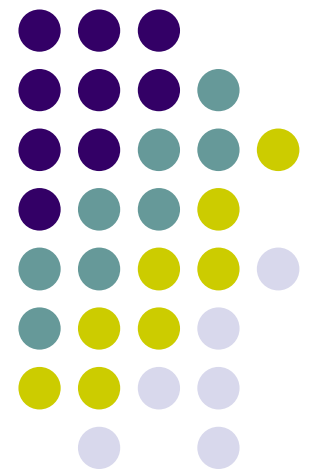


Evolving Landscape of Primary Care in Singapore

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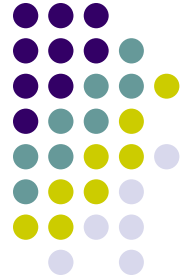


Outline



- Why describe it?
- What was done in trying to describe it?
- What are the findings?
- What conclusions?

Why describe the landscape?



There is an increasing recognition that primary care provides the necessary integrative links with the whole enterprise of healthcare access and cost-effective service utilisation.

What was done in trying to describe the evolving landscape?



Methodology – find out

1. What has been **said** about primary care in Singapore
2. The landscape changes that are **happening**
3. **Gaps** in health care that primary care can fill



What findings? *Sayings (1):1*

- **Ms Yong Ying I (2007 Oct 20)**
 - We believe that GPs can and should play a major role in the national healthcare landscape. My Ministry therefore it is time that we bring together the GP Community for discussions about national level healthcare strategies.
 - With a growing elderly population, and a growing chronic disease burden, the need is to manage wellness and prevent or delay problems, and to manage chronic conditions on a continuing basis. Patients therefore need continuing care, not episodic care. Chronic disease effort also involve widespread adoption of clinical protocols at the primary care level
 - Major roll-out of standardised IT systems to GPs – supports long term outcomes, for both primary care physicians and their patients.
 - Right-siting of clinically suitable patients from SOCs to GPs... significant scope for this

Conversation with MOH – Making Primary Care Work



What findings? *Sayings (1):2*

- **Mr Khaw Boon Wan (2007 May 16)**
 - IT holds the key to contain rising healthcare costs and, at the same time, ensuring quality healthcare
 - Seamless, integrated care for patients across the whole healthcare ecosystem remains like the Holy Grail – widely sought by many, but still a distant, seemingly unattainable goal.



What findings? *Sayings (1):3*

- **Mr Goh Chok Tong (2008 Mar 30)**
 - The first goal is to raise the standard of care in primary and step-down care sectors to a higher level. The primary care sector needs to be empowered and equipped to take on bigger roles in areas such as the management of chronic disease, mental health and in-community ageing.
 - While commonsense tells us that this is the right thing to do, getting it accepted by the public will not be an easy task. It is not just about further upgrading the capabilities of the primary care and step-down care sectors, which we must do. It is also about getting the pricing, financing and subsidy system right and changing the bias against step-down and primary care.



What findings? *Sayings (1):4*

- **Mr Khaw Boon Wan (2008 May 09)**
 - As he (Dr Tan Cheng Bock) sees it: “Aesthetics is... not medical practice. It does not heal but only enhances appearances. The practitioner of aesthetics is not treating sick patients but healthy individuals.”
 - He (Dr Tan) hoped that MOH could do more to encourage and enable GPs to stay involved in national health programmes, such as chronic disease management programmes.
 - What value, Medicine? How much are you paying your GP for a consultation session on managing your diabetes which may save your toe? How much are you paying another for a session to whiten your skin?

Opening of the Singapore Disease Management Conference 2008 & 1st
International Conference on Healthcare Transformation



What findings? *Sayings (1):5*

- **PM Lee Hsien Loong** (2009 Aug 16)
 - Government is gearing up our healthcare system for an ageing population... older patients being admitted more frequently. After their acute condition has stabilised, they no longer need intensive treatment but are not well enough to go home.
 - “More” itself is not enough. Singapore needs to build up step-down care – community hospitals, nursing homes, general practitioners, and home care. .. Health Ministry is working on upgrading home care to help caregivers.
 - Another key step is to link up acute hospitals with community hospitals, so that once a patient has stabilised, he can move to the “sister” community hospital and receive “slow medicine”.
 - The best way to keep healthcare costs down is to maintain healthy lifestyles.

