



P R E S I D E N T ' S C O L U M N

**Symposium: Surviving General Practice:
The Changing Healthcare Landscape**

The Family Physician (FP) aspires to deliver primary, personal, comprehensive and continuing care. The changing healthcare landscape in Singapore challenges each of these roles.

Two surveys of primary care done in 1993 and then 8 years later in 2001 revealed the changing landscape and are tabulated in Table 1 and Table 2. The findings of the 1993 were published in the Singapore Family Physician 1994 (Vol. 20:2 page 75 -91) while the paper for the recent survey is still in preparation.

Table 1 shows that though the absolute number of consultations in private General Practitioners' (GP) clinics and the public sector polyclinics has gone up in tandem with the increased population, the attendance per person per year has declined from 5.2 to 4.0. The encounter-load per GP has dropped from 40 to 33 encounters per day due to the dilution factor as the number of GPs has increased by about one-third. The polyclinic share has remained about the same at 18%.

There is a decline in young children seeing both private and public sector FPs as shown in Table 2. This could be accounted for by the increased number of primary care paediatricians in the community. The polyclinic now sees a greater proportion of continuing care problems such as hypertension.

These trends can be explained by the fact that primary healthcare is increasingly delivered by a plethora of healthcare providers. Most specialists accept consultation from patients who directly access them without medical referral. In recent years, pharmacists in the private sector also provide consultation on self-medication for a slew of medicine declassified from prescription to over-the-counter and pharmacist-dispense. In addition, primary care is provided by state registered traditional Chinese physicians.

The trend of setting up specialist clinics in polyclinics to make it convenient to patients who need specialist referrals can be viewed in two ways. These clinics could empower FPs in polyclinics to handle more complex cases in a share-care model but it

Table 1: Changing Landscape – Statistics of Primary Healthcare Survey – 1993 and 2001

	1993	2001
Population	3.3 m	4.1 m (↑25%)
Total Attend.	16.6 m	18 m (↑8%)
Attend/pat/yr	5.2	↓4.4
No. GPs	1103	1480 (34%)
Pat/Day/GP	40	↓33
GP share attend As % total	13.6 m (82%)	15 m (83%)

Table 2: Changing Landscape – Statistics of Primary Healthcare Survey – 1993 and 2001

	1993	2001
<5yrs at FP	12%	↓8%
Elderly pop	5.8%	6.4%
Polyclinic old	11%	↑16%
GP Old pat	5.8%	↑6.4%
URTI GP (Poly)	38% (28%)	↓30% (24%)
HPT GP (Poly)	5% (15%)	↓8% (18%)

can also disenfranchise FPs by functioning as an outpost of the hospital specialist departments to sequester patients that only need primary care after their more complex medical problems are resolved.

There is a decreased burden of what is traditionally considered illness. Patients live longer and enjoy a life relatively free of infirmities. There is however greater illness attribution giving a new dimension to what constitutes personal care. This stems from unbridled access to information, product advertisements masquerading as health education and inordinate focus on self over society coupled with a weakening of medical authority to arbitrate the resultant demands. Delivering personal care for cosmesis such as skin-peels, new wave anti-ageing treatment once at the fringe of general practice may distract from the more important tasks of providing good personal care by attention to healthy living and managing common diseases well.

FPs do provide comprehensive care for the majority of common ailments. However, the term, comprehensive healthcare now needs to be re-defined in the fast changing healthcare landscape of heightened patient expectations and market-driven proliferation of specialized services. Take for example ailments like headache and sprains after serious illnesses have been excluded. The proverbial aspirin may be not all that is expected. Must the FP himself be skilled in providing stress relieving therapy for headache and basic physiotherapy for sprain or should he refer patients to these specialized services because they are now more readily available, shift the cost and be found wanting for not providing these services?

The FP is challenged to provide continuing care of the multiple diseases and problems of ageing. The specialists do not have the numerical capacity to tend to the masses. The multiple diseases also confound the compartmentalized organization of specialists' services. Further, there is a burgeoning need for stepped down and domiciliary care.

The FP needs therefore to redefine his roles in the light of the changing healthcare landscape. It is not the survival of the form of the FP practice that matters. The focus should not be on the market share of the different FP sectors be it solo, group or polyclinic practice. Such a fixation fragments the fraternity and undermines the central role that

FPs should play in the healthcare system. It is the survival of the core values of what the four roles when taken together exemplify that is at stake.

Though there are erosions into each of these four roles in recent year, the FP must have the confidence that because the care he provides is firmly anchored on core values integral in all four roles as a whole, only he alone can provide an integrated sustainable healthcare solution. Only then can contextual vocational training be revved up to level up the whole fraternity. If the FPs believe in these values and equip themselves with the necessary skills, patients, payers and policy makers should understand why they should give the 'focus back to the FP'. An integrated primary care system with FPs providing all four roles is more effective and efficient than the aggregate of disparate services that would evolve if left unchecked.

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