

Vision and Future Development of Primary Care in Hong Kong

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WHO/UNICEF International Conference on Primary Health Care, 6-12 September, 1978
The Lenin Place, Alma Ata, USSR. Source: WHO Chronicle 1978; 32: 4109-30

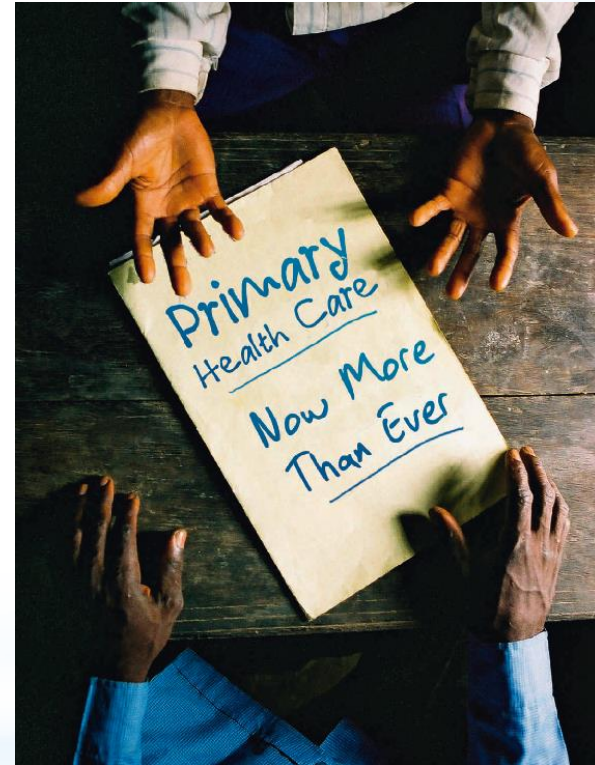
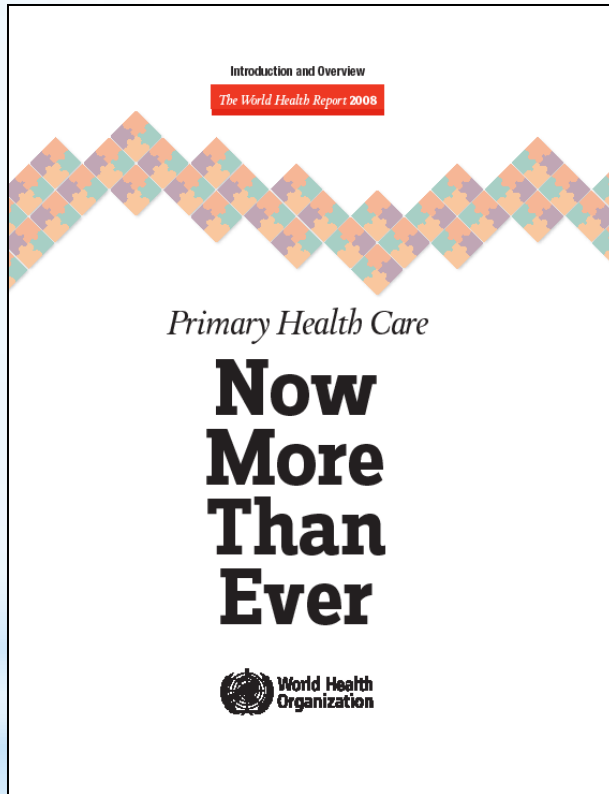


Declaration of Alma-Ata 1978

- * **Health for All by the Year 2000**
- * **Primary Health Care**
 - is the key to health for all
 - should be universally accessible
 - addresses the main health problems
 - promotes self-reliance
 - should be sustained by a mutually supportive referral system
 - requires multi-professional team work



WHO World Health Report 2008



“PHC– Now More than Ever”

