ADVANCING ACADEMIC FAMILY MEDICINE IN NUHS AND BEYOND

INTERVIEW WITH PROF DORIS YOUNG

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Prof Doris Young (MBBS [Melb], MD [Melb], FRACGP) graduated from Faculty of Medicine, University of Melbourne, and completed family medicine (FM) training in Australia. Over the last 35 years, Doris has been involved extensively in educating and training medical students, registrars, GPs and other health professionals in adolescent medicine, general practice and primary care research. In the last ten years, she has also been actively building general practice/FM education and research capacity in Hong Kong and in China.

Doris has published widely in the area of general practice integration models with the wider healthcare system, and her research focuses on trialling innovative models of care in the primary care setting to improve health outcomes for people with chronic diseases in culturally and linguistically diverse and disadvantaged communities.

Doris moved to Singapore in January 2015 and in 2016 took up a part-time role as research advisor to National Healthcare Group Polyclinics. She joined National University of Singapore in January 2017 as a professor in the Division of Family Medicine. On 1 February 2018, she was appointed the inaugural Head of a new Department of Family Medicine at National University Health System (NUHS).

Can you share on the development of FM in other countries and "what works" and "what doesn't"?

What works?

From my experience, countries that have good health outcomes, good accessibility and good equity have strong primary care systems. This means that their patients' first port of call is the GP, who is properly remunerated to provide evidence-based care to the community. These countries invest money in primary care, and the community values their family doctor and trusts their GPs to provide value-added care. In addition, their FM academic fraternity is a strong discipline that works together to strategically deliver care that is well aligned and this may take quite a lot of time to develop.

The most cost-effective healthcare system is where the majority of care is delivered in the community that is co-ordinated by well-trained family doctors/GPs working with a multidisciplinary team, and where the primary care system is well integrated with secondary and tertiary hospital care.

What does not work?

This is when family doctors don't look after a family/population, providing only episodic care that is not well integrated with the rest of the healthcare system. This encourages "doctor-shopping" behaviour, resulting in fragmented care. FM development also doesn't work in countries where FM is not perceived as a specialty in its own right and not valued by their community, including their government.

What is the funding model of primary care in Australia?

a. Paying GPs to manage patients

Currently, most primary care services like GP visits are funded through Medicare. GPs receive most of their remuneration through fee-for-service (FFS) payments, which is where the GP bills an amount for the provision of an individual service. Around 82% of GP services are bulk billed, meaning the GP directly bills Medicare for the patient visit rather than bill the patient.

But not all GP services are paid for in this way. A growing number involve "blended payments", where as well as FFS, the GP receives an incentive payment as a "reward" for providing an improved level of service. Practice incentive payments (PIP) are currently being paid for a wide range of enhanced services such as the provision of after-hours care and teaching medical students to manage patients with chronic conditions such as asthma or diabetes.

FFS and incentive payments make up the bulk of GP remuneration in Australia. But the rise of chronic diseases like diabetes has led to calls to reform this blended payment system in order to support more multidisciplinary team care, with alternative models such as capitation.[1]

b. Paying GPs to train students

It took a ten-year journey from an honorary system of "begging GPs to teach" to the current system whereby GPs receive remuneration for teaching students. It is never about money-making but to compensate them for time and income lost. In return, these designated "teaching-GP clinics" have to undergo training and meet accreditation guidelines which raise the status of the GP clinic as a quality practice involved in student teaching.

Thus, "teaching money" must follow the "teachers and the learners" and now in Australia, there are many very passionate GP teachers who are good role models and provide competent training for our residents and students.

How does the College of Family Physicians play a role to advance FM?

We need to see the "end product" then work backwards. The end product is to have highly regarded GPs who are respected by the community and recognised as specialists in their own right, who receive proper remuneration and have good work-life balance. The respect from the public is very important, and every person or family should have a family doctor. In Australia, 90% of the people have a GP. In the UK, it is 100%.[2] Everyone should have a good GP who looks after them and their family members.

