(continued from Page 7: A Tale of 3 Clusters)

Dr Chua Chi Siong, Medical Director, Jurong Community Hospital

College Mirror (CM):
What is your role in Jurong Community Hospital?

Dr Chua Chi Siong (CCS):
I am the Medical Director of Jurong Community Hospital (JCH) and together with my team of clinicians, nurses, operations, HR and finance personnel, oversee the running of the hospital. From the clinical viewpoint, apart from being responsible for the standards of clinical care at JCH, I worked very closely with the clinicians in Ng Teng Fong General Hospital (NTFGH) to ensure that patients who require post-acute and rehabilitative care are seamlessly and safely transferred across to receive the required care at JCH en-route to recovery. Knowing that many of the patients will require well-coordinated post-discharge care involving not just family physicians, but also other community health and social partners, I worked with different teams to ensure that discharge care plans are developed and communicated to relevant partners for good continuity of care.

CM:
How will the larger cluster affect the delivery of care to community hospital patients in the western part of Singapore?

CCS:
Prior to the latest reorganisation, there was already strong vertical integration between the restructured and the community hospitals. With the larger cluster, we aim to build on the existing relationship and work arrangements to better integrate care from the community to the home. As a larger cluster, we will be able to leverage combined resources, expertise and greater opportunities to ensure patients receive well-coordinated care across both restructured and community hospitals. For example, one of the key changes in this reorganisation is that each of the new cluster now has a Polyclinic group so that post-discharge care can be further smoothened for better continuity of care.

CM:
What are the opportunities the re-organisation present to a family physician in ILTC sector.

CCS:
A well-trained family physician will have skill sets and ethos that allow him to contribute in a variety of healthcare setting. MOH has identified family physicians to play a crucial role in the further development of the ILTC sector. There is now greater opportunity in terms of training to realize the full potential of family physicians to contribute to patient care across setting and, for those who are interested, to participate in care in more than one setting (as well as involvement in teaching and research).

CM

A Primary Care Doctor's Perspective of Public Healthcare Sector Restructuring

by Dr Ng Chee Chin David, FCFP(S)

From a macro perspective, restructuring our public healthcare system into 3 regional clusters is a move in the right direction. The perceptible duplication and fragmentation arising from having 6 fairly autonomous regional health systems will hopefully be reduced in time to come with the breakdown of boundaries and better interfacing between services. In the spirit of care integration, this reorganisation places the cluster HQ firmer in the driver's seat by overseeing a larger geographical area as well as crucial components of the public healthcare system from tertiary hospital to polyclinics. It however remains to be seen how well the mergers will drive the clusters to focus more on community and primary care, an objective clearly desired by the Ministry of Health.

The shift of care into the community has always been the intention of Ministry in the face of an increasingly aged population. Care provision in the community necessitates the building of meaningful and mutually beneficial relationships with community healthcare elements like the GPs, ILTC providers and also social organisations as well as other government or grassroots agencies like the Police, schools, People's Association. That network of relationships built on trust undergirds every collaboration that true integration within each region will ensue.

Thus, it is important that the clusters take on the mantle of managing the health of a population by going beyond traditional institutional barriers, bridging the public-private divide and looking hard at what will really benefit the health of the population they serve.

Some potentially thorny issues, however, need further in-depth exploration:

1. Accountability vs. porosity
Accountability is demanded from regional population management to the individual physician/GP in the heartlands. However, the population and private providers alike are not beholden to the care of their geographical cluster. How does the Ministry intend to hold accountability in the midst of porosity? Unlike other geographically larger countries where regional health organisations are physically far apart from each other or their patients are bound to their services through insurance contracts, our 3 regions (and their patients) are packed in a small island of no more than 600 square kilometres. That some of our patients will cross regions when seeking healthcare is a given, and it is very unlikely that the ability of patients to cherry-pick services across cluster boundaries will be curtailed. So accountability for care outcomes and population health may need to be limited to certain sub-populations or omit those who venture out of the cluster, or are identified as obligate cluster-hoppers.

2. Value Proposition
Value = Outcomes/Cost
What outcomes are we looking for in this restructuring exercise? How do we measure cost or the constituent costs of long-term care? In primary care where the focus is on prevention and early diagnosis, how do we measure complications delayed and costs avoided downstream? Value is notoriously hard to show. The job is made harder when there is no available data, difficult data collection, potentially unreliable subjective/qualitative data or red tape. Porosity, as mentioned above, makes the job even more challenging. And that is exactly why we need to think through these carefully before jumping on the bandwagon of change. The user may be convinced of value by a conglomeration of success anecdotes, but will the stakeholders be convinced likewise? It is therefore vital that system enablers like IT be built to pervade the entire healthcare cluster, with the aim to make information more accessible to instigate regular review and improvement. To continue driving in darkness risks ruin by ignorance.

At the meso level, the polyclinic clusters have been impacted the most in the restructuring exercise with the creation of a third polyclinic cluster from the existing two. Whilst not seismic, this move is major enough to generate activity for the 3 polyclinic HQs for the next few years to come. Capacities are going to be stretched, to say the least as a whole new leadership team shapes up under the NUHS cluster.

Over the years, our polyclinics have morphed into centres for chronic care delivered in a team-based model. With this restructuring and desired closer linkage with hospitals and cluster at large, this trend will likely continue as polyclinics transform further to care for the growing number of complex chronic, geriatric patients and other patients specifically decanted from specialist services. There will be increasing cross-institutional accountability for these groups of patients as well as the call to extend care beyond the walls of the polyclinic into the community and home. Transformation of this nature will take time and the polyclinics will have to grapple with both external reorganisation and internal transformation despite an overt struggle with adequate resourcing.

The private GP community carries 80% of primary care and almost 50% of chronic care in Singapore. This renewed emphasis on population health management in the public sector could afford the opportunity for GPs to band together for greater collaboration with the public clusters. I suspect the same issues of accountability and value proposition to both users and stakeholders whilst keeping an eye on bottom line will emerge, and both the public sector and private providers need to work hand in hand to ensure they share a common vision for the region. College also plays an important role in facilitating such conversations and advocating on their behalf to relevant agencies.

On a personal level, having worked for many years in one of the clinics affected by restructuring, it really isn't easy letting go of the clinic and staff. Thinking about the people I worked with, the memories and conversations that took place in the corridors, jokes shared at the spine of the consult rooms, patients seen, friendships forged. It is hard realising that they will soon leave and be part of another organisation. And for some staff, the anxieties and uncertainties are palpable. Yet others are more positive and hopeful for the future. The way restructuring impacts individual staffs is sometimes unanticipated, even if at all carefully and comprehensively engineered. A nurse told me that as a result of moving to another cluster, she will face a lot more hassle claiming medical benefits for her son – might just be a hygiene factor to consider for the effectors of change, but a host of unintended and unexpected consequences for others.

Beyond the issues mentioned above, I would argue that there needs to be an articulation of what the healthcare system as a whole is or is not, to be, where different healthcare elements sit in the overall scheme of things, their mandate, roles and responsibilities. This also needs to be coupled with intentional engagement of the public, and of staff as well. Public mind-set and expectations need restructuring in tandem with the organisational restructuring that is taking place. Indeed, the social compact between the healthcare system and members of the public needs to be renegotiated. Only then will the painful throes of restructuring truly bear fruit for both providers and recipients.

CM