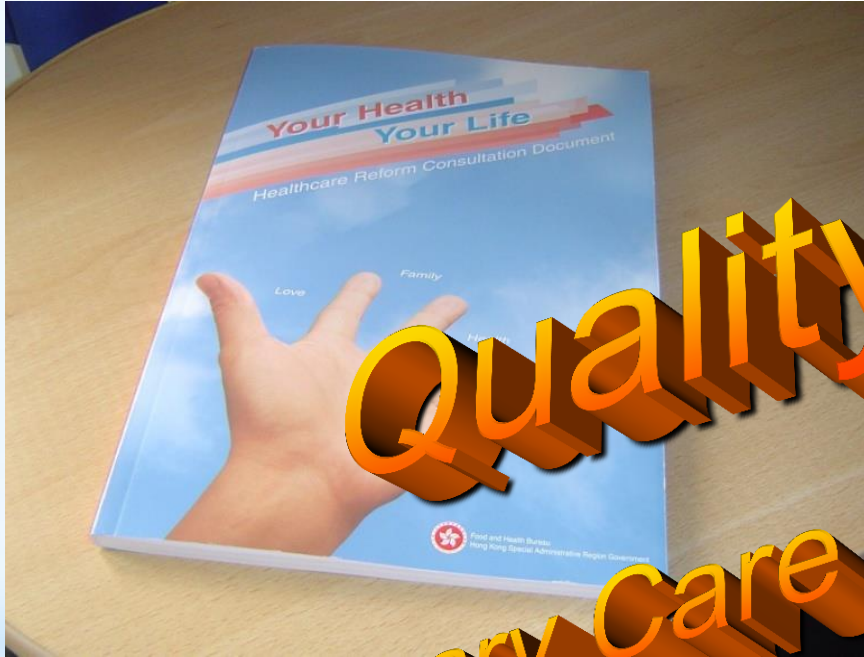
WHO World Health Report 2008

Reforms to translate “health for all” from aspiration to implementation

1. Universal coverage: ↓ service gaps & fees
2. Service delivery: comprehensive & skilled (Primary Care)
3. Public policy: financing & resources
4. Leadership: collaborative & strategic



Vision of Primary Care in HK



Quality
Primary Care for ALL



Purpose of Future Primary Care

- * For the aging population with multi-morbidity
 - Keep people healthy & happy
 - Enable and empower self care
 - Prevent & reduce morbidity & disability
 - Co-ordinate care & reduce treatment burden

- * Against the rising health care cost
 - Manage >90% of illnesses effectively
 - Keep people away & out of the hospital
 - Appropriate & cost-effective use of resources



Person-centered
(enablement, whole-person,
co-ordinated, continuous)

**Quality
Primary Care**

Best Practice
(effective,
evidence-based)

Comprehensive
(prevention,
chronic disease
multidisciplinary)





**Keys to Quality Primary Care:
Family Doctor Led &
Multidisciplinary**

Evidence from the World

- * Primary care provided by family doctors/
general practitioners are most cost-effective^{1,2}

- * A higher supply of GP/FP, but not other PC
doctors, was associated with
 - lower mortality rates^{3,4}
 - higher early cancer detection rates^{5,6}

1. Franks P, Fiscella K. *J Fam Pract* 1998.

2. Weinberger, M., Oddone EZ, *NEJM* 1996.

3. Gulliford, M.C., *J Pub Health Med* 2002.

4. Shi L, et al. *J Am FP* 2003.

5. Campbell RJ, et al. *Fam Med* 2003.

6. Ferrante JM, et al. *Am B Fam Pract* 2000



Evidence from HK

People who Have a Family Doctor are

* More likely to

- have healthy life style
- receive comprehensive care
- have continuity of care
- experience person-centered care
- improve after a consultation
- be more enabled in self-care

* Less likely to

- use A&E or hospital when ill



Lam et al, SHS-P-10 Report, HHSRF, Food & Health Bureau 2009



Family Doctor = Less A&E or Hospital Use

N=3148	Family Doctor Vs. NRD	Family Doctor Vs. ORD	ORDVs. NRD
Service Use in Last Illness		Odds Ratio	
Any med care	2.486*	1.342*	1.853*
A&E Attendance	0.479*	0.624*	N.S.
Hospitalization	0.458*	0.514*	N.S.