In order to produce high-quality GPs/family practitioners, we need to expose the students early to FM, provide good role models and mentors, and craft an interesting curriculum which will make FM residency attractive. We need every player to play their part to encourage more quality residents to choose FM as a specialty. The College of Family Physicians has a big role to raise the status and standards of FM as a specialist discipline, make it financially attractive and have a strong voice in the relevant healthcare decision-making bodies to promote the value of having a robust primary care system in Singapore.

Is there any fundamental similarity and difference between FM and specialist training and education?

What is similar?

FM is a specialty in its own right, just like cardiology or neurology. We also have our own core curriculum and skill sets that require training to reach competencies. Continuing medical education (CME) is also crucial to maintain knowledge and skills, and adopt evidence-based practices to improve health outcomes.

What is different?

Breadth, and not depth, of scope of practice is the focus of FM. In order to acquire skill sets in various disciplines across multiple settings (eg, GP clinics, polyclinics, home care), FM doctors need to receive relevant training for their practice needs. The core curriculum cannot be too diffused, but has to set the standard of what is required to train family doctors to provide safe and unsupervised medical practice in the community.

Can you share your experiences in teaching FM to undergraduates and postgraduates?

From my experience working at University of Melbourne for the past 30 years teaching general practice to medical students and residents, we need to expose undergraduates to general practice early and also throughout the medical course so that they have an understanding of the role of GPs in the healthcare system. We need a defined curriculum to develop knowledge, skills and attitudes unique to general practice, and these must then continue into residency training.

How can FM in NUHS develop as an academic clinical programme?

It is very exciting for NUHS to have a stand-alone department of FM, whose mission is to raise the academic standing of FM. To do this well, we need to have more FM curriculum time throughout the five years of the course and recruit passionate teachers to deliver education using innovative technologies. We will also need to integrate undergraduates with postgraduate residency training and develop CME so that everything we do has an evidence base to them.

The academic standing of FM is also measured by its success in research. I plan to set up a primary care research unit and bring together collaborators to develop research themes and answer research questions that arise from primary care perspectives. I hope to instil a research culture among the staff, medical students, residents and GPs, and provide training for them to engage in research. Finally, in order to move towards delivering world-class research, I want to link up our GP researchers with FM/GP colleagues internationally as well as expose our younger doctors to other primary care research experts.

What roles can FM play in a specialist-centric restructured hospital?

In Singapore, some FM doctors already provide high-quality clinical services in the areas of aged care and rehabilitation, especially in community hospitals. However, I see the added value of FM doctors in hospitals to focus on providing ambulatory care and establish a unique role in facilitating transitional and home care from hospital to the community. Ultimately, FM doctors can also help to navigate care back to the patient's GP.

We are now at an exciting time for the development of FM in Singapore. Our Minister for Health, Mr Gan Kim Yong, explained that in the Healthcare 2020 Master Plan, we need to: (i) move beyond hospital to the community; (ii) move beyond quality to value; and (iii) move beyond healthcare to health. These three moves are critical in preparing us to meet our long-term healthcare needs in a sustainable manner. What do you think of these Singapore initiatives?

I think the move is timely, in particular the move from hospital care to the community.

Hospital to community

The most important criteria for the successful implementation is to select the right type of patients that can be appropriately shifted to the community. Many people, after receiving acute and subacute care in hospitals and are now stable, can go back to the community to receive care. These can be shared medical care or social and community support care.

Quality to value

When a government invests so much money into the healthcare system, they want to know whether there is "value for money". I think this is important to quantify to avoid too much spending to get "quality" and yet not get the value of the dollars spent. Measuring this is important for an effective and affordable healthcare system.

Healthcare to health

Finally, this is obvious that we should not treat the sick too late or when they develop multiple advanced complications. We need to emphasise the importance of health promotion, self-management and staying healthy. This shifts the mindset of the community to be more self-reliant and responsible to maintain their own health rather than merely depend on doctors and nurses to fix their problems. This revamped healthcare, with a broad base in the community, will then truly be good value for money! ◆

References

1. Sivey, P. New funding models are a long-term alternative to Medicare co-payments. The Conversation. Available at: https://goo.gl/oofPBg.

2. The First Full Professor of Family Medicine Has Big Plans for Teaching and Research at NUS. Available at: https://goo.gl/eW5CwU.