What findings? *Landscape changes* (2):1



- Healthy lifestyle – overnutrition, lack of exercise, overweight is a problem = **more PCPs to be skilled in this area; need continuing follow up for optimal results – need to convince patients to pay for this kind of counselling care**
- Prospective medicine – to view patients as lifestyle risks, to high risk states, to chronic disease casualties = **we need to implement this in a big way as the new paradigm of screening**

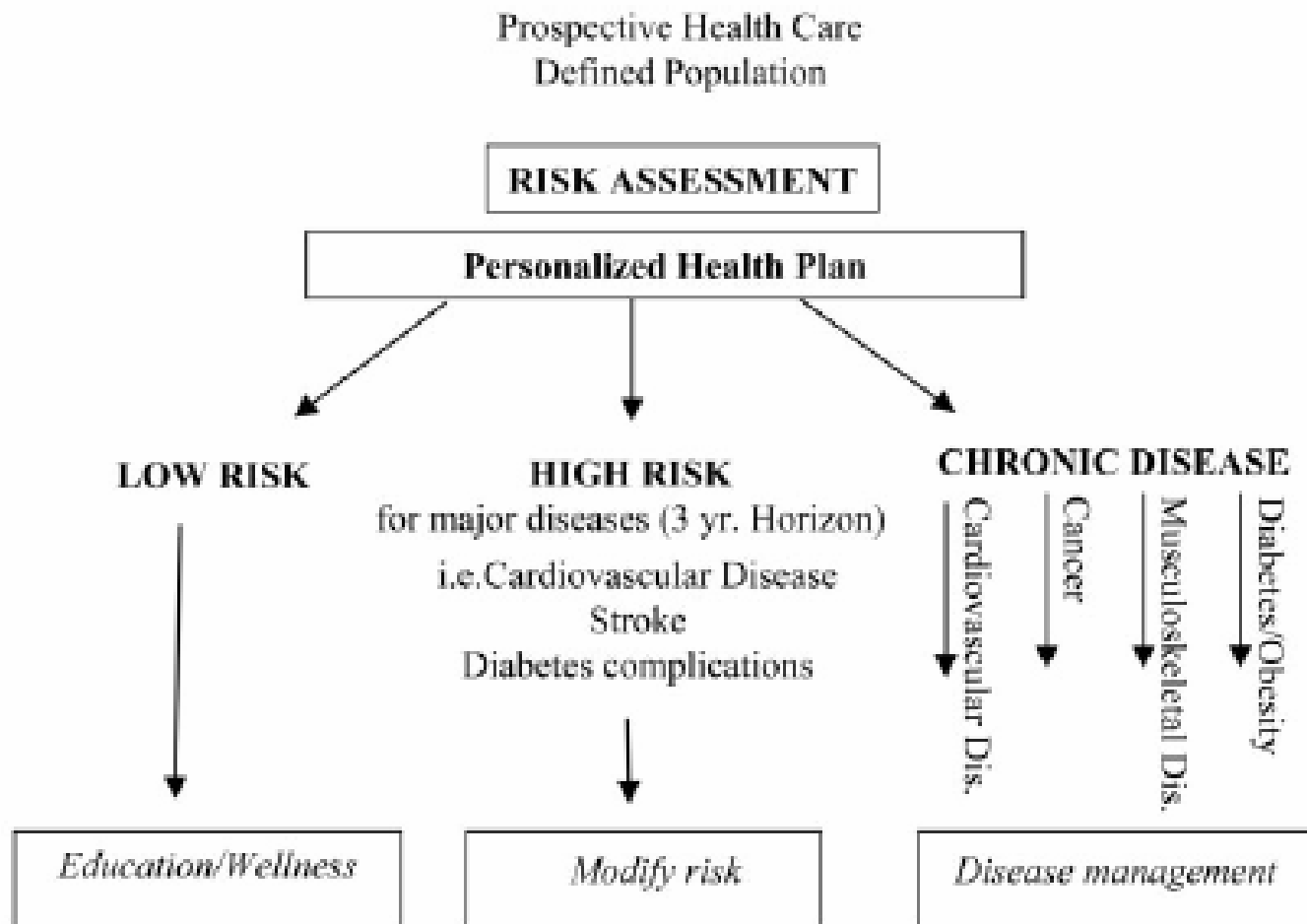


Fig 1. The connect that needs to be made in personalised care

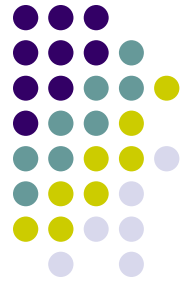
Synderman R & Sanders Williams R. Prospective Medicine: The next healthcare transformation. Acad Med 2003, 78(11):1082

