A Vision for Better Primary Healthcare

DMS's Conversation with the SMA Council, 13 January 2005

Reported by Dr Lee Pheng Soon and Dr Toh Han Chong

"When the Ministry identifies a major issue that is worth pursuing, we go through a number of professional and public consultations. Only if the majority favours the change, and only if it will clearly benefit healthcare in Singapore, will we proceed. It is not our intention to force things."

With this, the Director of Medical Services (DMS), Prof K Satkunanantham set the tone for the evening of 13 January 2005, where he engaged the 45th SMA Council in consultative dialogue and shared his vision for the next steps in Singapore's primary healthcare.

ENABLING THE FAMILY PHYSICIAN: CRITICAL TO SINGAPORE'S FUTURE

"The demographics of Singapore will change. Currently, the elderly constitute about 8% of the population and they consume close to a third of government healthcare costs. By 2030, the proportion will increase to 18% and will consume close to half the cost. That is a very big sum, and cannot be left unaddressed. So the issue is: Can we continue to site much of the healthcare of this age group within tertiary institutions? The cost becomes more untenable when you realise that some of these patients have multiple problems that are managed separately by as many as four or five Consultants from different departments. This care within tertiary institutions already uses a large part of our healthcare budget, and the proportion will get larger as the population ages. We therefore need to relocate more healthcare back to the community."

For the current Family Physicians, the plan is to *enable* them in two ways: First, to enhance their clinical activity, with greater emphasis on consultation and continuing care. Second, to encourage, recognise, and reward those Family Physicians who have, or who choose to upgrade by pursuing a sub-specialty interest.

"More primary care physicians alone will not reduce the load on tertiary institutions. You must go beyond this and have sub-specialised Family Physicians, be it in geriatrics, psychiatry, palliative care or even sports medicine. You can also have functional groups of (non-identical but synergistic) Family Physicians working together in the same area. So, if you have a patient who needs greater attention to palliative care than you are comfortable managing yourself, you may refer him to your colleague with further training in that sub-specialty instead of to a Specialist in a tertiary-care institution."

For new medical graduates, there will be tailored opportunities to better prepare them to enter family medicine, better qualified and with more skills. "If sometime soon after graduation, a Medical Officer decides that he wants to be a Family Physician, we can offer him the Masters of Medicine programme, as well as some time in the Polyclinics as background training."

The SMA Council agreed that while the ideal situation would be having a Family Physician in charge of overall management of most of the patient's problems, doing this properly will take much more time than we currently allocate per patient, and operating costs have to be recovered. Could

Page 7 ►

◄ *Page 6 – A Vision for Better Primary Healthcare*

Director of Medical Services, Prof K Satkunanantham"

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the public be educated on the true value of seeing a Family Physician, pay enough to make this new vision work, and even be prepared to pay a premium for a good one able to offer sub-specialty care?

Prof Satku stressed: "If patient care initially requires a Specialist, it does not always mean that continuing care also needs a Specialist. After his condition is worked out and stabilised at the tertiary institution, the patient can be sent back to the community, to his family doctor, for continuing care. In addition, this Family Physician is best placed to continue his management in the context of the spectrum of other conditions that this particular person may also have. If you achieve that, then logically, patients will pay somewhere intermediate between the current GP charge, and that of a visit to the Specialist, provided the Family Physician delivers the necessary level of care. Otherwise, confidence will be lost and we are back to square one. The Family Physician must therefore have greater depth, both in his personal clinical capability and in his relationship with the patient, and be really involved in his chronic disease management. Hypertension and diabetes will be the first two big things that we will roll out in this aspect."

MANAGING CHRONIC DISEASES

The Disease Management Programmes will first be implemented at the Polyclinics. However, the SMA Council was concerned whether the Family Physician in a solo or small practice will be able to achieve the same standards of care. This concern is not just based on training and qualifications. They simply do not have economies of scale of the Polyclinics, and therefore can never match the latter's relatively cheaper medication, or have paramedical facilities like X-rays, and services like podiatry, dietetic advice, and so on.

"Disease Management Programmes (and their specified standards of care) will be implemented first for the Polyclinics, then we will roll them out to the private GPs. Initially, it will be voluntary. We are doing all this cautiously, and starting small before we gradually increase our expectations. We will not emphasise consumption (of tests and standards) and will not require Family Physicians to have all the various steps done. But the patient outcome must be good. How you achieve it, whether by clinical assessment or laboratory tests, is up to you, and we do not want to micro-manage."

The SMA Council reminded the DMS that patients of private doctors currently have no access to subsidised care (in a tertiary institution), except by referral through a Polyclinic. "The current situation where private GPs have to refer to the Polyclinics for the subsidy will be corrected to some extent by the means test (which will be gradually introduced). It is needless work for doctors. When the means test is here, it will not matter who makes the referral."

"Let us work together to address this issue. My interest is not only to provide for the Polyclinic patients, but for patients across the nation. I do understand many of you are restricted in the resources open to you as Family Physicians in private practice. And if that is the problem, we will have to address it. Not to address it means not caring for some Singaporeans. And I will definitely look into it."

LET US ALL WORK TOGETHER

"We (the MOH) cannot improve healthcare all by ourselves. We want the professional bodies to be directly involved. Very simply put: the Academy of Medicine and College of Family Physicians will be responsible for the academic aspects of Specialists and Family Physicians respectively. The Singapore Medical Association would be responsible for: (1) being the liaison body with the public; and (2) coordinating, educating and managing the aspects that affect every doctor's life – professionalism, ethics, health law, practice, and medico-legal matters. These are common grounds for both the College and Academy, but instead of trying to duplicate activities, let one entity (SMA) roll it out. If either the College or the Academy want to build on the SMA's work to meet their bodies' additional special needs, let it be done as an additional role following the SMA's lead in this direction."

Prof Satku concluded the evening by bringing us back to our reason for being. "In the end, my objective is that our patients must be better taken care of. It is why most of us have decided to do Medicine. Today, what I shared with this Council is something that will bring better care for our patients. It will not be easy, but with your support, our joint efforts will bring us that much further." ■