# A "GP" for the COMMUNITY HOSPITAL

Text by Dr Wong Tien Hua

Singapore's population is ageing rapidly, with the number of people aged 65 years and older set to double to 900,000 by 2030. There will be a tremendous strain on healthcare services, stretching the capacity of tertiary hospitals and specialist centres. The Ministry of Health (MOH) has been planning to boost primary care and keep healthcare closer to the community. In their 2017 Committee of Supply Budget Statement, MOH listed three key shifts for a future-ready healthcare system, one of which was moving "beyond hospital to community". They stated that "there is a need to shift our healthcare delivery model from one built around the hospital to one that can meet the needs of more Singaporeans closer to their homes, at primary and community care settings".

## Primary care's changing landscape

Primary care in Singapore is changing and moving away from the provision of healthcare services at traditional point-of-care locations, such as the polyclinics in the public sector and GP clinics in the private sector.

A spectrum of healthcare services now exists in the spaces among large tertiary hospitals, primary care facilities and the community. *Intermediate and long term care* (ILTC) services are available for patients who need care beyond hospital stays, as well as for frail and at-risk seniors in the community who need assistance with daily activities. Such ILTC services include home care, day care centres, community hospitals, nursing homes and hospices.

Patients who are admitted to acute hospitals can be warded in an intermediary facility, such as a community hospital, to recuperate before being discharged. Elderly patients with chronic medical conditions, such as dementia or stroke, who need daily nursing care as they do not have families or caregivers, can be looked after in nursing homes over the long term. Terminally ill patients who require palliative care can be admitted to the hospices.

## Integrated care, transitional care

It can be seen that healthcare delivery can no longer be defined by the primary care/tertiary care model that we have grown accustomed to. Patients seek and utilise healthcare services based on their medical condition, stage of the illness, social needs and the accessibility of support services in the community.

The ideal care for elderly patients would be delivered by family members within their homes, with the right support from visiting healthcare services. This will avoid the need for expensive hospitalisation and the risk of hospital-acquired infections. Unfortunately, this cannot be the case for everyone, and patients today find themselves being shifted around the various facilities and services depending on their situation and requirements. Because patients are *transitioning* between different facilities – from one healthcare provider to another – they become vulnerable to problems with care coordination, such as lapses in communication when one medical team hands over the case to another.

*Integrated care* is a much talked about concept to streamline care delivery, and is used to address the problem of fragmented care. Integrated care could mean vertical integration where patients experience seamless health provision up and down the healthcare continuum. It could also mean integration across different sectors such as allied health, social services and health promotion.

*Transitional care* specifically addresses the coordination and continuity of care as patients are transferred from one healthcare facility to another, or even between different care teams within the same location.

## New healthcare settings

Community hospitals have been receiving much attention in the past few years. They started in the 1990s as facilities for step-down care to help lower healthcare costs, and were run by voluntary welfare organisations, with some funded by charities or religious groups along with funding assistance from the Government. Such community hospitals include St Luke's Hospital, Bright Vision Hospital, Ren Ci Hospital and Ang Mo Kio - Thye Hua Kwan Hospital, just to name a few.

In line with the concept of care integration and better transitional care, we are now witnessing the development of community hospitals co-located with general hospitals – a logical choice especially when community hospitals are part of the planning in the design of these new general hospitals. Examples include the Jurong Community Hospital (400 beds) integrated with Ng Teng Fong General Hospital, which started operations in 2015; Sengkang Community Hospital (400 beds) integrated with Sengkang General Hospital, slated to open in 2018; and Outram Community Hospital (550 beds) to be located within the Singapore General Hospital campus by 2020.

With the addition of bed capacity in community hospitals, it is evident that they will in time reshape the system of patient care delivery in Singapore. Patients will find themselves spending less time in acute hospitals after a procedure, or after an acute event such as a stroke, and will be transferred very early to a community hospital for recovery and rehabilitation.

## The generalist physician

Since community hospitals are a relatively new entity in the healthcare scene, the role of the physician in community hospitals needs to be defined. There is no "specialty in community medicine", so to speak, and the requirements of a community hospital involve elements of rehabilitation medicine, geriatric medicine, palliative medicine, internal medicine and psychiatry. However there are also areas such as care integration, working with multidisciplinary teams, risk assessment and prevention, care planning and communication, and comprehensive care that require training and clinical exposure.[1]

It seems that the needs of community hospitals are best served by doctors who have a broad base of knowledge to provide comprehensive care, instead of being focused on one particular specialty, akin to a "generalist physician".

## Role of the family physician

Minister of Health Mr Gan Kim Yong said in his interview with the *Straits Times*[2] that he plans to encourage more primary care physicians to be trained as family physicians. At the end of 2015, there were 1,659 family physicians out of more than 8,200 non-specialists, the majority of whom were GPs. In his speech at the National University Health System Division of Family Medicine's 30th anniversary dinner, Permanent Secretary Mr Chan Heng Kee said that he envisions doubling of these 1,700 family physicians to 3,500 over the next ten years. Most of these family physicians would be serving in primary care such as in the polyclinics and private GP clinics, but they would also have a choice to work in the community hospital as a "GP".

Whether trained family physicians are best placed to look after patients in community hospitals is a question worth exploring. Our current system of family medicine residency and training is a very rigorous programme that prepares doctors for careers as family physicians. Family medicine is a specific field and has characteristics such as being the first point of contact in the healthcare system, dealing with all health problems regardless of age, looking after the patient longitudinally over an extended period of time and managing undifferentiated illnesses.[3] These skills will not be applicable in a hospital environment where recuperating patients typically stay for three to four weeks. Moreover, the term "family physician" does not evoke an image of a doctor practising in a hospital environment, but this is only a matter of awkward terminology.

There are, of course, areas in family medicine training that enable the family physician to be well positioned as the "generalist physician", such as having the ability to take account of the patient's illness in the context of the patient's life circumstances, working in multidisciplinary teams and making efficient use of resources, having good communication skills, and being able to bridge the gap between the hospital and the community with their intimate knowledge of the services available, among others.

Community hospitals will ultimately be staffed by doctors who are interested in practising in a hospital environment, and like to be involved in transitional care, whether they come from internists, geriatrics or family medicine backgrounds. The requirements of such a role in transitional care need to be clearly defined and training modules for competency in this area can be introduced in the various training programmes, to prepare doctors for a unique role in the healthcare delivery system. ◆


***References***

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