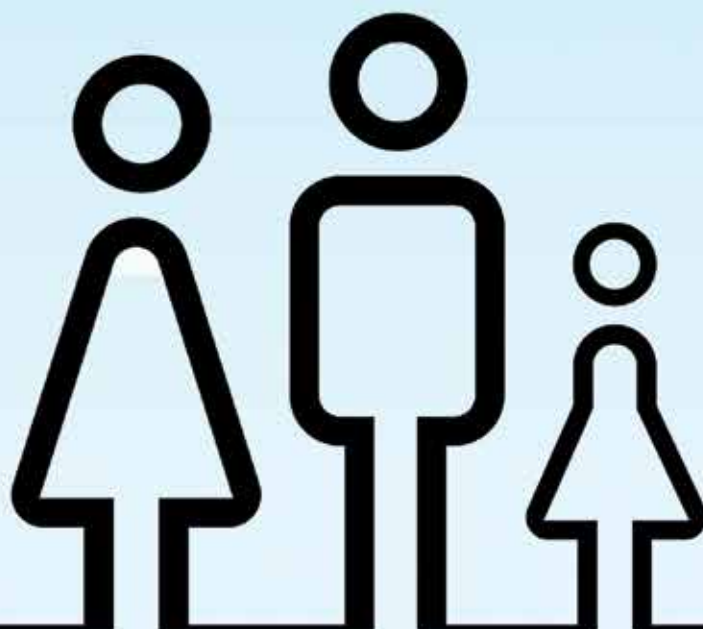




Renaissance of Primary Care and Family Medicine in Singapore

By A/Prof Chin Jing Jih



Medical specialisation: boon or bane?

These days, many patients grumble that the healthcare system is too complicated and difficult for them to navigate. Services, especially medical specialties, are so narrowly defined in what they do (and what they don't) that a symptom or problem deemed outside their function or expertise will almost always result in a referral to another specialty or service. Usually, this means another appointment on another day. This is a familiar experience among patients with multiple diseases and medical problems, as they tend to be given a myriad of appointments to consult different specialists, to undergo numerous investigations at separate departments, and to see various allied health professionals and therapists, not forgetting the assorted medications they have to take many times each day. Some, whose illnesses present with complex or atypical clinical features, embark on a perplexing journey of moving from one clinical specialty or subspecialty to another, before they eventually hit the appropriate specialty service or specialist that is able to offer them definitive treatment.

In general, for many patients, particularly those who are older and less educated, the healthcare experience tends to be one filled with frustration, anxiety and disorientation. They yearn for a resourceful and accessible doctor who has a bird's eye view of their various conditions and medical appointments, who can coordinate their care by providing liaison and timely access to the appropriate services, and manage any duplication or conflict in treatments. This doctor will plan the overall management of the patient, including preventive care, and will be a partner and advisor in making treatment decisions. Interestingly, such a doctor is not a novel or futuristic concept, but already exists today, and is better known as the family physician or GP.

To be fair, medical specialisation is not intended to create inconvenience and confusion for patients. On the contrary, it is the pride of modern Medicine, and allows specialists to be highly equipped with knowledge and skills in specific areas, thereby becoming more adroit at conquering many difficult medical challenges that were once regarded as incurable or immitigable. Singapore's heavy investments in specialised tertiary Medicine in the 1980s and 1990s have paid off well, as we have achieved excellence in our standard of medical care, serving both our citizens, as well as patients from the surrounding regions.

Developing an effective and integrated primary care system

In the past, when Singapore's population was predominantly young, we were able to meet most of our healthcare needs with a good public healthcare system and a highly hospital-centric tertiary care system. But when our population started to age rapidly in the last ten years, the landscape began to change. While still functioning,

the healthcare system started to come under immense pressure as the highly specialised tertiary services have been unable to meet the multi-faceted needs of patients who are older, more dependent functionally, and burdened with a great number of chronic diseases affecting more than one organ system. And when medical specialisation is not matched by a proportionate development in broad-based general Medicine, particularly at the primary care level, the imbalance became more overt, like an unstable gait caused by a pair of asymmetrically developed lower limbs. In fact, it has become clearer that the greater the degree of medical specialisation, the greater the need for an effective and integrated primary care system.

