

FROM THE MEDICAL CHAIR

Fresh Hope

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The move away from hospital-centric care for patients and the worried-well is inevitable, just like means testing is inevitable. Why? Because it is too expensive to run and no country can afford it long term. Expensive care does not equate to good or excellent care. In fact, the medical error rate is probably the highest in a hospital setting where care is complex, complicated and patient's health status unstable because of the insults to the body, natural, or iatrogenic. In the last category, some are self-inflicted through neglect, ignorance or poor compliance. Others include the wrong diagnosis, too many cooks/specialists/health professionals spoiling the "soup".

So, let us do some scenario planning to help our general practitioner colleagues prepare themselves for a more fulfilling role. Their expertise and skills should not go to waste with fringe medicine which the medical schools do not teach. Yet GPs have learnt them because society allows them such lucrative practice when they use their medical licence to deliver such "products". I will list five possible scenarios for your consideration.

1. Portable subsidies for health care. Government would always have to subsidise the poorer strata of society because they alone need subsidies the most. Today, this is not portable and more changes are to come to make them portable to those who qualify. The other issue is instead of portable subsidies to pay for services at the point of care, the subsidy should be to pay for medical coverage and insurance. Linked to these two issues is the need to limit consumption. The doctor's role in all these is the ethical issue of practising evidence-based medicine, that is, effective (delivering good outcome, not witchcraft which is the other end of the spectrum), and cost-effective (effective but within the budget available, and not costing the moon). The latter includes systemic changes and infrastructure like IT connections for information flow, e-consult with specialists (instead of sending patients), video consult using skype, etc.

2. Home care. With 'ageing in place' as the motto, hospital care should be the last resort and only when needed. Today, because it is hospital-centric, the public rushes to hospital after waiting a long time for their medical problem to fester, erupt and become life-threatening. Nobody wishes to pay for prevention because if they feel no pain, no symptoms, they do not feel the need to do anything. So, the home becomes a dangerous place when the elderly falls in the toilet. Then, modifications* are made to ensure home safety. "There is no place like home"; more so, the older one gets. So, keep the home going and deliver whatever care into the home, rather than sell the home and transfer the elderly into scenario three.

3. Nursing homes and homes for the aged sick. This will grow for the simple reason that there will be more elderly with us and not all would have the good fortune of staying healthy and then dropping dead. So, scenario two will hold for as long as is possible but after that, for some, there is the need for scenario three.

4. Community hospitals. As hospital care deals with the really sick needing significant interventions (there are the really sick who don't want or need significant interventions, hence the Advance Medical Directive), once the patient is stable, it makes economic sense to continue care at the community hospital. This economic sense must be realised by the patients. Today's funding mechanisms appear to thwart this.

5. Hospital Specialist Outpatient Clinic. Instead of being run by hospital doctors/specialists, the GP should run them with a view to transferring these patients from the hospital base to the GP clinic in the community. So, the first few visits are at the hospital and with rapport established, and the medical problems defined and stabilised for continuing care by this same GP, the patient will leave the hospital SOC. The funding mechanism should be such that the payor (insurance or government subsidy) would put pressure on the patient to move in this direction.

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