ORD=other regular doctor; NRD= no regular doctor; NS=not significant

* *Odd's ratios shown are significant by multivariate logistic regressions*

Fung CSC & Lam CLK et al. BMC Health Services Research 2015; 15:42.



Multidisciplinary PC Saves Lives

Observed Events in 5 y 2009-2013	ARR (RAMP-DM Vs. Usual Care)	NNT	HR [†]
Any complications	↓ -13.05%	8	0.597*
CVD	↓ -11.64%	9	0.509*
CHD	↓ -7.78%	16	0.448*
Heart Failure	↓ -4.69%	21	0.442*
Stroke	↓ -3.29%	30	0.641*
ESRD	↓ -0.77%	130	0.444*
STDR	↓ -1.41%	71	0.496*
All-cause mortality	↓ -13.39%	7	0.438*

ARR: Absolute risk reduction; NNT: Number Needed to Treat;
 8,570 RAMP-DM subjects and 8,570 usual care subjects were matched by propensity score
 † HR Hazard ratio < 1 indicates risk reduction for events compared to usual care group, by
 Cox regression adjusted for socio-demographic and clinical characteristics
 * Significant differences $p < 0.05$ compared to usual care group



Multidisciplinary PC Saves Public Health Care Cost

Public Service	Cost per DM subject (HKD)		
	RAMP-DM (N=8570)	Usual care (N=8570)	Difference
RAMP-DM set-up cost (mean)	41	N.A.	41
RAMP-DM administrative cost	5	N.A.	5
RAMP-DM ongoing cost over 5y	1,222	N.A.	1,222
Public health care cost over 5 y	94,461	152,573	-58,112
Total costs over 5 years	95,725	152,573	-56,848

Projected to 62,940 uncomplicated DM patients enrolled to RAMP 2009 – 2011: HA saved 3.5 billion & reduced 8,991 deaths & 7,867 DM complications from 2011-2015





Future Development of Primary Care in HK

Investment in Primary Care

- Earmarked resources to strengthen primary care (15% health budget*)
- Dedicated leadership & administration to protect, steer, support & co-ordinate primary care
- Incentivize primary care to provide preventive & chronic care
- Break down the public/private cost barrier



* *De Maeseneer et al. BMJ 2008; 336:518; doi: <https://doi.org/10.1136/bmj.39496.444271.80>*



A Family Doctor for Everyone – Family Doctor Registry

Primary Care and Primary Care Directory:
for primary care providers



Empower the Family Doctor

- * **Named family doctor is part a person's essential health information**
- * **Foundation of health service delivery**
- * **Preventive, first contact, co-ordinated, follow up & shared care**
- * **Implementation of best practice**
- * **Quality assurance & accountability**

