**RETURNING THE FOCUS TO THE GP**

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"Returning the focus to the GP" is one of the key ideas that the Minister for Health has asked the cluster chiefs to work towards. The GP has long been neglected and the time has come to address this.

Why is there a need to address the issue? The answer is that unless this is addressed, there will be choke points in the government healthcare facilities. Presently, the health care system results in the choking of patients in the public sector because of three factors: funding, infrastructure and perceived inadequacy of the GP.

**Infrastructure overutilises the hospital system**

The GPs in Singapore have been described as doctors who do "triage and tend to minor illnesses". Considering that sixty percent of our doctors are non-specialists, it can be seen that the GPs are severely under-utilized. People flock to hospital specialist out-patient clinics (SOC) perceiving that they get value for money. The hospital system is also allowing patients to do so instead of being referred back to their GPs when the level of care is within the competence of the GPs. The result is that the hospitals will become choke points as its doctors strive to look after a big load of patients that could have been better taken care of by the GPs.

**Perceived inadequacy of the GP**

A snippet from the Straits Times, 7 Feb 2000 tells us a lot about the perception reasons for the present state of affairs in the health care delivery system. The report "Self-referrals add to queues at hospitals" carried a side story of a patient, Mr Moorthy, who has mild diabetes. He was reported to have called the Singapore General Hospital without getting a referral from his GP. He asked for "the best" in the endocrinology department. He was reported to have said," I wanted to make sure I was in the hands of a good doctor. What a GP can do is limited… I have a mild form of diabetes that the GP did not give me any medication. With the specialist, I can be sure he will keep abreast of the latest developments in the endocrinology field." His fallacy is to perceive that his GP is useless and that specialists are required to deal with his mild diabetes.

**Funding has resulted in choke points**

Funding for ambulatory care by public subsidy is in favour of the Specialist Outpatient Clinics (SOCs). For many public servants and employees of government-link companies, visits to private practitioners, whether specialists or GPs are reimbursed at $10 per visit irrespective of the amount incurred while only a small percentage of the bill from SOCs need to be paid by the patients out of pocket. Therefore, for most chronic conditions, patients pay less out of pocket by visiting SOCs even though the total bill for such visit may be higher than that of the GPs for the same condition and medicine.

The polyclinics too have become choke points because of the funding structure. There, patients are subsidized by some 50% so that the polyclinics attract loads of patients because there is no means test. The doctors there are harassed as they fight to see numbers beyond their coping ability.

**The erosion**

And how do some GPs make sure that they can survive in the setting of patients going to Polyclinics? They have to charge rates comparable to polyclinic charges, which are heavily subsidized, and hope to earn enough by seeing patients on volume. They also do things that do not add to the needed care, such as facial peels. The former way of seeing patients forces the doctors to deal only with superficial problems with no time for more serious ones that they can actually attend to given more time on their hands. Of course, this reinforces the patient's notion that the GP is no good for anything except the very minor things. And they then decide that the GP's work is not worth very much.

The new service of facial peels serves a want and not a need. One wonders if patients desirous of such a service should be counselled rather than peeled. After-all, growing old and being wrinkled cannot escape the march of time, no matter how many layers of skin are peeled. One needs to face the eventual reality, and it may be better earlier than after many peels. Also with declining number of patients to see, GPs are more likely to be pressured to prescribe medicines that are not really indicated. What is worrying in the future is the necessity for more GPs to resort to more of such activities as the numbers of doctors leave the heat of overwork in public sector to partake in the shrinking pie of patient load in the private sector.

**The fallacy of numbers**

I remembered the Minister asking round the table if we have enough doctors in one of the meetings with him. My answer was different from the rest. I said we have too many but they are not properly deployed. There are many reasons to account for the under-utilisation of the GPs and also the urgent need to level them up in the service that they are able to provide.

Also the numbers of doctors that are really needed for Singapore may need to come under scrutiny again, notwithstanding the hasty decision by the Government to increase the numbers to be trained by 50 some two years ago. And what numbers are the second medical school going to churn out is also food for thought, unless it is aimed at training doctors for countries who have inadequate resources.

**What needs to be done?**

The three words, infrastructure, perceived inadequacy and funding need to be addressed if we are to be able to return the focus to the GP and in so doing, unchoke the hospitals and the polyclinics.

**Infrastructure reform**

Perhaps the most important point here is the extent that healthcare system is to be market driven. It is easy to develop services to serve market wants rather than needs. There will be a need to do this if the hospital and other healthcare organizations are seen as profit centers.

And the necessity to look at health needs as a nation may escape many in positions of power. To be truly cost-effective in the healthcare paradigm, the infrastructure must support services that will result in better health care at the cheapest price possible. Taken this way, the hospital must be

willing to give away or reduce those services that makes money but could be done more cheaply by the GP.

Health screening stands out as the best example. Why are the hospitals offering executive health screenings, which is a primary care activity, to the general population when the mission of hospitals is to provide cost effective secondary care? Has the bottom line become so important that our health institutions lose sight of their primary mission? The first thing the hospital needs to do is to divest those services that may be profitable but could be provided more cheaply by the GP and thereby give the focus back to them.

