



MINISTRY OF HEALTH
SINGAPORE

SPEECH I BY MR KHAW BOON WAN, MINISTER FOR HEALTH

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“More Resources, Better Sharing”

1. Last year, Er Lee Bee Wah nearly brought the House down with a colourful Hokkien proverb. She wanted to stress the importance of forward planning and preparing for the future. In ancient China, the Prime Minister of the State of Qi (春秋时期齐国), Guan-Zhong (管仲) put it more strategically: “一年之计，莫如树穀；十年之计，莫如树木；终身之计，莫如树人。” Guan-Zhong’s political thought is that public policies must look far beyond one or even ten years, as affairs of the state impact people’s lives and one important public policy is to nurture talent and cultivate people. I try to bring this philosophy into my work.
2. As Health Minister, my job is to look at healthcare, not just today or tomorrow, but over a much longer timeframe. Within a few years, I would be retired and potentially become a customer of healthcare providers for the subsequent 20 years. To me, health policies are not drawn up in a vacuum or just about focusing on numbers. Health policies are about creating a good healthcare system that is sustainable and relevant to real people, like you and me.
3. I have some advantage of a long association with the Health Ministry. I had the opportunity to study other healthcare systems and think through many issues. There is no perfect healthcare system, but there are positive elements in some which can be incorporated, just as there are clear pitfalls we must avoid. Health policies need a long lead time to see results. As healthcare is an emotive subject, we need to consult the public widely and patiently for each policy change. A radical, big-bang complete overhaul approach to health system reform is not advisable. Instead, it is through a series of deliberate, carefully-considered incremental policy changes over many years that we build



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a sustainable healthcare system. That is how we have built up our 3Ms framework over 25 years and how we are continuing to make it stronger.

4. As a result, Singaporeans can be proud of our healthcare system. It is far from perfect. But the WHO has rated it number 6 in the world. It has enabled Singaporeans to enjoy a high standard of care. With less abuse in the system, our health spending at below 4% of GDP is the lowest among developed countries. We should try to retain this ranking.

We Continue to Build

5. Hence, we continue to build for the future. Last year, I announced a 10-year capital development plan, costing \$2 billion. This will expand our capacity further. We are busily implementing this plan.

6. But like Mdm Halimah, Mr Yeo Guat Kwang and Dr Amy Khor, I worry about rising healthcare costs. Our population is expanding and rapidly ageing. New technology is generating more sophisticated treatment which is almost always more costly. There is a big debate right now in the US and the UK on Avastin. It is not a cure but some studies show that it could prolong the life of a late-stage breast cancer patient by about 2 months. But it comes at huge price tag: US\$100,000 per year for some patients. Many families will be financially ruined just to try extending the life for a few weeks with much suffering for the patient.

7. Back here in Singapore, we know we need to improve the doctor-to-patient ratio to allow enough time for each patient. Our doctors and healthcare professionals are over-worked, and at some point, they need a life too. I know our Director of Medical Services, Prof Satku, is sleeping less and less, juggling between his surgeries at NUH, meetings at MOH and with international counterparts. The situation is the same for many senior consultants, such as Prof Benjamin Ong at NUH, Prof Philip Choo at TTSH and Prof Tan Ser Kiat at SGH. But it is not just the senior consultants. Our younger doctors too are also working day and night to meet the needs of increasingly more demanding patients and relatives. Dr Fatimah Lateef, Dr Lam Pin Min and Dr Lim Wee Kiak can testify to this. Our doctors would like to enjoy a better work-life balance. But the patients keep coming.



8. Not just local patients. An increasing number of foreigners are coming here for treatment. This is good for the economy and a testament to our high standard of care, but it puts pressure on manpower. At least two new private hospitals will open by 2011. We will face a worsening staff shortage. Our specialists are trained in the top centres around the world. They are much sought after. We need to ensure our remuneration packages are competitive to retain this key talent.

9. It is not just our doctors we try to retain. This is a point stressed by Mr Zainudin. The booming hospitality sector driven by the IRs will put great pressure on other manpower. Healthcare workers are going to have other opportunities outside healthcare. We need to keep them in healthcare with comparable pay and working conditions.