What findings? *Landscape changes* (2):2



- ❑ **Elderly care** – increasing importance – old people have more co-morbidities, they recover more slowly, more medium and long term care is needed = **more PCPs are needed here – more high end kind of work, hospitalist experience needed – acute care, community hospital care, day rehabilitation, home medical care**

What findings? *Landscape changes* (2):3



- ❑ **Right site care** – specialist outpatient clinics are full; need for stable patients to be right sited to PCPs = **need more PCPs who are exposed, briefed, made more confident are needed here – more high end kind of work. Need to convince patients to make the move to their neighbourhood GPs. We must continue to try to move our stable SOC patients there**

What findings? *Landscape changes* (2):4



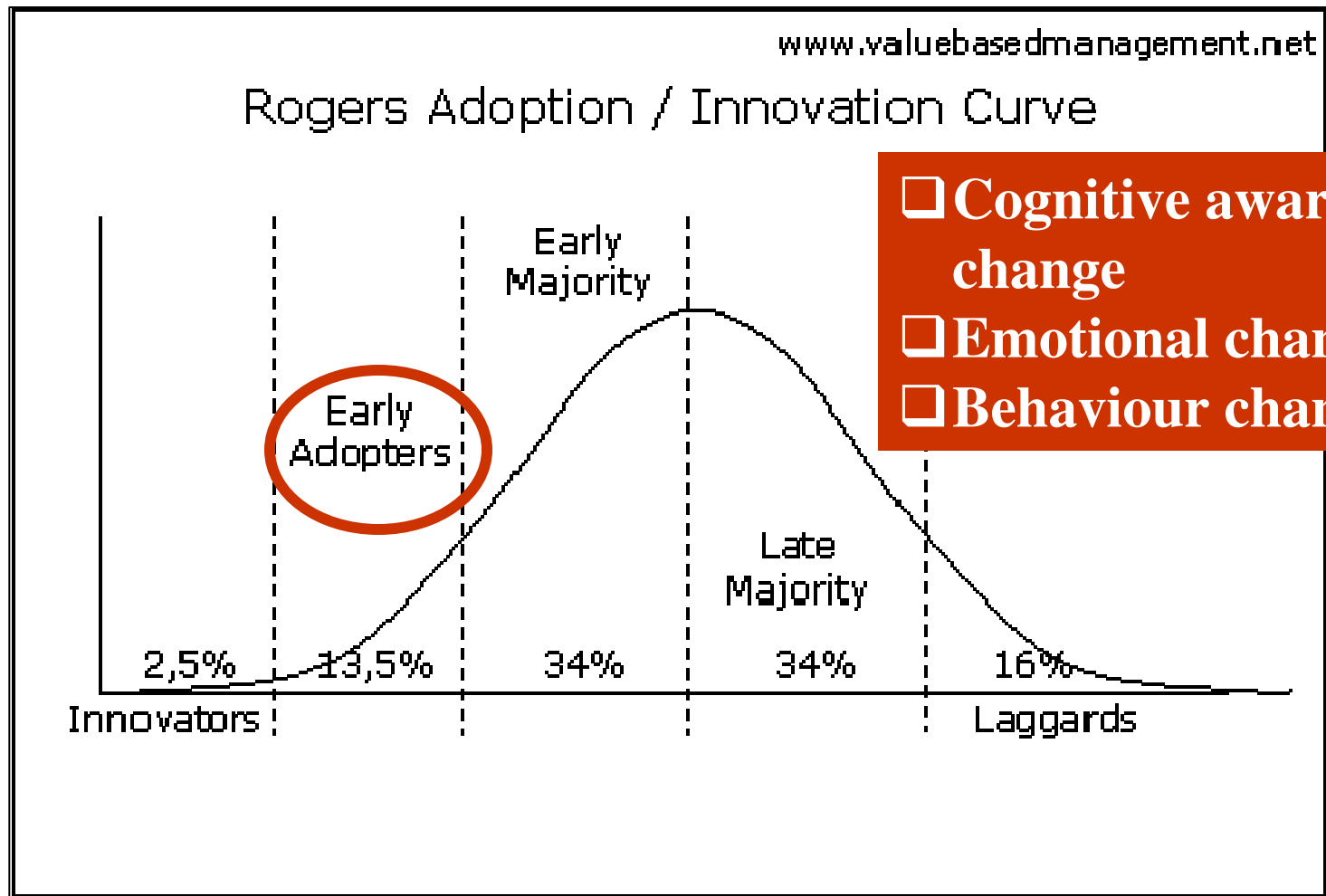
- ❑ **Integration of care** – integration of records within clinic, outside the clinic, and across the island = **a big challenge that will only succeed if there is synergism of efforts**
- ❑ **Patient's continuing care record** – stored in a thumb – can display continuing care information – will help in enhancing motivation of self-care

