DOCTORS' HOPES FOR Healthier SG

The Healthier SG initiative, announced on 9 March 2022, is an upcoming major reform of Singapore's healthcare system. It seeks to shift the country's medical focus from simply treating illnesses to ensuring overall health and general well-being. In this Feature, we hear from doctors of various healthcare sectors what they hope Healthier SG can achieve for their respective specialties and patients.

Text by Dr Alex Wong

Mrs Y was the first patient to ever walk through the doors of my practice. She was a cheerful lady who lived in a single bedroom HDB above my clinic. Despite her personal struggles, she remained a faithful wife, a loving mother to a troubled son and a deeply sensitive soul with a sunny outlook on life. It might sound like the start of a romance scam to say this, but medically speaking, I already knew her before I had met her.

Like a thousand other patients I had met in my career as a physician, here was yet another set of intractable medical issues beyond what I could resolve with my limited resources. In her late fifties with a history of heart disease, dyslipidemia and a touch of renal impairment, she walked awkwardly and with a slight limp. The limp was a result of her worn-out knees, oedematous shins and a body mass index that was double digits away from the wrong side of normal. The help she needed was far beyond that of what the Community Health Assist Scheme (CHAS) and outpatient MediSave could provide. I shook my head and sighed as she exited my consultation room.

It hurt, in that all too familiar, hollow sort of way.

Dr Zubin Damania, of "ZDoggMD" Internet fame, once accurately described this feeling as "moral injury". *The Lancet* defines moral injury as "understood to be the strong cognitive and emotional response that can occur following events that violate a person's moral or ethical code."[1] When a physician cannot practise to the standard of care they feel is owed to their patients, they undergo moral injury. Having been through literally all parts of the healthcare system, I can testify that no specialty sustains more moral injury in this manner than family practice. Despite being the "lifestyle" specialty, family medicine consistently ranks on numerous ranking scales as one of the top specialties for "burnout".[2] In the UK, family practice burnout has reached unprecedented proportions, with GP numbers falling year on year and 69% of Britons saying that they lack confidence that they can get an appointment with a GP at a time when they want one.[3]

Where are we now?

GP practice in Singapore unfortunately presents even more unfavourably. With professional consultation fees going as low as $6 to $10 per patient, a fraction of the fee in the UK, GPs are typically seeing triple or quadruple the load that UK GPs see to make ends meet. A recent local news article featured a telemedicine administrator suggesting that it was "very possible" to do 100 $10 consultations a day – 4.8 minutes a patient. No wonder patients in Singapore complain that their GPs "don't care".

A UK recruiter I approached to help me recruit GPs for Singapore once confessed that, despite the dire situation in the UK, he could not see himself successfully recruiting for Singapore as the workload and pay "seemed inconsistent" with what was attractive. Dismal payouts from insurance and third-party administrators abound. Proffered remuneration rates for

procedures are ten times lower than the lower bound of Ministry of Health (MOH) specialist fee benchmarks, so low as to be untenable. GPs would rather refer out than do the procedures themselves, which results in a slow deskilling of GPs. Healthcare costs, which both MOH and private insurers are concerned about, continue to escalate as specialists end up doing procedures in an OT that GPs could do equally well in their office.

The trope of the under-trained, uncaring GP is literally just that: a trope. A chronically underfunded primary care practice can hardly be expected to do procedures or even spend significant amounts of time counselling patients. It becomes little more than a referral centre for specialists.

How long do we continue like this before we start facing issues with severe primary care provider burnout, the same way the UK has?

Where do we go from here?

Where indeed does the role of Healthier SG (HSG) feed into this?

The issues around our chronically underfunded primary care are legion. CHAS expenditure in 2017 was $154 million,[4] and the anticipated HSG primary care expenditure in 2022 will be $400 million against a backdrop of an $11 billion healthcare expenditure.[5] HSG is a welcome step in the right direction, and hopefully only the first. If private primary care represents roughly 80% of acute patients and half of all chronic patients seen, then it should not receive less than 10% of healthcare funding.

Obviously, nobody would love to see primary care work well in Singapore more than our primary care practitioners. Their hope, of course, is that HSG represents an opportunity to reboot the patient-GP relationship in Singapore. MOH's push to get one patient to cleave to one family physician and to initiate healthcare plans via preventive health counselling is heartening.

We hope that it results in the appropriate subvention.