The problem, however, does not lie with medical specialisation limiting the expertise of the doctors to particular diseases and organ systems that they are best trained to treat and heal. Instead, the crux of the issue is in achieving the right balance between doctors who specialise in depth (based on organ systems or technology) with those who specialise in breadth. Rapid growth in tertiary care without a proportionate investment in primary and preventive care can potentially result in a lopsided system that is ultra-expensive. Such a system also has a tendency to confront and deal with potentially reversible and controllable chronic conditions only when they deteriorate beyond the capabilities of primary care and end up as catastrophic admissions into acute hospitals. Costs aside, this is suboptimal Medicine that does not benefit both patients and the profession. As we work hard to enhance quality, increase access and improve affordability in our healthcare system, fortifying primary and preventive care has become a key strategy. Policymakers are increasingly willing to commit resources to primary care with the aim of achieving not only better care for patients, but also in greater value for the resources invested in healthcare.

But efforts will have to go beyond merely increasing the numbers of GPs alone, for we are certainly not short of well-trained GPs. A game-changing approach will have to include a fundamental adjustment in the design and delivery of primary care. Primary care practitioners need to be plugged into the collaborative network hosted by the relevant Regional Healthcare System. The model of care needs to be patient-centric, in order to yield quality and cost outcomes that patients seek. While we should not copy wholesale models of care advocated in other countries, the *patient-centred primary care* advocated in the US is particularly enlightening. Its seven metrics – 1) superb access to care, 2) patient engagement, 3) clinical information systems, 4) care coordination, 5) integrated and comprehensive care, 6) ongoing, routine patient feedback, and 7) publicly available information about practices – are all useful benchmarks to develop a new system of care that is truly patient-centric and value-adding.

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Putting all stakeholders on the same page

One common predicament that has plagued many nations is the separate accountability of the primary and tertiary healthcare systems. The failure to achieve clinical targets or outcomes in one system is often conveniently blamed on the other. Such a defensive blame culture has to be addressed by designing a structure of accountability where both sectors are held equally responsible for all clinical and operational outcomes. This would be more likely to motivate both primary and tertiary care to collaborate closely as one unit, so that the only common goal is to achieve the best possible outcomes for patients. To achieve sustainability, this system has to be supported by an aligned healthcare financing model that puts all stakeholders' performance into one combined responsibility.

Such a philosophy and approach is best epitomised by New Zealand's Canterbury District Health Board (DHB), a health system rated as one of the best performing in the world by independent UK charity The King's Fund, for their praiseworthy work in integrating health and social care. The Canterbury DHB advocates a healthcare alliance model that strives for “high trust, low bureaucracy”, runs on “one health system, one budget”, believes in “best for patient, best for system”, and most importantly, has a system of joint accountability where “everyone wins, or everyone loses” – some very understated but spot-on principles indeed.

Undergraduate and postgraduate Family Medicine education and training will have to be redesigned to adequately prepare doctors for this change. The programmes need to have a balanced emphasis and exposure to both hospital and community Medicine. Students and trainees will have to be familiar with the local health and social care services landscape, and how these services are integrated to form a network of care. They need to have a wide breadth of clinical exposure and be comfortable with team-based care in a multidisciplinary setting. Overall, this will involve a certain degree of shift in the emphasis of the curriculum from the hospital to the community.

Patients will need to adjust as well. They should move away from their fascination with high-tech equipment found only in hospitals, and learn to value continuity over

convenience and to respect broad-based care as much as they do specialist care. They should learn to appreciate the work of their family physicians and be willing to pay First World consultation fees after receiving First World primary care services. They need to nurture relationships based on trust and collaboration with their primary care doctors, making the latter their first port of call whenever they have symptoms or problems.

Dr G Gayle Stephens, a central figure who played a key role in the emergence and evolution of Family Medicine as a specialty in America, opined in his book, *The Intellectual Basis of Family Practice*, that Medicine is always influenced and shaped by the ideas and social trends of its time. Echoing this, it is widely agreed that Family Medicine as a specialty must reinvent itself in recognition of the profound changes that have occurred in the ways Medicine is now practiced. It is therefore my earnest belief that general practice and Family Medicine now stand at a pivotal point not only in their own history, but also in Singapore's healthcare history.

With a rapidly ageing society, an alarming rise in the cost of hospitalisation, and an exponential escalation in the burden of chronic vascular and degenerative diseases on the population, there can be no better moment than this for Family Medicine to claim its rightful place in the healthcare ecology. This discipline, I believe, is well poised to provide the much needed balance in our healthcare delivery system, and convert a large proportion of our healthcare spending from cost to investment. In recent years, we have seen some innovative changes introduced by the local Family Medicine leadership and the Ministry of Health, together with the 2,000 odd GPs in this country. My very best wishes goes to them as they continue on this transformative journey which, I expect, will radically change the health status of Singaporeans. *Carpe diem!* ■



A/Prof Chin is President of the 55th SMA Council. Like most doctors, he too has bills to pay and mouths to feed, and wrestles daily with materialistic desires that are beyond his humble salary. He, however, believes that a peaceful sleep at night is even more essential.