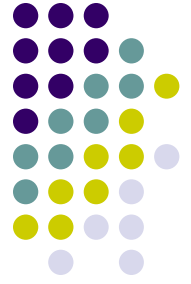


What findings? *Gaps to fill (3):1*

- ❑ Need for mind set change for patients to accept PCPs as able to provide high end care – & willingness to pay for the service. Individual doctors and profession need to work on this via the people, policy makers, and press
- ❑ Need for mind set change for PCPs to provide high end care in chronic disease, step-down care, elderly care & not to waste time with aesthetics -- & create the willingness for patients to want to pay for it
- ❑ Need for mind set change for PCPs to take on hospital based care as part of their work – there is a growing need for such work -- & create an enlargement of engagement from primary care

Connecting care – a challenge





What findings? *Gaps to fill (3):2*

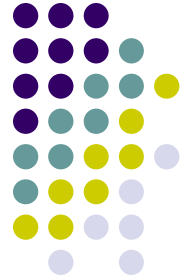
- ❑ Know the technology to connect care – the emerging 3 – for most
 - (a) Prospective medicine – connecting risks & disease
 - (b) ABCDEF – connecting primary care to elderly care
 - (c) Hospitalist care – connecting inpatient & outpatient care
- ❑ Know the technology to connect care – the global 3
– for some – those who will be working outside Singapore



The global 3

- Connecting with social development goals – *social determinants*
- Global health – *connecting health globally*
- Where there are no doctors – *Primary health care*

(a) Prospective Medicine. Going upstream & taking action



Lifestyle changes needed *

- Diet
- Exercise
- Wt control
- Smoking

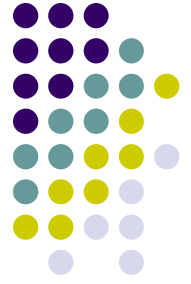
High risks *

- HT
- DM

* = modifiable factors

Disease & disability

- IHD
- Stroke
- Renal
- PAD
- Others e.g. eye



The blood pressure example

- ❑ Not done well across the world (30% controlled)
- ❑ Need to work on the barriers
 - ❑ Cognitive awareness
 - ❑ Emotional change
 - ❑ Behavioural change
- ❑ **Accept that some change is better than none**



The cognitive awareness

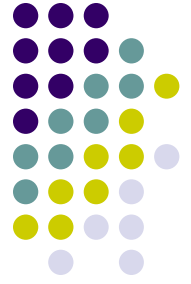
- ❑ 420,000 men and women were followed up for intervals of 6-25 years.
- ❑ 6 mm Hg difference in DBP associated with 37% fewer strokes and 23% fewer CHD deaths and nonfatal myocardial infarctions.
- ❑ Most or all the long-term potential benefits were achieved within 3 years of beginning treatment.

