Prof Chee Yam Cheng, Assistant CEO (Clinical), NHG

Primary Care Partnership Scheme

INTRODUCTION

For too long Singapore has focused its health manpower training resources on hospital practice and specialists. This has included overseas attachments and experiential learning in world-renowned centres through arrangements at the highest administrative levels, with favourable terms to public sector staff (doctors, nurses, allied health professionals) and the overseas receiving institutions. As a result the number of well-trained health professionals in the hospital sector and in specialist centres, both private and public, has allowed Singapore to claim healthcare as one important engine of economic growth.

What about the primary care sector? One view is that it has been neglected over the last 30 years to run its own course. This has resulted in the present situation where the practice of aesthetic medicine is more lucrative than the practice of Family Medicine. Occasionally, we hear anecdotal accounts of patients who are rich enough to pay for wrinkle treatment and continue to go for wrinkle treatment on an ongoing basis (as though it were a chronic disease) but who are not willing to fork out a far smaller sum for a good and worthwhile medical consultation on preventive medicine within the family practice. This is indeed an undesirable state that we want to avoid.

While the government's share of the hospital specialist practice is serving 80% of the nation's needs, primary care provided by the government polyclinics constitutes only 20% of family practice. The private family doctors provide the bulk of primary care, yet receive no government resources to do their job better. Has the market failed? Has polyclinic subsidy without means testing resulted in the less than optimal use of the expensive Family Practice set ups where solo practitioners work long hours trying to make ends meet? I think so. Subsidy has skewed and spoilt the market such that the private practitioner is unable on pure economic business sense to make a decent living doing the traditional thing, which is, see patients (not customers) with medical conditions, and not customers with no illness but who are willing to pay big bucks for a transient beauty uplift.

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Come January 2009, things will change. Government subsidy will flow to the private family doctor who elects to manage and treat patients (not customers) with chronic medical diseases. The Primary Care Partnership Scheme (PCPS) will be extended to patients with chronic diseases who consult their family doctor. Patients from the lower income group can qualify to be on the PCPS. With this scheme, hopefully a pool of patients who currently see polyclinics for chronic diseases will revert to their family doctors for more personalised care. In other words, a cohort of patients that qualify for subsidy can now choose to have this subsidy paid to their family doctor. For this cohort with portable subsidy, seeing a specific family doctor regularly will enhance your Family Practice. Certain terms and conditions will apply.

TERMS AND CONDITIONS

The first is that the patient has a diagnosis of diabetes, hypertension and/or hyperlipidemia to qualify for PCPS. It could be one, two, or all three diagnoses in a single patient.

The second is that the patient qualifies for subsidy and is willing to port this over from the public sector polyclinic to the private sector by choosing and staying with a specific family doctor

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for the care of these ailments. Should you need to refer the patient back to the hospital Specialist Outpatient Clinic, the patient remains a subsidised patient even though you, the family doctor made the referral.

The third is that the amount of PCPS subsidy for these three conditions will be equivalent to that provided to polyclinics.

The fourth is that there is an annual subsidy cap per patient. There would be two tiers of caps, one for patients with less severe (and therefore lower dollar cap) and the other for patients with more severe chronic diseases.

In return, the PCPS doctor on this scheme will be required to submit data on the bill incurred by each patient per visit. This serves two purposes. The first is to determine the adequacy of the subsidy, and the second is to allow outliers to be identified. In addition, the PCPS doctor will also be required to submit clinical data as per the current Chronic Disease Management (CDMP) framework.

The public will have access to information detailing the prevailing range of polyclinic charges for similar conditions and consultations. This would set a bench mark for what would be acceptable charges and charging.

CONCLUSION

PCPS is not new. It exists today. It exists for acute medical conditions for the needy elderly and disabled adults. This will remain. What is new is the extension of PCPS to include coverage of chronic medical conditions. In January 2009, these conditions are three in number; they are diabetes, hypertension and hyperlipidemia.

I would encourage family doctors true to their vocation and calling to help manage the ever-increasing pool of such elderly patients. This is why you went to medical school. This is what medical practice is all about; treating patients (not customers) with evidence-based medicine to make a difference to their outcome, prevent complications and help them lead a healthy life. These patients are truly in need of your expertise. Now, government funding will help them pay you, their good doctor, for the excellent care you provide. ■

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Thank you.