Editorial

Bridging the Gap between Primary and Specialist Care: Formidable Challenges Ahead

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The strong guiding hand and deep pockets of the state have brought about the growth of hospitals and national specialist centres while leaving the primary care sector largely to free market forces. Thus, it is not surprising that the evolution of Singapore's healthcare system has largely favoured specialisation and tertiary care.

However, primary care has not been stagnant and, through the efforts of many pioneers including Associate Professors Goh Lee Gan, Cheong Pak Yean and Lim Lean Huat, it has taken tentative steps towards attaining its rightful place in the healthcare system. Nevertheless, optimum benefit to individual patients and the whole health system can only be achieved by better bridging the gap between specialist and primary care. The present era of medicine requires all of us to work together, as no single provider can adequately or cost-effectively manage all the medical and psycho-social issues associated with chronic diseases. Although formidable challenges lie ahead, this is the first time that this specialist journal has sought to specifically address specialists' interactions with primary care: this in itself is a cause for optimism.

We have sought local papers on thriving shared care programmes that tackle major chronic diseases,[1-3] comparative research between primary and tertiary healthcare,[4,5] and commentaries on ongoing collaborations between family physicians in patient care improvement[6] and post-graduate training.[7] We also have invited papers from respected US and UK authors on improving the transition of care between hospital and community in medication use and palliative care respectively.[8,9] In the spirit of this issue, effort has been made to include both primary care physicians (PCPs) and specialists as authors in each paper and in the peer review process.

What are some of the roadblocks to integrated healthcare that lie on the horizon? These problems include the inadequacy of a viable business model that bridges the specialist-family physician divide and a generation of minds moulded to "favour" tertiary care practice. In chronic disease management, patients remain un-persuaded of the personal benefits of right siting despite the Ministry of Health's best exhortations. Meanwhile, PCPs lament the economic folly of spending 30 minutes counselling patients on lifestyle modification, under the current business model of primary care. Within current restructured hospital funding mechanisms, Lim et al[10] suggest that providers with an eye on the bottom-line may be rightfully lukewarm about right siting; similarly Wee et al[11] describe the operational challenges facing well-meaning providers working to improve patient care.

Unfortunately, there are very few financial and policy models that incentivise key stakeholders to embrace greater teamwork between primary and tertiary care providers in chronic disease management. Our local medical school has perhaps not placed enough emphasis on primary or community care, despite the majority of its graduates becoming PCPs. So, a re-orientation of the medical school curriculum towards family and community practice, and sustaining the message that the specialist track is not the default route of every young medical graduate, would help to blur the lines between specialist and primary care.

The distinction of the specialist from the PCP also fractures the healthcare community, and needlessly suggests to patients that there are differences in skills between the 2 activities. In practice, the differences are more imaginary than real, as the majority of common clinical conditions can be adequately managed by either. Arguably, it is high time to completely re-examine the basis of this dichotomy, and consider whether specialists should simply be defined by higher training and qualifications instead of their area of interest (e.g. internal medicine specialists, occupational specialists, family medicine specialists, etc). Lee's contribution on the hospitalist movement is timely, as it brings a fresh perspective to the role of family physicians in hospitals, the traditional domain of specialists.[12]

What else can be done? The editors' natural inclination is to shy away from calling for more government intervention but, in this instance, as the largest purchaser and provider of healthcare, the state must play a larger role in correcting some of the distortions to allow for genuine removal of this specialist-primary care gap. For example, while the low

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charges levied by public sector polyclinics are undoubtedly a lifesaver for many poorer Singaporeans (as expressed in the paper by Lim and Joshi[4]), these same low charges, without means testing, distort the market by effectively constraining what private providers can charge. Charging low prevents an escalation in primary care costs, but is, at the same time, a deleterious financial disincentive for PCPs to care for patients with chronic diseases in a substantial way. Polyclinics and hospital outpatient clinics remain overcrowded while private sector PCPs experience ever decreasing patient loads.[13]

The state needs to engage and empower private PCPs (general practitioners), both emotionally and financially, to play a greater role in the national healthcare framework. The postgraduate training of family physicians already involves specialists,[7] so perhaps it is time for family physicians to become involved in specialist training. Such cross-fertilisation of ideas and experiences between specialists and family physicians during their advanced training may improve understanding of one another's domain settings, their strengths and limitations, and promote future closer collaboration and cooperation.

As in most other countries, primary care research in Singapore is relatively under-developed compared with specialist research. Focused funding and greater resources are needed to build research expertise among family physicians, both within and outside academia. Collaborative research between hospitals and primary care, particularly in healthcare delivery, transfer of care, and health outcomes, needs boosting. What of the future? At the moment, it looks promising. The Ministry of Health has declared that strong primary care is critical for a successful healthcare system,[14] and it is contemplating a Register of Family Physicians to recognise those with postgraduate training.[15] It also recently invited all private PCPs (general practitioners) to a forum to discuss strategies to play a greater role in wellness, disease prevention, patient education, and chronic disease management.[16]

The papers in this issue are a testament to the budding research and education relationships between primary and hospital physicians. We hope they stir up debate and stimulate greater integration of its specialist readers with primary care. With our rapidly ageing population and growing burden of chronic diseases, such positive changes are urgently needed, and we cannot afford to allow the momentum to dissipate.

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