MacMahon et al. Hypertension 1989 13(5 suppl):145-50



Have a sticky message

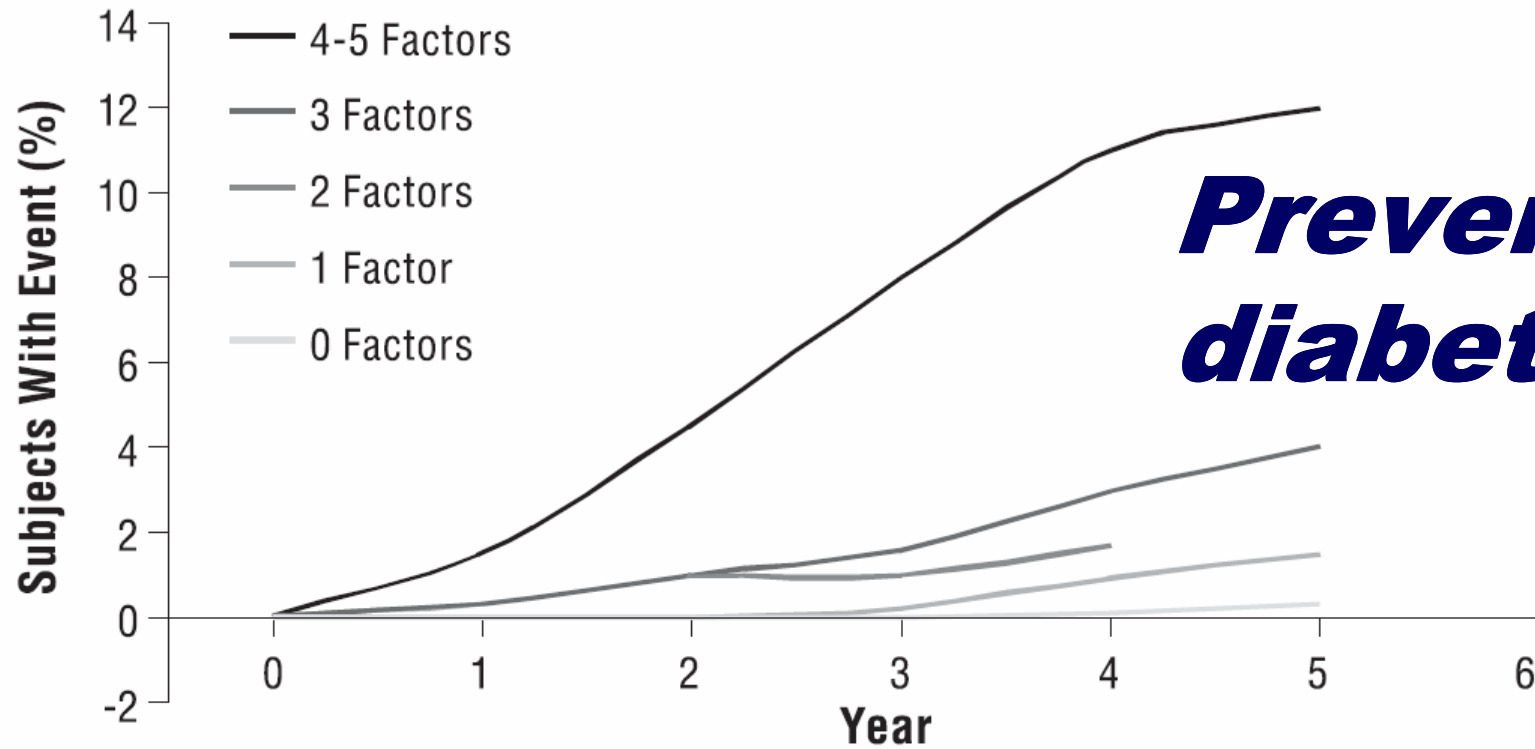
- ❑ Blood pressure control is for everyone
- ❑ Need to get a buy-in from patients, press, policy makers, and profession
- ❑ Fact 1 – A reduction of 6 mm Hg in DBP – results in 37% fewer strokes & 23% fewer coronary heart disease deaths & nonfatal heart attacks – **can be achieved by moderate exercise**
- ❑ Fact 2 – **Blood pressure control any amount is better than nothing.** Also diet, exercise, and weight control for everyone will make a difference by reducing DBP by 3-5 mm Hg or more for each lifestyle change.



- Successful intervention in creating awareness of the value of BP reduction opens the receptiveness for other personalised care plans



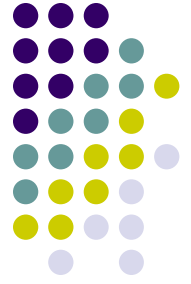
FIGURE 6 Diabetes Incidence by Number of Metabolic Syndrome Components³⁴



Prevent diabetes

Diabetes risk increases synergistically when at least 4 risk factors are present. Risk factors evaluated comprise metabolic syndrome symptom clusters. Those factors are increased waist circumference, blood pressure, triglycerides, and fasting glucose levels as well as decreased high-density lipoprotein levels.

Adapted with permission from Sattar N et al. (2003).³⁴

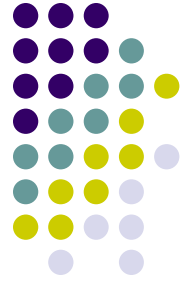


Therapeutic lifestyle change (TLC)

TLC for those with high DM & CVS risks

- ❑ **Atherogenic diet** – saturated fat <7% total fat; dietary cholesterol < 200 mg/dL; total fat 25-35% of total calories
- ❑ **Physical inactivity** – 30-60 min mod intense aerobic activity daily
- ❑ **Abdominal obesity** – 7-10% loss of BW from baseline; caloric deficit 500-1000 kcal daily; physical activity

