

Value the patient as a person: Answering the call for a person-centred model of care

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There has been a change in patients' attitudes towards healthcare professionals in recent decades, coupled with an increasingly evident shift in the care paradigm. In 2015, the World Health Organization released a framework of care that recommends healthcare professionals consciously consider the perspectives of individuals, carers, families and communities. Practitioners and policymakers are graduating from a more prescriptive culture towards a more consultative form of practice known as person-centred care (PCC),¹ where a person—more than a patient—is valued as an active participant in the health service and an expert of their perceptions and experiences.² PCC advocates for more equality in the doctor-patient relationship.

The need for a PCC model is clear, not least because of the growing presence of multimorbidity. In a recent systematic review, the global prevalence of multimorbidity among adults is estimated at 37.2%, rising to 51% in those above 60.³ The consequences of such a landscape can be devastating, with multimorbidity reducing the quality of life, worsening mortality rates, and increasing healthcare utilisation and expenses.³ While applying conventional disease-centric care models to multimorbidity will likely lead to fragmented care, integrated care models guided by the principles of PCC could streamline care.

The adoption of a PCC approach to care delivery is increasingly gathering interest. In countries like Australia, Sweden and the UK, regulatory bodies and advisory committees have been set up to ensure healthcare transformation aligns with the core values of PCC.^{2,4,5} In 2007, the UK implemented personalised care and support planning through the Year of Care Partnerships (YOC).⁶ This model enables patients with long-term medical conditions to identify their treatment goals through focused conversations with their physicians. Mirroring the YOC, a team from Singapore comprising endocrinologists and primary care physicians collaborated on the Patient Activation through Community Empowerment/Engagement for Diabetes Management (PACE-D)

trial to evaluate the efficacy of personalised care and support planning in optimising glycaemic control.⁷

Patient engagement and activation are at the core of any PCC model. Engaging patients involves strengthening their roles as co-producers of health services and policies, thus enhancing mutual accountability and understanding between patients and healthcare professionals. Activating patients means supporting them to develop confidence and skills to engage in care, mainly focusing on achieving specific improvement goals for diseases.⁸ While the vision of PCC may seem intuitive, health services need to be sufficiently organised to support it directly. A fundamental lack of understanding of its principles among patients and healthcare professionals, a paternalistic practice culture, and the absence of a facilitative infrastructure are current barriers to a successful PCC model in Singapore. The Donabedian model of examining health services, which focuses on the domains of structure, process and outcomes, may be adopted as a framework to guide the implementation of PCC (Fig. 1).⁹

A redesign of the healthcare structure is imperative in creating a conducive environment for PCC to flourish. First, infusing a culture of codesign is particularly helpful in better engaging patients. The development and maintenance of systems within our healthcare institutions traditionally involved only administrators and healthcare professionals—ironically, an area that needs more active input from patients who are the end users of our healthcare systems. Patient advisory councils and the involvement of patient advocates in designing care pathways are active ways to engage patients in shaping the care they would like to receive. Patients and healthcare professionals may codesign the development and implementation of programmes to better educate themselves on developing personalised care plans and self-management strategies. Second, a revamp of the healthcare infrastructure is necessary. Hospitals and clinics may be given a more person-centric touch through modifications that

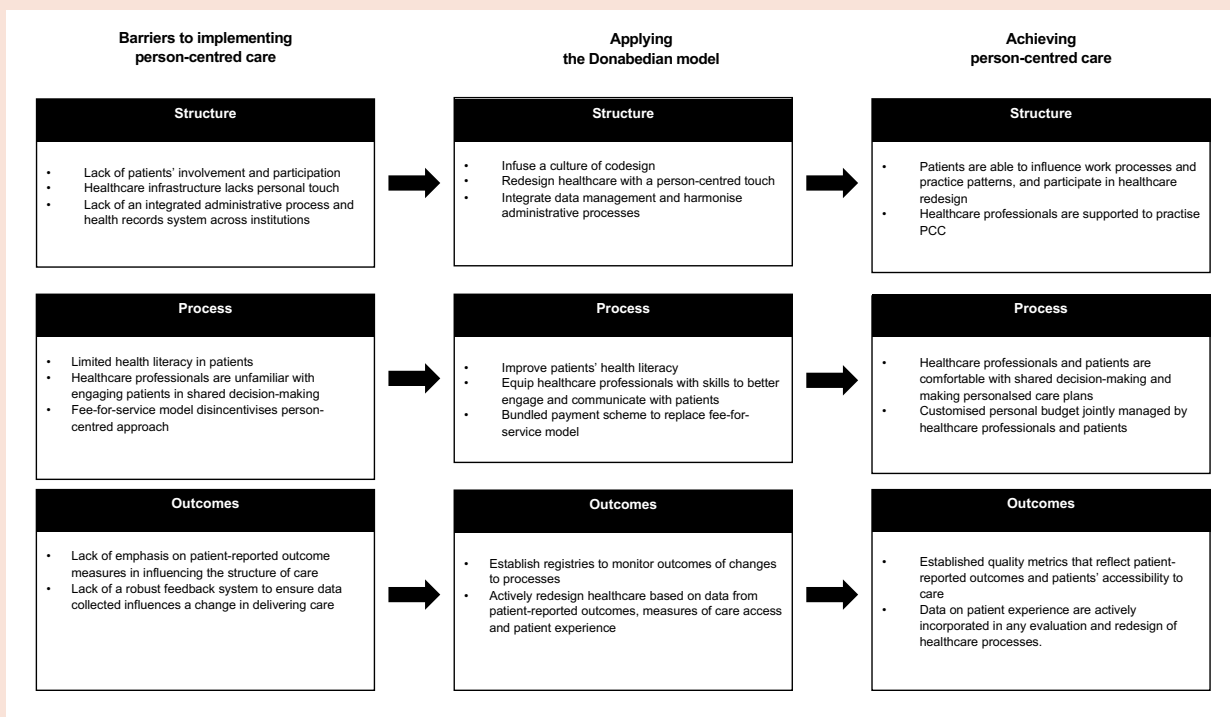
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Fig. 1. Applying the Donabedian⁹ model of examining health services to the implementation of a person-centred care model.

