

The Primary Care Masterplan – *Some Thoughts*

By Dr Wong Tien Hua

According to the Ministry of Health's (MOH) Primary Care Survey 2010, private general practitioners (GPs) currently represent 81% of all primary care doctors. However they only look after 55% of chronically ill patients. Polyclinics (outpatient departments or OPDs) represent 19% of the primary care sector, but manage the remaining 45% of patients with chronic diseases. The numbers reported are not surprising as many patients with chronic diseases are hesitant to see their GPs for more expensive care, preferring instead to go for subsidised treatments at polyclinics.

The MOH Primary Care Workplan Seminar was held on 8 October 2011 to address this issue, and to gather feedback from public and private sector primary care doctors on the proposed Primary Care Masterplan. The Primary Care Masterplan aims to:

- Provide better support for GPs to manage patients with chronic diseases;
- Facilitate the sharing of patient information with GPs through the National Electronic Health Records; and
- Ensure that primary care remains affordable.

Current situation for private solo GPs

Many GPs operate as solo practices with one resident doctor/business owner covering the operating hours. Some clinics have two or three doctors covering shifts. As the family doctor, the GP provides primary care services in the local community over a long time span. His patients have been seeing him for many years, from newborn vaccinations, to schooling days, and then on to adult working life. The GP therefore has intimate knowledge of his patients' medical and social needs; care is very personalised.

In order for GPs to function effectively in chronic disease management, they would need to be adequately trained and brought up to date with the latest care protocols and clinical targets. GPs would also need more support services to enable them to better utilise community resources.

I believe that many GPs are now more than adequately trained to handle chronic diseases. The publishing of MOH clinical guidelines and the professional development courses offered by the College of Family Physicians, Singapore, such as the Graduate Diploma in Family Medicine, have done much in recent years to enable interested GPs to upgrade and keep up to date. With the continuous medical education (CME) system introduced some years back, many GPs have upgraded themselves through self-study and attendance at CME activities. The recent implementation of the Family Physician (FP) Register saw many experienced GPs voluntarily signing up for accredited courses. The FP Register will help raise the bar and compel young doctors contemplating a career as a family physician

in the community to seek higher qualifications.

Solo GPs, however, lack service support. Due to busy clinic hours, many lack the time that is required for counselling patients on disease modifying behaviours such as proper diet and exercise. Diet counselling, laboratory tests, x-rays, and diabetic retinal photography (DRP) have to be referred out. Patients are therefore often sent to various places for assessment, e.g., they may be asked to go to one place for DRP, another for x-rays, and another for diet counselling. This not only leads to much inconvenience for the patient, but is also hard for the GP to track where the patient is going and whether the patient is getting appropriate care. Costs are incurred from transportation, and services may end up being duplicated. There are also administrative costs such as typing referral letters, arranging for appointments, and sorting out reply letters. Lapses in communication between the GP and the referral centres are not uncommon.

Raising the standards of GP training and providing better service support will not by itself solve the chronic imbalance of patients. At the end of the day, cost factors still play an important role in driving patients' health seeking behaviour. MOH has tried different schemes in the past to level the playing field and channel more patients away from the overcrowded OPDs. Schemes such as the Primary Care Partnership Scheme (PCPS) and Medisave for chronic diseases have been around for a while, but have not really made a very large impact on the primary healthcare landscape.