10. That is why I have sought a substantial increase in budget. As noted by Mdm Halimah, this Health Budget will go up by 19% over the last budget, a significant increase of \$421 million.

11. It will fund both hardware and software and more initiatives to improve clinical outcomes and increase productivity. Our bed-to-population ratio will go up from 1.6 to 1.8 (per 1,000 population) by 2015, but it will still be lower than the rates in other developed countries today (US: 2.7; UK: 3.1). We will watch over our average length of stay in acute hospitals, which at 5.3 days is amongst the lowest in the world and must remain so. This means that a patient who is medically fit for discharge must vacate his bed to go home or to a nursing home if necessary. We need to price our hospital facilities correctly, so as to discourage unnecessary hospitalisation.

And Add Headcount

12. Dr Fatimah Lateef and Mr Zainudin stressed the importance of getting more manpower to cope with rising demand and I agree. We are spending \$1.9 billion over the next 5 years to expand our pool of doctors, nurses, pharmacists and allied health professionals by 40%. We are actively recruiting from abroad to supplement the local pool. We have some success. Last year, NUS graduated 230 doctors. We recruited 438 doctors who graduated overseas. The increased budget will also allow us to double the number of scholarships for the allied health professionals to 120 this year. We are starting



a new scholarship to sponsor some graduates of Nanyang Polytechnic to pursue a one-year degree conversion course overseas.

13. These increases should lead to better service levels, but they will also add to our cost. Our health spending will go up from 4% of GDP to 5% or 6% in the medium term. They will fuel healthcare inflation which Mdm Halimah, Mr Yeo Guat Kwang and others expressed much concern about.

Higher Inflation

14. In a previous Parliament Sitting, I have explained the high healthcare inflation in Singapore in the past one year. At 6.3%, updated to 7.4% recently, it was exceptional to the norm of about 2% per annum for several years. There were several contributing factors to the exceptionally-high rate. Huge imported cost increases were a major factor, pushing up prices of medical supplies and medicine, both western and traditional.

15. The imported cost increases have affected the private sector. Last week, Dr Ahmad Magad related a personal experience when his daughter was hospitalised in a private hospital. He said that he almost fainted when he saw the bill of nearly \$2,300 for a 2-day stay.

16. The public sector is not spared such imported inflation. But part of the cost increases was also due to higher public expectations, and their demands for higher-end care.

Rising Expectation

17. Let me give one example: attendances in our emergency departments. Last year, the number went up by 11%, a very high rate. In the previous 3 years, the rate of increase was 7% which had already alarmed us, as that was higher than the previous 10-year average of 4.5% per annum. What is happening? Our population is not growing at this rate. Are Singaporeans getting sicker? Are we getting into more accidents? Or are we now rushing to Emergency Departments too readily, and perhaps unnecessarily? There is



hence a need to price our services properly so that we do not inadvertently attract non-emergency patients to our emergency departments. Non-emergency patients should go to their family GPs and not rush to emergency departments and compete for the resources meant for the critically-ill.

Managing Rising Cost

18. We will do our best to manage cost escalation. During this period of high inflation, our public hospitals will be particularly careful. They cannot freeze their charges, as imported inflation will have to be passed through. But they will not add to these cost increases unnecessarily. They will also play their part by promoting the greater use of generics and standard medical supplies and helping the patients to get treated at the right settings. For this, our hospitals need the co-operation of our patients.

Patients Can Play A Part

19. Indeed, in healthcare, patients have a big part to play.

20. First, stay within our 3Ms framework. Contribute to Medisave. All employees do. But many self-employed and casual workers are still not regular contributors to Medisave, or are not contributing enough. We must persuade them to do so and do more, for their own good. Let us not forget the housewives too. Husbands should help contribute to their Medisave Accounts. CPF Board has a voluntary contribution scheme. I urge all husbands to top up their wives' Medisave Accounts, especially if they are full-time home-makers. This must be one of the basic duties of husbands.

21. Second, subscribe to MediShield. I agree with Mr Yeo Guat Kwang that all Singaporeans should subscribe to MediShield. 77% of Singaporeans do. But the remaining 23% need to come in too. Newborns are now automatically covered. With CPF and MOE, we will sign on all children and youths in schools. In addition, we are working with NTUC to get workers to buy MediShield for their spouses. Through these efforts, we aim to raise MediShield coverage to 85%, and then we shoot for 90%.

