to the more remote areas where the population was not large enough for a permament, brick-and-mortar clinic to be established. In areas only accessible by water, there were two

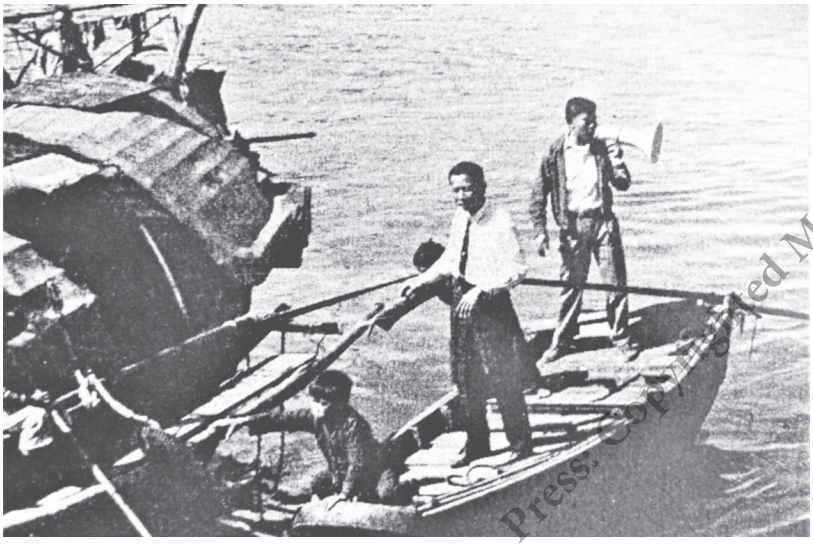
Figure 6.5 Health visitor giving health education to villagers

Reproduced by permission from Hong Kong Medical and Health Department Annual Report 1964–65, opposite 18.

Figure 6.6 Flying doctor going into a remote village to visit the sick (helicopter in the background)

Reproduced by permission from Hong Kong Medical and Health Department Annual Report 1961–62, opposite 45.

Figure 6.7 Hailing boat people for immunization



Reproduced by permission from Hong Kong Medical and Health Department Annual Report 1961–62 opposite 45.

motor launches to bring services, including medical, dental, and minor surgery, to the community. A helicopter came into service, taking "flying doctors" to remote regions unreachable by car or boat (Figure 6.6). In a medical emergency, when traveling by car or boat would be too slow, the helicopter would also be called in. Mobile traveling clinics and motor launches (Figure 6.7) were recruited for immunization or vaccination campaigns, taking doctors and nurses to these communities, including the boat people. Health visitors often traveled along to give talks to the local community.[16]

Call for Healthcare Reform

Following the 1970s, infectious diseases were no longer the major causes of death in Hong Kong, due to the hard work of the staff of the Medical and Health Department; however, there was still much work to be accomplished in medical services for the people of Hong Kong. The focus of the Medical and Health Department began to shift to personal curative

care. More hospitals were built to accommodate the ever-changing and improving medical technology of electron microscopes, computerized tomography scanners (CAT), positron emission tomography (PET) scanners, and magnetic resonance imaging (MRI) machines. As these life-saving technologies evolved, the demand for these high-tech services increased, escalating the cost of hospital care. When the Hospital Authority was founded in 1990, it consumed about 90% of the budget for hospital services, while only 10% was left for the new Department of Health.

Changes in Disease Pattern

Despite the virtual eradication, or at least, control of, the infectious diseases that plagued twentieth-century Hong Kong, economic progress and the comparatively higher standard of living resulted in new problems for medical professionals. The positive effects of a more prosperous economy include advancement of medical services, better nutrition, and greater resistance to infection, all amounting to extending human life-expectancy and reducing infant, maternal, and overall mortality. At the same time, increased income led to the adoption of the Western style of living with its accompanying consequence—the progressive increase in lifestyle diseases such as cancer, cardiovascular and cerebrovascular diseases, obesity, and diabetes.

The pattern of diseases changed. Since the 1970s, instead of seeing patients with infections or infectious diseases in the clinics, the doctors in the general outpatient clinics began attending to patients with chronic noncommunicable diseases. In the 1980s, the demographic pattern in Hong Kong also changed—people were ageing, leading to higher prevalence of chronic noncommunicable diseases. In 1997, the general outpatient clinics had 5.3 million patient-visits. Of these, 32.3% had acute respiratory infection, 24.6% hypertension, 7.6% diabetes, 6.6% skin diseases, and 5.5% musculoskeletal problems. Chronic noncommunicable diseases accounted for about 60% of all deaths in Hong Kong.[17] These diseases, while not infectious, are associated with high morbidity, prolonged disability, and a significant burden to society.

Studies have shown that the prevalence of these chronic diseases can be reduced by lifestyle changes, and disabilities can be avoided by early detection and early treatment by primary care physicians, who are the first point of contact for most patients. But, in the 1980s, Hong Kong hardly

had any primary healthcare to speak of, and medical officers, who were overworked in government clinics, had no time to consider prevention of chronic diseases. A stronger primary care system was desperately needed to strengthen prevention and management of chronic diseases, and to care for the elderly.[18]

Rising Cost of Healthcare

Hong Kong continued to prosper until 1997 when it was handed over from Britain to China. Thereafter, it suffered a series of setbacks, including most notably the Asian financial crisis of 1998 and the SARS epidemic in 2003. It was not until 2006 that Hong Kong's economy recovered fully, and, as its expenditure on healthcare continued to increase during periods of growth, the government began to fear that healthcare costs were no longer sustainable in the future with the rising cost of medical care and the increasing demand for more expensive, advanced services.[19]

Importance of Primary Care

Another driving force for change was the 1978 Declaration of Alma-Ata, when the World Health Organization (WHO) declared that governments should give greater emphasis to primary care services as a method to improve the health of their populations.[20] There is vast international data to show that the primary healthcare approach is the most efficient and cost-effective way to implement a healthcare system that produces better outcomes at a lower cost, with improved accessibility and higher user satisfaction.[21] The WHO promoted the primary healthcare approach as the key to achieving the goal of "Health for All" by the year 2000.[22]

Primary Care Reform: Health for All

To expedite healthcare reform, the government established the Working Party on Primary Health Care (WPPHC) in 1989. In December 1990, the WPPHC released a report[23] which determined that the government had neglected to provide adequate healthcare services in Hong Kong, and that a clear commitment toward primary healthcare was badly needed. At the recommendations of the WPPHC, the Department of Health was