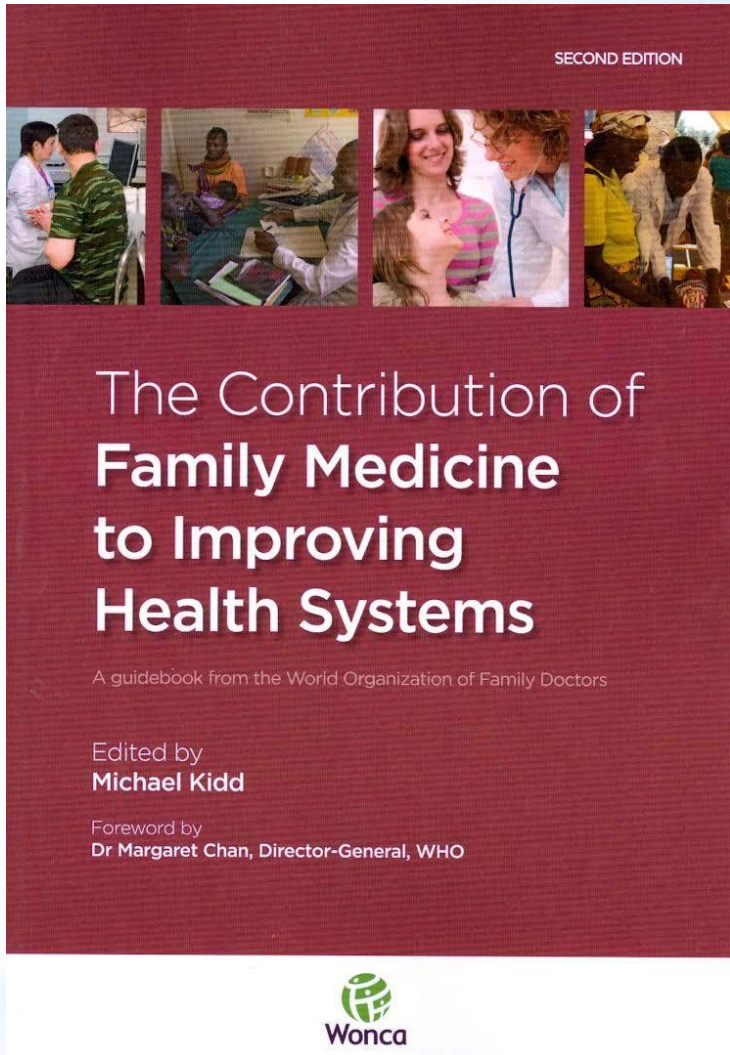


Enable Quality Primary Care

- * Sufficient manpower of trained and competent family doctors
- * An infrastructure to provide multidisciplinary primary care in the community
- * Adequate, accessible & affordable drugs, laboratory & other services to all
- * Shared health record (eHR) & I.T. support
- * Big data health & health services research in primary care to inform practice
- * Evidence-based primary care references



“ Family doctors need training that will allow them to master the distinct body of knowledge, attitudes and skills that are necessary for optimal practice in the communities they serve.”



<https://www.crcpress.com/The-Contribution-of-Family-Medicine-to-Improving-Health-Systems-A-Guidebook/Kidd/p/book/9781846195549>



Training of Family Doctors for HK

- * 3700 family doctors (1 per 2000) for 7.4 million (4100 for 8.2 million by 2043)
- * 937 trained (747 FHKAM (FM) or FHKCFP) & 190 trainees in training of FM at end 2017
- * Shortage of 2763 (3163) trained family doctors
- * Projecting from FM training enrollment capacity
 - 32 per year (average of 2013-2017): 86 (99) years
 - 100 per year (historical high): 28 (32) years
 - 150 (30-35% of graduates as the UK): 18 (21) years
 - 225 (50% of graduates as Canada): 12 (14) years



Multidisciplinary Primary Care Team

For every family doctor (Patel M et al. Am J Manag Care 2013; 19: 509)

- **3.3 nurses/medical assistants**
- **1.4 clerical staff**
- **0.2 pharmacists**
- **0.5 social workers/ mental health providers &**
- **Other health professionals**



The future of primary care
Creating teams for tomorrow

Report by the Primary Care Workforce Commission



"With its highly skilled workforce, effective multi-disciplinary teams and well-developed IT systems, the NHS is in an unparalleled position to develop a modern primary care system that is truly world class."



Key Roles of Hospital Authority

- * Commitment to FM training posts & training
- * Enforcement of the family doctor led health service delivery system
- * Safety net to assure quality PC for all
- * Seamless care between 1^{ry} and 2^{ry} care
- * Innovation on multidisciplinary PC models and programmes
- * Benchmark on quality PC
- * Big data to support PC HHSR



Quality Primary Care for All in HK