22. Third, the middle- and high-income Singaporeans should top up their basic MediShield with riders provided by private insurers for admission to Class A/B1 wards or



private hospitals. MediShield is designed only for Class B2/C hospitalisation. It is not designed for private wards. Many Singaporeans are still under-insured, probably due to inertia or possibly ignorance. We will continue the public education.

Government Will Do Its Part

23. Government will do its part. First, we are strengthening Medifund and ElderCare Fund. The \$600-million top-up to these funds this year will provide our hospitals, community hospitals and nursing homes with more resources to help patients who need additional assistance.

24. Second, I am finalising the details of the next reform to MediShield, to further improve its coverage of large B2/C bills. I welcome Mr Yeo Guat Kwang's strong support for the proposed reform. This is taking some time as we are trying to keep premium increases affordable, while increasing payout to cover nearly 80% of large bills, two contradictory objectives.

25. For most age groups, balancing these objectives is not too hard. But for the very old, above 80, this is simply not feasible. We are making our actuarial consultants repeat many iterations to optimise the trade-offs. Still, the old will have to face a larger premium increase. To help them cope with this, Government will be topping up the Medisave Accounts of elderly Singaporeans. With this top-up combined with the MediShield loyalty discount, an affordable package may be possible. I target to finalise the details next month. We will time the Medisave Top-ups to precede the implementation of the MediShield reform.

26. Mdm Halimah suggested that we raise the maximum coverage age for MediShield. It was raised to 85 in 2006. We will review this periodically. But we do need time to gather more local data to correctly establish the premiums for those in higher age groups, taking into account the prevailing life expectancy.



Heavy Health Subsidy

27. Above all, the main strategy to help lower income Singaporeans cope with rising healthcare cost is our heavy subsidies for Class B2/C patients. At 80% or 65% of cost, these are large subsidies. Last year, direct subsidy for these patients was \$1.5 billion. This year, it will likely exceed \$1.7 billion. Indeed, the bulk of the budget increase will go towards caring for subsidised patients.

28. The question is who should constitute “subsidised patients”. For whom are Class B2/C wards built? I put these questions forward during my public dialogues recently. The vast majority of the participants were clear in their reply: Class B2/C should serve the bottom 20% or at most 30% of Singaporeans. This used to be the case. Indeed when we first started, Class C beds were clearly for the poor, at the bottom 10 or 15% of Singaporeans, and were furnished as such. Over the years, as we improved Class C wards and services, more lower-middle income patients chose them. Today, the bottom half of Singaporeans form the bulk of Class C and B2 patients. It is now a very different scenario from the days when Class C and B2 wards were first conceived.

29. And budget permitting, I would like to continue to upgrade the subsidised wards. But as we raise their service levels and narrow the differences between Class B2/C and Class B1/A, we must expect more and more higher-income Singaporeans to be attracted to them. There is no barrier to entry. Anyone who puts up their hand today can get into a Class B2/C ward and get the high subsidy. This must mean greater competition for the same health subsidy. This is the reason why we need to introduce means-testing in the subsidised wards now.

30. Over many dialogues, I have explained this to a good cross-section of Singaporeans. The concerns raised by Mdm Halimah, Amy Khor, Yeo Guat Kwang, Sylvia Lim, Siew Kum Hong, Ong Seh Hong and Low Thia Kiang were similar to those I have heard during the dialogues. I am heartened by the people’s understanding and support for this policy, after hearing my explanation and clarification. I have assured Singaporeans that we will take a practical approach to means-testing. We will be flexible at the margins to help those who may appear to be of high-income but who have exceptional financial liabilities. We have decided to set the criteria more loosely so as to mitigate the impact on those who may be affected.



31. The Clerk of Parliament will now distribute the parameters which will define our means-testing framework. Please refer to Annex A of the handout.