We hope to teach patients how to exercise, conduct simple physiotherapy, diet and calorie count. We hope to be able to provide simple procedures at an affordable rate and bring point-of-care testing, ultrasonography and dermoscopy to primary care the way our British colleagues in the National Health Service have. We hope to do ever more for our patients, but from whence comes forth the funding?

Many colleagues have raised concerns with regard to the sufficiency of HSG subvention. The points they make bear merit. A GP practice is after all very much a solo commercial entity. To remain viable and to continue to service its community, it needs to pay the bills.

Costs escalate every year. The bidding on rentals of new HDB clinics now regularly exceeds that of specialist practices in Mount Elizabeth Hospital. Our clinic assistants and drugs cost us similarly, yet consultation, medication and procedural fees are a fraction of what specialists charge. Small wonder that older GPs are openly discussing early retirement in the face of the current primary care landscape.

At a recent HSG town hall meeting of more than 500 primary care practitioners, Minister for Health Mr Ong Ye Kung assured us that he has heard our feedback. "If it doesn't work for you, it doesn't work for us" was the promise. He then elaborated on a restructuring of the healthcare plan and a relook at the numbers.

It was reassuring to hear that our Minister for Health is actively listening to GPs. We hope that this is the beginning of a fresh public-private conversation on healthcare, because the truth is that if it doesn't work for us, it doesn't work for our patients either.

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Dr Wong is a partner in a small group practice and serves in the SingHealth Delivering On Target Primary Care Network as an executive committee member. In his not-so-spare time, he attempts to be a loving husband to his wife and father to his three daughters. He suspects that he sometimes succeeds but will likely have to wait another two decades before he's entirely sure.

With its holistic home care services provided by trained care aides, nurses and doctors, Jaga-Me hopes to bring quality care to home-bound patients

Text and photo by Dr Cindy Yeo

I am a family physician caring for patients in their homes and in nursing homes. Many of my patients are frail with many comorbidities. Would HSG be applicable to them even when they are already quite advanced in their illness trajectories? Are we able to help them become "healthier"?

Let us go back to the fundamentals of HSG. MOH has stated that they will take a life-course approach to drive population health.[1] Efforts will be redoubled to promote overall healthier living, while taking targeted health measures for specific segments of society. The five key features of the programme are:

- Mobilisation of Singapore's network of family physicians;
- Patient care plans;
- Community partnership to support better health;
- National HSG enrolment programme; and
- Support structures and policies.

Though the initiative's name suggests that it is primarily a move towards a "healthier" Singapore, there are also efforts to improve care outreach to the population. Many of my patients require assistance in their daily living and though they suffer from many comorbidities, it would still be beneficial to delay further decline and prevent complications that might arise from their chronic diseases. We should also not forget the caregivers caring for them. Without them, who would look after these vulnerable individuals? The following are my hopes for how HSG can help these patients and their caregivers.

Improved healthcare access for patients with limited mobility

In the past few years, we have seen many home-based medical services and telemedicine systems set up. We have also seen how initiatives such as home vaccinations and home recovery programmes have helped those with limited mobility live well during the COVID-19 pandemic.[2]

With Singapore's rapidly ageing population, home-based medical services will be needed to support care in the community. This is especially so as hospital care is more expensive and may not be the best place of treatment due to the increasing prevalence of chronic and progressive conditions.

Financial incentives are important to direct care-seeking behaviour. Right now, schemes such as CHAS and MediSave are still not claimable for home care services. Non-COVID-19 vaccinations are also not subsidised for patients who cannot travel out and need to be vaccinated at home.

We will need to engage and train our doctors and nurses in community care. How can we mobilise our healthcare workers out of the clinic and into the community? Financial incentives can be one such perk. We need to also ensure our healthcare workers' safety and competency of care in the community.

In order to ensure good continuity of care, patients' data flow between primary care, community care and hospitals must be maintained. Right now, private GPs are able to view hospital records and medications prescribed by polyclinics and hospitals with National Electronic Health Record (NEHR) access, but there are challenges with the integration of medical records across different systems. I look forward to the day when private clinics and home care services are able to seamlessly access and input our own data (eg, diagnoses, laboratory results and medications prescribed) into the NEHR regardless of cluster or clinic, so that if patients get admitted, hospital staff are able to view the changes and updates without any difficulties.

Promoting health screenings for those already frail may not be an ideal approach. However, for diabetics and those chairbound, foot screenings and eye checks would still be helpful to preserve their quality of life (QOL). Bringing them out of the house may not be easy, so home visits for such health screenings might be an option. These screenings could be incorporated with home nursing visits via cross-training of our community nurses. Portable eye-scanning machines would be useful for detecting retinopathy or abnormal eye pressure during such home visits.