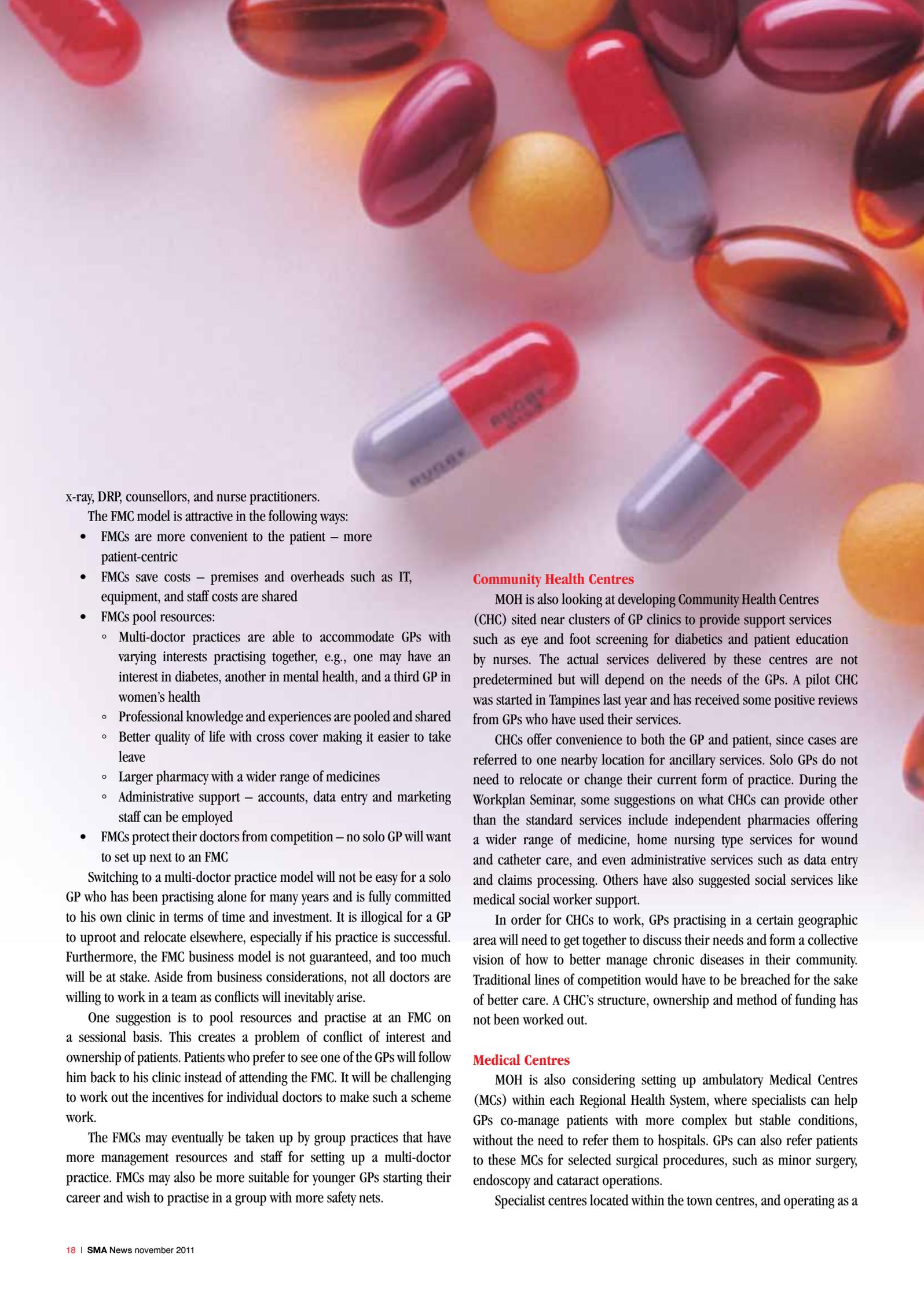
Providing better support – FMCs, CHCs and MCs

MOH has proposed the setting up of three types of primary care facilities in order to provide support for GPs:

Family Medicine Clinics

The Family Medicine Clinic (FMC) model is a multi-doctor family practice model similar to current polyclinics, except that it would be based on a private practice business model with government support in terms of subsidies and land space to start the business. It is envisioned that small groups of GPs can come together to set up such FMCs to share resources and take advantage of economies of scale. FMCs in one form or another is not new – large multi-practice medical centres currently exist, but are mostly located in central town areas and are operated by large group practices. In contrast, the proposed FMCs will be set up specifically to address chronic diseases amongst the population in HDB town areas.

FMCs will bring groups of family physicians together to practise under one roof, with the benefits of one-stop services such as ancillary care,



x-ray, DRP, counsellors, and nurse practitioners.

The FMC model is attractive in the following ways:

- FMCs are more convenient to the patient – more patient-centric
- FMCs save costs – premises and overheads such as IT, equipment, and staff costs are shared
- FMCs pool resources:
 - Multi-doctor practices are able to accommodate GPs with varying interests practising together, e.g., one may have an interest in diabetes, another in mental health, and a third GP in women's health
 - Professional knowledge and experiences are pooled and shared
 - Better quality of life with cross cover making it easier to take leave
 - Larger pharmacy with a wider range of medicines
 - Administrative support – accounts, data entry and marketing staff can be employed
- FMCs protect their doctors from competition – no solo GP will want to set up next to an FMC

Switching to a multi-doctor practice model will not be easy for a solo GP who has been practising alone for many years and is fully committed to his own clinic in terms of time and investment. It is illogical for a GP to uproot and relocate elsewhere, especially if his practice is successful. Furthermore, the FMC business model is not guaranteed, and too much will be at stake. Aside from business considerations, not all doctors are willing to work in a team as conflicts will inevitably arise.

One suggestion is to pool resources and practise at an FMC on a sessional basis. This creates a problem of conflict of interest and ownership of patients. Patients who prefer to see one of the GPs will follow him back to his clinic instead of attending the FMC. It will be challenging to work out the incentives for individual doctors to make such a scheme work.