**Funding**

Funding is a big word and it ranges from the unwillingness of society as a whole and the Ministry to support the idea of paying the GP adequately for the work done by them. Why pay the GP $10 reimbursement for his work when the short consultation fee is calculated to be $20. And this shortchanging the GP is also done by companies. I was told by a group of company doctors, they cannot table a consultation fee recommended by the SMA. Some managed care companies too are also shortchanging their participating GPs. Of course, the shortchanged doctors try to claw money back by various means. They are not dumb. In other words, to return the focus to the GP to do good work, society must be willing to fund these frontline doctors adequately.

It would be interesting to get our health economists to calculate the amount of money saved by the patient, his family and society if we are to get our GPs to treat chronic diseases early and adequately enough to reduce and prevent complications. Today, every body is skimping to save this money that is paid to the GP and then pay the big money and suffering to the hospital at a later date. Maybe if people like Mr Moorthy in the Straits Times report on 7 February is willing to pay their GPs half the specialist fee he pays the endocrinology unit in SGH, he will be assured that he will get the time and care that he has not yet received.

Talk about funding for the GP to be trained and you will receive answers like “why can’t they pay for it themselves”. Yet, the Health Ministry has a sizeable budget for sending specialists overseas to be trained. Why? Because the training of specialists is seen as an investment for health care. The Ministry needs a paradigm shift in their perspective towards training of GPs. Perhaps, one-tenth of the training budget could be invested on the training of GPs to improve primary care in Singapore.

The funding structure of the Government polyclinic too needs to be reviewed. A simple means test can be introduced. Those who can afford are welcome but they should pay market rates. Those who cannot pay can register themselves for a subsidy. By the rest paying market rates for the consultation and medicine, the extra funding that is earned could be used by the polyclinic to pay for more doctors to be on the staff. This will reduce the numbers of patients to be seen by each doctor and allow these doctors who want to do good work to remain in the public sector to do so. The polyclinic is often woefully short of its complement of doctors.

The Government polyclinic can play an important interface role between the hospital and GP. It could be a place for provision of higher end GP services such as minor surgical procedures, second opinion, diet counselling and investigations. For the polyclinic to play this role, the hospital will need to divest some of its funding and resources to it such as seconding their specialists to work some sessions in the polyclinic to provide the interface care services. Again, such ideas are likely to end nowhere until hospital administrators see beyond the hospital as a profit center to the people served as the ultimate beneficiary.

With funding reform and infrastructure support of GPs, these doctors can then move away from earning by volume and concentrate on providing higher level health care and unchoke the bottlenecks in SOCs and Government Polyclinics.

**Perceived inadequacy**

Part of the perceived inadequacy of the GP is of course, true; at least in some. GPs in Singapore are a heterogeneous group, ranging from doctors with very little experience to those who have undergone training in Family Medicine. The difference in levels of training and experience has thus resulted in the general perception of inadequacy by patients and specialists. There is a need to explore the need for formalized training for doctors intending to practice Family Medicine. This through time will create a more homogeneous group of GPs who are all trained and have the ability and skills to provide a higher level of care.

In our current situation, how many GPs see the meaning of improving themselves? The whole system is so tilted against them that it penalizes those who want to be conscientious. Their patients will still label them as “useless” and make a bee-line for the specialist the moment something like diabetes is uttered as has indeed been recounted above.

Perhaps for a start the hospital could work with the GPs to level them up. I see departments in hospitals in both the clusters already making arrangements to train the GPs in their catchments to involve them as partners. This is a step in the right direction.

One more step that could be done by the hospital is to credential those GPs who are trained and willing to provide a higher level of care to their patients as preferred primary care partners. This applies also to the trained doctors in the Government Polyclinics. This will put the shared care idea into something meaningful and real. Thus, only doctors who have the requisite skills of anticoagulant therapy, for example, will be in the preferred list for patients requiring this type of care. The idea of preferred primary care partners can be extended further: for example, only those who are willing to be credentialed as chronic care providers and willing to subject themselves to self or external clinical audits are in the preferred list. In other words, the hospital doctor has control of who he sends his patient to, as well as to ensure that the patient’s perceived inadequacy is unfounded.
It is also important that society, the profession and the Ministry recognize in a visible way, that the present-day GPs are NOT homogeneous. We should recognise those who are trained, those who are willing to improve themselves and those who are able. A way of doing so is to pay these doctors equitably for caring for the more difficult problems. This is a sure way of shifting the focus back to the GPs. In a similar vein, the trained doctors in the Government Polyclinic should see more of the more difficult cases than their junior colleagues.

I understand the College of Family Physicians is intending to set up its register of College Certified Family Physicians for those who have the MMed (Family Medicine) qualification. It is also intending to set up the Dip in Family Medicine (DFM) to train GPs on a large scale of 100 - 150 per year. These too will qualify to be on the College Certified Family Physician register. For holders of the MMed (Family Medicine), the College has since 1998 instituted a pilot Fellowship programme to hone their knowledge and skills further.

**Conclusion**

We should take up the Minister’s idea and go for it. This is an invitation to the 1500 GPs in Singapore to progress beyond being triage officers and minor illnesses carers. There is also the hospital perspective that I would like to deal with in another President’s Forum. Could I invite viewpoints from our hospital colleagues?