include allocating private rooms and spaces to facilitate conversations, extending the duration of consultations for sharing ideas between physicians and patients without time pressure, and prompt provision of interpretation and language services.⁹ Third, harmonising administrative workflows across institutions and the availability of an integrated electronic platform that enables the seamless sharing of health records and medical information between care providers could improve the efficiency of care delivered to patients.

Evaluating the patient-healthcare-provider interaction is pivotal in effecting a person-centred change in the processes within healthcare. Healthcare providers must change the way that patients are engaged and strive to work towards developing personalised care plans—through shared decision-making, as opposed to being overtly prescriptive in their practice. To this end, healthcare professionals need to be more responsive and sensitive to patients' values and preferences through a deeper understanding of their psychosocial and cultural contexts. There is also an imperative need for healthcare professionals to cultivate communication through actively listening to their patients, including the sharing of medical information with patients. From the patients' point of view, knowing about their health is essential in empowering them with the confidence and desire to have an opinion about their care. However, health literacy often needs

to be improved. A recent national survey of older adults found that over two-thirds of adults had difficulties reading, understanding, exchanging and using health information and resources.¹⁰ Programmes to improve people's medical knowledge and understanding of their medical conditions are thus vital.

A restructuring of the healthcare financing framework is necessary to incentivise PCC adoption and an essential step in effecting a person-centred change in the care delivery process. As the principles of PCC mainly drive the adoption of qualitative changes in a health system, financial incentives positively associated with quantitative tasks may be ineffective in nudging an uptake of PCC. Bundled payment schemes, which assign costs based on an overall assessment of a person's utilisation of health services, might be a better alternative in encouraging physicians to adopt principal ownership of persons, compared to the conventional fee-for-service model.¹¹ In Singapore, patients may claim up to SGD500 to SGD700 yearly for outpatient payment of any chronic disease covered by MediSave, a national medical savings scheme apportioning a part of a citizen's income for healthcare needs.¹² Such a payment scheme may be customised to serve as a personal budget jointly managed by patients and their principal physicians, promoting conscious care provision and resource utilisation based on a commonly agreed upon action plan.

In assessing the effectiveness of any new model of care to deliver PCC, the choice of tracked outcomes should be an accurate measure of PCC. We can consider building national quality registries to provide real-time feedback on care processes. In addition to tracking administrative data that reflect access to care (e.g. wait times for referrals to specialists), indicators that reflect patient-reported outcome measures and patient experiences—including the health-related quality of life, patients' psychosocial outcomes and their assessment of care—should also be included⁹ because data will help inform the process of refining PCC delivery.

On top of the suggested tangible changes to the healthcare system, the medical fraternity must recognise that a fundamental change in the practice culture is essential, as the move towards PCC challenges the conventional organ-specific, disease-centric and specialty-based approach to medicine. Health systems must adapt to facilitate this change. First, to develop a less fragmented approach to patient management, specialists should adopt a more generalist approach, and generalists need to be supported to practise with a deeper understanding of specialised care.¹³ Such a culture has been fostered in Alexandra Hospital in Singapore, which has successfully driven the inaugural implementation of an integrated general hospital model that exemplifies the principles of PCC.¹⁴ Second, health systems should emphasise the holistic concept of a principal physician to reduce the fragmentation of care frequently encountered when patients have multiple concurrent providers. In Alexandra Hospital, from our internal quality data project in 2021, we note that at least 90% of patients had their care by different parties consolidated and thus saw only one physician. Third, our health system should break down silos, enabling collaboration and sharing of information about PCC indicators between healthcare institutions, academic centres, community partners and government.

The Healthier SG campaign, a nationwide initiative the Singapore government launched in July 2023, is an example of us gravitating towards a PCC model. In the spirit of a culture of codesign, the white paper on Healthier SG was shaped by consultations that the government had conducted with over 6000 residents and stakeholders, including primary care and community partners.¹⁵ Singaporeans are encouraged to take ownership of their health, participate actively in preventive health measures like annual screenings, and develop long-lasting and trusting relationships with their family physicians—principal physicians who oversee their

health. With the introduction of digital applications like HealthHub and Healthy 365, which are compatible with personal digital assistant devices, Singaporeans have greater and easier access to their medical information and data. Such initiatives that improve the transparency and the availability of medical information can better support patients and healthcare professionals in the shared decision-making process and in the development of personalised care plans.

Much is still needed to realise the dream of delivering PCC in Singapore. The culture of how we design and deliver care needs to change. It will take a strong mandate and commitment from Singapore's healthcare fraternity to carry this through and to make that all-important shift to value our patients more as persons. As Hippocrates prophetically said more than 2500 years ago, "It is more important to know what sort of person has a disease than to know what sort of disease a person has."

Declaration

The authors declare that there are no affiliations or financial involvement with any commercial organisation with a direct financial interest in the subject or materials discussed.

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