The FMCs may eventually be taken up by group practices that have more management resources and staff for setting up a multi-doctor practice. FMCs may also be more suitable for younger GPs starting their career and wish to practise in a group with more safety nets.

Community Health Centres

MOH is also looking at developing Community Health Centres (CHC) sited near clusters of GP clinics to provide support services such as eye and foot screening for diabetics and patient education by nurses. The actual services delivered by these centres are not predetermined but will depend on the needs of the GPs. A pilot CHC was started in Tampines last year and has received some positive reviews from GPs who have used their services.

CHCs offer convenience to both the GP and patient, since cases are referred to one nearby location for ancillary services. Solo GPs do not need to relocate or change their current form of practice. During the Workplan Seminar, some suggestions on what CHCs can provide other than the standard services include independent pharmacies offering a wider range of medicine, home nursing type services for wound and catheter care, and even administrative services such as data entry and claims processing. Others have also suggested social services like medical social worker support.

In order for CHCs to work, GPs practising in a certain geographic area will need to get together to discuss their needs and form a collective vision of how to better manage chronic diseases in their community. Traditional lines of competition would have to be breached for the sake of better care. A CHC's structure, ownership and method of funding has not been worked out.

Medical Centres

MOH is also considering setting up ambulatory Medical Centres (MCs) within each Regional Health System, where specialists can help GPs co-manage patients with more complex but stable conditions, without the need to refer them to hospitals. GPs can also refer patients to these MCs for selected surgical procedures, such as minor surgery, endoscopy and cataract operations.

Specialist centres located within the town centres, and operating as a



satellite arm of a regional hospital has been tried before.

Some have been successful, yet others have failed. The key to success is to be able to enlist the support of the GPs within the area as a source of referral. Issues of affordability and accessibility (location and operating hours) are also important.

Addressing affordability – expanded PCPS and Medisave scheme

A new expanded PCPS scheme was announced on 15 August 2011, and will take effect by the first quarter of 2012. The qualifying income for the PCPS will be raised from the current \$800 to \$1,500 per capita monthly household income. At the same time, the age criteria for eligibility will be lowered from the current 65 to 40 years old. By doing so, the pool of patients covered by the new PCPS scheme will increase by a factor of more than 20 to 710,000 persons.

Medisave withdrawal limits for outpatient treatment of chronic diseases will also be raised from \$300 to \$400 per Medisave account per year. The scheme will be renamed Medisave400. Medisave400 can also be tapped on for preventive mammogram screening and selected vaccinations. About 112,000 chronic disease patients will stand to benefit from the scheme.

This figure of \$1,500 per capita is the median per capita monthly household income in Singapore. A sole breadwinner who earns \$6,000 a month to feed his family of four will qualify. By definition, this median number theoretically covers half of the GPs' pool of patients who are above 40 years old, but the impact will be felt even more so by GPs who practise in HDB estates, where the proportion of families who qualify will be larger.

Of course patients not only need to fulfill the income and age criteria, but must also suffer from one of the prescribed list of eight chronic diseases, and not everyone who qualifies will sign up for the scheme. But certainly the pool of patients is going to be significant, and the questions facing GPs now is – could they afford not to join the PCPS scheme?

One of the factors that could be a barrier to GPs signing up for PCPS is the administrative process that is yet to be finalised.

Most GPs want to spend time with their patients and will not like complicated and restrictive claims procedures. The online portal for Medisave withdrawal is currently time consuming to use, requires a two-step authentication process to log in, has a slow refresh rate resulting in lengthy waits, and the site automatically blocks the user after a period of inactivity. A GP doing data entry for Medisave claims can therefore only access the site during his administrative hours after work.

The online interface and claims process must also be in real-time, for fear of the possibility of encountering patients who have exceeded their PCPS claims limit from multiple visits to different clinics. There are also the additional responsibilities of data entry of key indicators (such as blood pressure and HbA1C), and the worry of clinical audits.

Conclusion

The Primary Care Masterplan is certainly a move in the right direction as it puts primary care and chronic disease management back on the agenda for healthcare reforms over the next few years. Some of the proposals represent paradigm shifts in the way primary healthcare is delivered by asking for more private sector involvement. The setting up of FMCs and CHCs will add more choices for patients in the community. The new expanded PCPS schemes could hopefully shift chronic care from crowded OPDs back to neighbourhood GPs. GPs should take this opportunity to rise to the challenge and to start to work together to realise the vision of one family physician for every Singaporean. **SMA**

Dr Wong Tien Hua is a family physician in private practice. He is Honorary Secretary of the 52nd SMA Council.