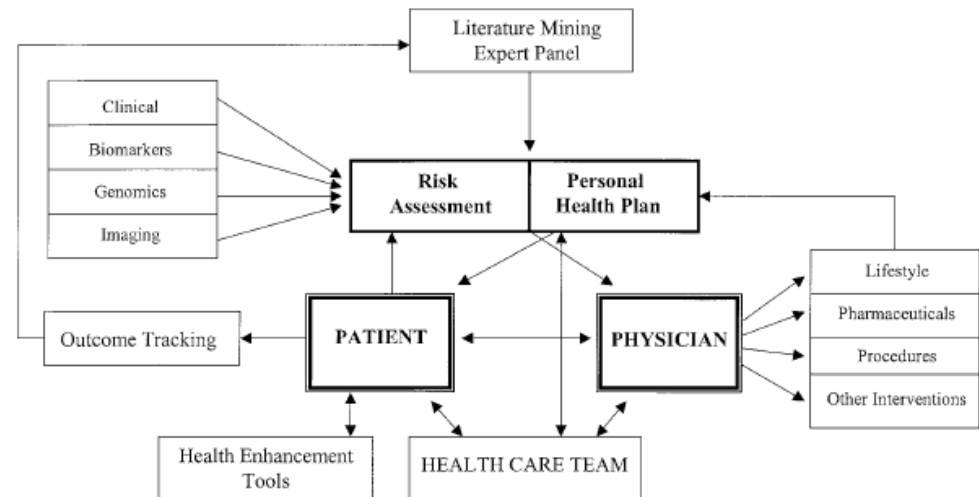
The support system needed



- For prospective care and personalised plans to happen systematically for everyone we need to have total support system – a lot of connecting care activities

Chronic disease management system

1. Organise care delivery
2. Use information technology
3. Decision support – CPG guidelines
4. System design – team approach, integrated care
5. Enable self- management – build independence
6. Community resources – self-help care groups, VWOs



Acad Med 2003, 78(11):1081

(b) ABCDEF – connecting primary care to elderly care



- Stott & Davis model
 - A - Acute problems
 - B - Behaviour modification
 - C - Continuing care
 - D - Disease prevention & health promotion
- Elderly care – additional elements
 - E – Environment to be disability friendly
 - F – Functional assessment – ADL, IADL, independent living



(c) Hospitalist care

The FP in the hospital

- Provide the interface care & transition care of patients between hospital & community care
- Canadian system – run by the FPs
- Singapore system – two hospitals with such a system. Other hybrids are developing

FPs are still struggling with the paradigm – need to just seize it – need to train successive crops of FPs to be hospitalist minded, besides being community based minded