32. Members will notice that the criteria and income thresholds are more generous than was discussed during the public dialogues. The vast majority of patients will not be affected by means-testing. All those who earn below \$3,200 per month will continue to enjoy the full subsidy. All housewives, retirees and children living in HDB flats and lower-Annual Value private properties will similarly be unaffected. We have taken such an approach after taking into account the feedback from several MPs including Mdm Halimah, Amy Khor, Dr Lam Pin Min, Jessica Tan, Dr Maliki, Dr Fatimah Lateef, Mayor Zainudin who have helped me to conduct some of the public dialogues.

33. Mdm Ho Geok Choo asked if means-testing will deter the higher-income patients from continuing to use B2/C. I will not be able to forecast how individual patients will respond to the change. But what I hope will happen is a greater awareness on the part of Singaporeans that we all should subscribe to MediShield, and that those who earn more than, say \$3,000 or \$4,000 per month should top up with a rider which would enable them to use the higher ward classes. If they do so, then they will not need to use Class B2/C and compete with low-income patients for such resources.

34. Mr Siew Kum Hong suggested even more subsidy, higher than 80%, for the very needy patients. In fact we do so today. Through Medifund, patients who cannot afford the current Class C subsidy get further assistance. Many end up paying nothing, which means a subsidy of 100%. But they have to be properly means-tested.

35. We are now working out the implementation details and we are confident that implementation can be automated and hassle-free. Like Mdm Ho Geok Choo, we want to keep the cost of implementation low. Some cost in computerisation has to be incurred, but the incremental cost should be manageable.

36. I agree with Mdm Halimah that we should simplify implementation. That is why we adopt a simplified approach to means-testing, by focusing on personal income, rather than



per capita household income. I agree with Mdm Ho and Mr Siew Kum Hong that the latter is a better gauge of financial ability, but implementing such a scheme will be very costly and intrusive to every patient, given the large volume of admissions and short stays in public hospitals. However, if specific patients feel that the simplified approach has unfairly treated them, we will then do a thorough means-test on such patients upon their appeal, based on the approach as currently used in nursing homes.

37. We will have the simplified approach, as set out in Annex A, implemented in all public hospitals from January 2009.

Conclusion

38. This Budget will raise our health spending to a new level. It will improve clinical care and go towards meeting part of the higher public expectations for shorter waits. It will have raise cost for both patients and the society. We should be mindful that this does not trigger further expectations and hence greater cost escalation.

39. Managing expectations and moderating expectations require full understanding by Singaporeans. At the clinical level, what is standard healthcare can be more objectively determined. There are established norms for, say, how diabetes ought to be managed, how speedily heart attacks ought to be handled. To keep cost affordable, we have experts to advise us on what constitute standard care which we will subsidise. If patients demand non-standard treatment when standard medicine or appliances are available, we will have to ask them to pay for it.

40. However for the non-clinical aspects of healthcare, say the number of days or weeks of waiting by non-emergency patients for a new clinic appointment or waiting time to see a doctor at the clinic, clinical care is unaffected by improvements in such service standard. If such enhancement is pursued too vigorously, it must lead to huge increases in health spending. We have to be cautious on this front. Our 19% increase in health spending this year will bring about some enhancement in such non-clinical service standard, but we should be realistic that it will not be on-demand service as in 5-star or even 4-star hotels.



41. I will do my part to ensure that Singaporeans will continue to enjoy healthcare that is among the best anywhere in the world. But higher spending often does not guarantee better health. Indeed, as noted by Mr Yeo Guat Kwang, it is the basics that we must continue to focus on which will bring about healthcare improvement: prevention and better management of chronic diseases. For this I need the full co-operation from all Singaporeans: don't smoke, keep clean, don't spread bugs, don't over-eat and keep active.

42. Just as an example, please refer to Annex B of the earlier handout. It shows the rapidly-growing obesity problem in the US and Europe. As the colour darkens, it means that the population there is getting more obese. As Asia modernises and embraces fast food, we will not be spared. Obesity is becoming a global epidemic. In terms of human cost, it is worse than SARS. It will kill many more but in a silent way.

43. Singaporeans like to eat, so we are vulnerable. We are not as obese as the Americans or Europeans yet, but we may soon be, if we are not careful. After cigarettes, obesity is the most important cause of global mortality and morbidity, and like cigarettes, it is preventable. We did a good job fighting cigarettes and our smokers' rate is among the lowest in the world. We should try to beat obesity like we beat smoking. We must not lose to obesity.