I look forward as well to allied health services becoming more accessible and affordable for those housebound or residing in nursing homes. These services, such as having a speech therapist assess one's swallowing or having a dietician assess one's regular nutritional intake and provide advice, do help these patients to be healthier with better QOL.

Screening for frailty – especially identifying the pre-frail group early – should be considered for one of the HSG free health screening tests for the older population or for those already with multiple comorbidities. Primary care doctors and multidisciplinary teams can begin interventions for these individuals in the community by providing nutritional advice and improving patients' exercise participation, which have been shown to be useful to slow down the progression of frailty.[3]

Increased support for caregivers

HSG could help to provide additional support and resources for caregivers who are taking care of patients at home and in nursing homes. This can include educational resources, financial support and access to respite care services to help alleviate caregiver stress and burnout. Respite care services, such as hiring home care aides on an ad hoc basis, are available, though not many take them up due to cost issues.

Mental health support for patients and caregivers

HSG could also place stronger emphasis on the importance of mental health and the well-being for patients at home and in nursing homes. This could include initiatives to increase their access to mental health resources and support services, as well as programmes to promote social engagement and reduce social isolation.

Nursing homes during the pandemic have mostly been in "lockdown" mode. I have witnessed many residents deteriorating much faster than expected in the past three years. A recent literature review also revealed that, caught by the social isolation, many nursing home residents' conditions have deteriorated with weight loss, mood changes and even cognitive decline.[4]

Encouraging patients' empowerment

HSG could empower patients to take an active role in their own health and well-being. This could include providing patients with the tools and resources they need to make informed decisions about their health. Though they may be housebound, many patients still have intact cognition and are able to make decisions. Planning for the present and future could be made more convenient for them. Advance Care Planning and Lasting Power of Attorney are some legal documents that patients could be encouraged to prepare for in advance. Such planning ahead helps families cope with challenges better, as these problems will have been anticipated prior and the patients' wishes would have been heard and recorded.[5]

Overall, my aspirations for HSG would be to create a healthcare system that is patient-centred and family-oriented, with its focus on the health and well-being of all Singaporeans, including those who are receiving care at home and in nursing homes.

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Text by Dr Victoria Wong

When I first heard about HSG in the early part of 2022, I was excited as its goal is not only a transformative shift from reactive disease treatment to proactively preventing them, but also a step towards consistent patient care delivery across the diverse primary care landscape. My hopes for this are early access to palliative care, fulfilment of care preferences and a dignified passing for all Singaporeans. This aspiration may be possible, as detailed in the White Paper for HSG. It elaborates that HSG will capitalise on our extensive network of family doctors and provide for every Singaporean a family doctor whom they can trust and discuss health goals with.

Role of palliative care in the HSG landscape

As a palliative physician, I envisage the future of palliative care dovetailing neatly into this HSG landscape enabling it to be accessible to all Singaporeans who may need it.

The vision of HSG is to empower the individual to take charge of their health through behavioural and lifestyle changes. This transformation of the healthcare system and improving QOL through preventive care and strong patient-doctor relationships is supported by the community network of family doctors and the three healthcare clusters.[1]

The goal of palliative care, as defined by the World Health Organization (WHO), is to improve the QOL of patients (both adults and children) and their families who are faced with problems associated with life-threatening illnesses. It aims to do this by preventing and providing relief from suffering through early identification and the accurate assessment and treatment of pain and other associated problems (physical, psychosocial or spiritual).[2] At first glance, HSG and palliative care appear to be at opposite ends of the spectrum of life. HSG is focused on preventive care and living healthily, whereas palliative care traditionally hugs the end-of-life portion.

However, palliative care does not start only at the end-of-life phase. It starts from the point of diagnosis of a serious illness, with increasing involvement over the course of the disease trajectory. Early access can help improve QOL and mood, increase survival and also a reduction in 30-day hospital re-admissions for patients under home hospice care.[3,4,5]

Palliative care also continues after the patient passes away, as family and loved ones will still need to be supported in their bereavement. Thus, both HSG and palliative care share a common goal of achieving the optimum QOL for the patients and their families.