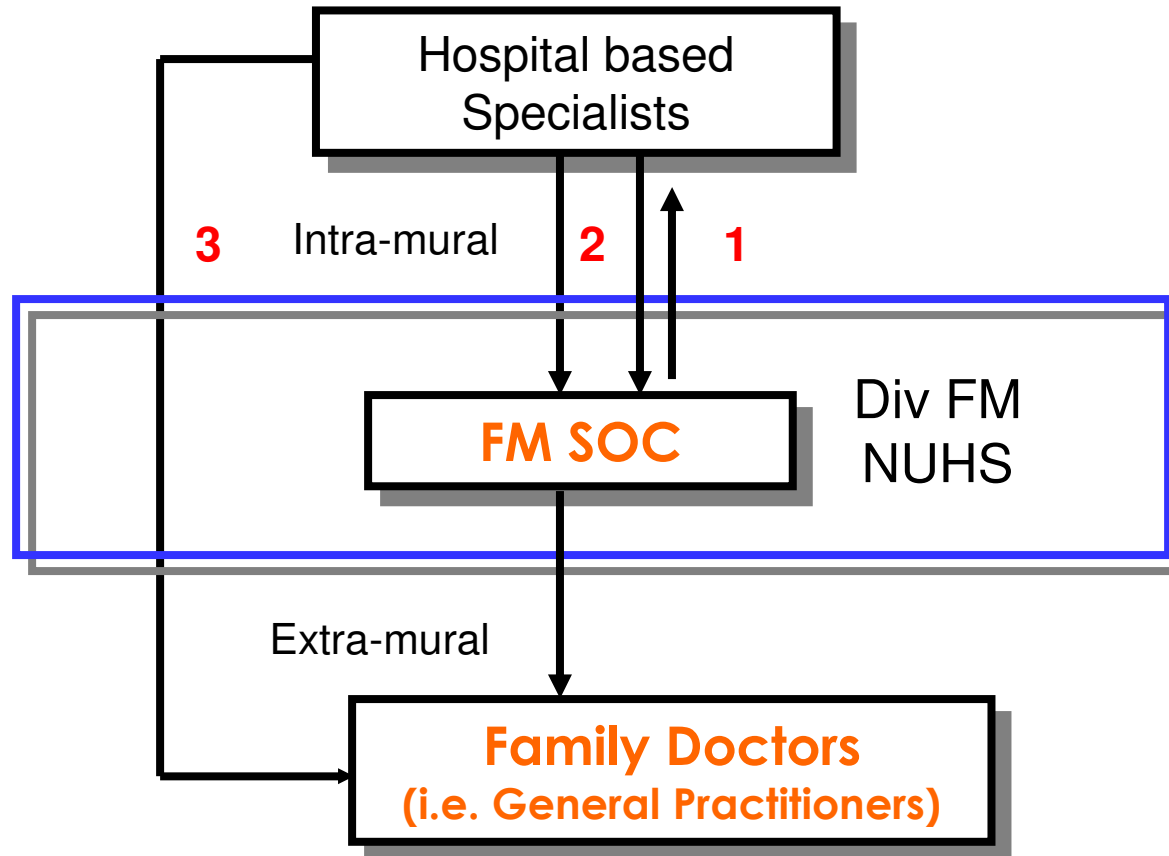


The End in Mind – the right siting initiative

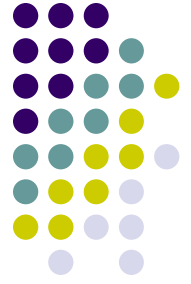
- ❑ Return stable hospitalised patients to the care of Family Doctors = clear SOC for new patients
- ❑ Right site stable patients to neighbourhood Family Doctors = clear SOC for new patients
- ❑ Build capacity & confidence for complex morbidity care, & interface care (growing importance) = longer term goal into the future



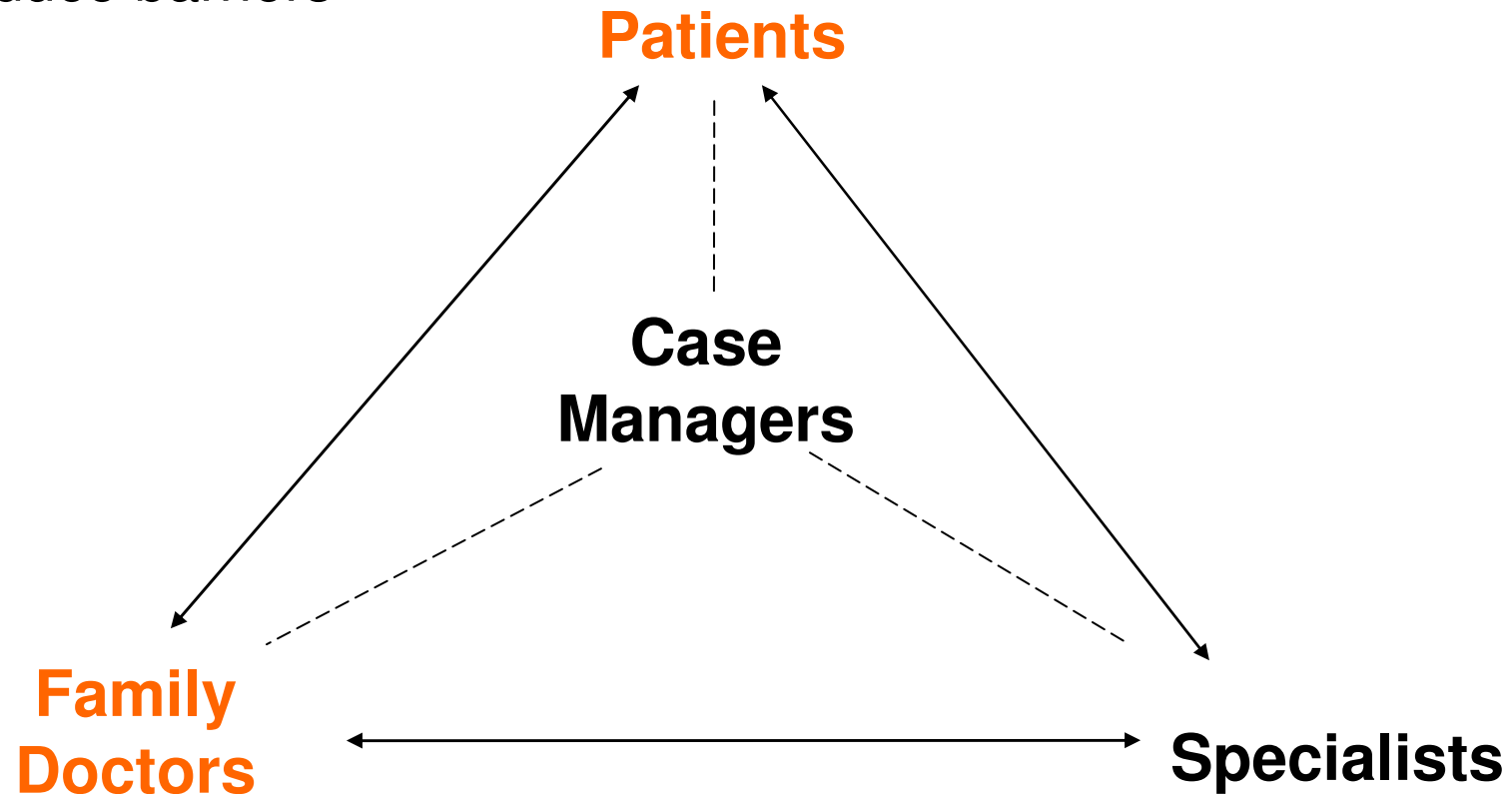
Example: NUHS Family Doctor Programme



*The issues of right siting -- Service Strategy **



Define Objectives, Increase benefits, Close gaps,
Reduce barriers



Barriers & Success factors in right siting



Table 1: Principles for working with general practitioners (GPs)

UNDERSTAND THE GP CONTEXT

1. GPs provide continuous, comprehensive and community-based care.
2. Patients often present to GPs with undifferentiated, mixed physical and psychological symptoms, and comorbidity is common.
3. GPs are time poor and juggling competing clinical demands and clinical roles.

PROVIDE CLINICAL SUPPORT

1. Provide general advice and primary and secondary patient consultations.
2. Supervise GP clinical work.
3. Assist GPs to navigate mental health systems.

PROVIDE EFFECTIVE EDUCATION FOR GPs

1. Choose training content that is relevant by focusing on high-prevalence disorders and common problems.
2. Adopt case-based teaching and skills-based approaches with rehearsal of skills in role-plays where possible.
3. Provide supplementary resource materials such as print-based or online patient education materials, psychometric tools and patient worksheets.

Blashki G et al. Primary care psychiatry: Taking consultation liaison psychiatry to the GPs. Australian Psychiatry Sep 2005; 13(3).



What findings? *Gaps to fill (3):3*

Research connecting care: Three areas

- Research on clinical issues (common diseases, chronic diseases, risk groups) including diagnostic strategies, health promotion and long-term management
- Health services research including primary care morbidity registration
- Research on education and teaching

Core content of GP/FM research (EGPRN)

Research it: Four domains



COLLECTIVE

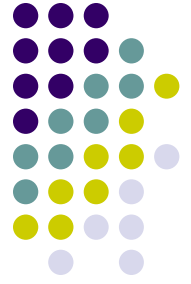
INDIVIDUAL

<p>II Patients</p> <p><i>Voices of patients, families, communities</i></p> <p>Participatory research</p>	<p>I Doctors</p> <p><i>Knowledge of doctors</i></p> <p>Self-reflection, journalism</p>
<p>III Systems</p> <p><i>Practice operates in a system</i></p> <p>Health services research</p>	<p>IV Disease</p> <p><i>Phenomena & interventions</i></p> <p>Observations, Epidemiology, Experimentation</p>

INNER REALITY

OUTER REALITY

Ref: Green L –
Paper in Kingston,
2003



What findings? *Gaps to fill (3):4*

Teach High end primary care, connecting care, & hospitalist care

(a) The ACGME 6 competencies

- Knowledge
- Communication
- Clinical care
- Problem based care
- System based care
- Professionalism



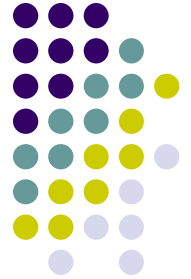
(b) The modern Bloom's taxonomy

Cognitive domain

- Knowledge -- knowledge, comprehension
- Application -- application
- Problem solving – analysis, synthesis, evaluation

Affective domain

Psychomotor domain



(c) Institute of Medicine quality domains

- Safety
- Effectiveness
- Person-centred
- Timeliness
- Efficiency
- Equity



What conclusions?

We need to get the 4 Ps – people, policy makers, press, and profession to move forward together:

- Make the mindset change to provide high end primary care, connected care, and hospitalist care
- Seize the day of making connected care as the next conceptual leap
- Research & Teach high end primary care, connected care, & hospitalist care