Palliative care and the family doctor

Singapore's population is ageing rapidly, and it is estimated that by 2030, one in five residents will be aged 65 years or more.[6] With the ageing population, the prevalence of chronic diseases is expected to increase. Majority of deaths in Singapore are due to complications of chronic serious illness (of which 26.4% from cancer and 70.3% from non-cancers or resultant complications in 2021).[7,8]

The family doctor plays a crucial role in managing patients with chronic diseases from beginning to end. Due to the trust and rapport from the long-term relationship between patients and their family doctors, the latter are well positioned to holistically support these patients to live and leave well. The doctors can initiate serious illness conversations and advance care plans in accordance with the individual's life goals that they hope to achieve. The doctor will also be able to tap on the expertise of palliative care services in the community for support as needed.[9]

Enabling family doctors

For family doctors to integrate the principles of palliative care into their practice when they encounter patients with serious illnesses, they need foundational skills and knowledge, such as basic pain and symptom assessment and management, the ability to conduct serious illness conversations and knowledge on how and when to seek support from established palliative care services. There are many educational opportunities for doctors, including but not limited to the Serious Illness Conversations Workshop by the Lien Centre for Palliative Care (LCPC), Postgraduate Course in Palliative Medicine for Doctors jointly hosted by the LCPC and Singapore Hospice Council, and the Graduate Diploma in Palliative Medicine from NUS Yong Loo Lin School of Medicine.

As more family doctors become equipped with general palliative care skills and knowledge, the overall accessibility to palliative care increases. Beyond training, family doctors also require access to relevant clinical information from hospitals and community palliative care services to be partners in the care of patients with serious illness. Family doctors together with their regional healthcare clusters can share information to address the individual's needs through the NEHR.

The costs of palliative care

Lastly, the elephant in the room is funding. The reimbursement to the family doctors should be commensurate with the responsibilities, which include additional assessments and longer consultation times. It is important that HSG funding standards recognise this additional work, which can result in cost savings to the healthcare ecosystem by reducing unnecessary interventions and hospital admissions.[5,10]

In the years to come, what I aspire for all residents in Singapore to achieve through HSG is to take control of living and dying well. Idealistic as this may sound, it should be embraced with optimism to bring this closer to reality.

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The HSG initiative is the beginning of Singapore's move to a Population Health model. Ten years down the road, how will historians write the story of HSG? On a long enough time horizon, what about HSG will eventually stand out as being important and memorable?

Healthier SG is for everybody

This shift means that health is for all, not just health for most. It is a fundamental truth that our health system is currently optimised for healthcare users, who are only a subset of the people who need healthcare services. This warrants a repeat for emphasis – not all people who need healthcare services use healthcare services. HSG gives our healthcare service providers, our community care partners and social service organisations the ownership and mandate to actively reach out to these underserved populations who need healthcare but do not use healthcare services for various reasons. HSG is structurally designed to be able to address and resolve this issue, through the framework of health ownership and resident ownership, and a health ecosystem of relationships. HSG is thus poised to protect those who would otherwise fall through the gaps of our health system.

Healthier SG must also be Happier SG

"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel." – Maya Angelou

HSG must make people feel good. We cannot have a healthier, but sadder Singapore. We must be ambitious and ensure that HSG is also Happier SG. If the perception is that becoming healthier means a lot of sacrifice, it will create a lot of resentment, leading to eventual pushback and citizens possibly giving up on their health. I earned my stripes in behavioural change on the topic of smoking cessation, where I saw that people who resented having to give up smoking were often angry and would inevitably relapse. Successful quitters are almost always happy – and they all found their own reasons to be happy. In the same way, HSG can only work and be sustainable in the long run if it is also Happier SG. At the national level, this could mean running HSG more like a movement rather than a programme.

Healthier SG must move people into a positive health state

The WHO defines health as not merely the absence of disease or infirmity, but as a state of complete physical, mental and social well-being. In our current healthcare model where we wait for the patient to fall sick, then attempt to treat and nurse the patient back to health, we are merely a repair shop. HSG may find success by helping people to perceive good health as a positive health state. This can move society to justify and encourage personal, communal and societal investments and actions to bring health from a start state of zero to a positive value.

In this regard, HSG can be a game changer that reshapes how we think about health, how we talk about health, how we invest in health and how people live their lives. When people are in a positive health state, they are more resilient to negative health events, can bounce back to health more quickly and stay healthier for longer. ◆

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> *"If we see good health as a positive health state, then we move from a -1 to a +1 model – a model that justifies and encourages investments and actions to bring health from a start state of zero to a positive value."*