



MINISTRY OF HEALTH  
SINGAPORE

## SPEECH II BY MR KHAW BOON WAN, MINISTER FOR HEALTH In Parliament: 3 March 2008

### “Living Long, Living Well”

1. Last week, I came across an article with a seductive promise: “5 easy steps to living long and well”. It is a serious article quoting the evidence gathered from a study on more than 2,300 healthy men over many years. When the study began in 1981, their average age was 72. At the end of the study, 970 men or 41% had survived into their 90s. The study was published last month in *The Archives of Internal Medicine*.

#### Secrets to Longevity

2. “The take-home message,” said Dr Laurel Yates, a geriatrician at Brigham and Women’s Hospital who led the study, “is that an individual does have some control over his destiny in terms of what he can do to improve the probability that not only might he live a long time, but also have good health and good function in those older years.”

3. The prescribed 5 easy steps are: abstain from smoking, manage weight, control blood pressure, regular exercise and avoid diabetes. I score 5 out of 5 but I believe that good genes and good karma play an important part too. The study focused on men but the prescription is probably applicable to women as well. In the same issue of the journal<sup>1</sup>, there was another study which monitored 523 women and 216 men ranging in age from 97 to 119. This study showed that a large proportion of people who lived that long, with minimal or no assistance, did so despite long-term chronic illness. In other words, some of the oldest of the old survive not because they avoid illness, but because they were able to delay or even prevent disability.

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<sup>1</sup> The 2 articles are “Exceptional Longevity in Men” and “Disentangling the Roles of Disability and Morbidity in Survival to Exceptional Old Age”.



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4. As life expectancy grows, there will be many more such studies and articles. Dr Lily Neo mentioned Okinawa and their experience of dealing with longevity. I went there last year and spent several days there. I visited a village called Ogimi with 3,500 residents. 17 of the villagers are more than 100 years old. I have never, in one sitting, met so many over 90 years of age, mostly ladies.

5. I have met many Singaporeans in similar age groups here, but largely in nursing homes and chronic sick hospitals. The Okinawans were different. They are active, busy and happy, and live independently. Few are bed-ridden in nursing homes. They were quick to share their secrets with me. Less scientific and more anecdotal, their prescription: sleep well, be happy, eat lots of vegetables and stay active.

6. These are some positive aspects of ageing. But ageing of the population is not all bed of roses. Dr Lam Pin Min's comment on dementia is just one illustration. Indeed, the ageing of population is the greatest challenge confronting healthcare systems around the world. Look at the US. Medicare alone which funds the medical care of the elderly takes up 3% of the US GDP. One quarter of Medicare spending goes towards supporting the last year of the patients' lives. This raises questions about the appropriateness of such spending.

## **Slow Medicine**

7. One reason is that current healthcare systems largely skew the practice of medicine towards high-tech medicine, at great financial cost and often with low quality of life for the patients. I have been referred a book titled "Slow Medicine" written by a geriatrician (Dr Dennis McCullough) at Dartmouth Medical School who is promoting a different approach – "a family-centred, less expensive way" as he put it. He felt that for many elderly patients, "modern medicine in its hospital-based, medication-obsessed, high-tech impersonality may hurt more than it helps".

8. He has many practical tips for children of elderly parents and worth sharing. First, while the parent is still vital and lively, children must not fool themselves that this happy situation will last forever. This is the time to re-insert themselves back into the



parent's life, to accompany them to doctor visits, and to raise unpleasant topics like the advanced medical directive or living will.

9. After a few more years, he said, it is time for the children to address the “can you still manage at home?” issues and to help create routines that compensate for a slipping memory and slightly wobbly balance. Then medical crises will inevitably arise. The children should then be vigilant to protect and “rescue the elderly from standard medical care”. By that, he meant medical care should, all the while, favour the tried-and-true, over the high-tech. For instance, instead of a yearly mammogram, a manual breast exam for the very old may suffice. And home tests for blood in the stool may replace the draining routine of a colonoscopy.

10. He added that the pace of care should be slowed to a crawl, hence the title of his book: Slow Medicine. For doctors, that means starting the medications at low doses and increasing them gradually. For children, that means learning not to panic and yell for an ambulance on every apparently bad day.

11. Though both comforting and worrying, it is a valuable contribution to the global discussion on ageing and how best should families cope with it.

## **Different Approach Needed**

12. Indeed, modern healthcare systems are not well-designed for the demands of ageing. They are geared towards acute care in hospitals, that is, treatment for only brief but severe episodes of illness, sometimes requiring high-tech care. But insufficient thought has been given to long-term chronic care. Good models are rare and far-between anywhere in the world. Proper chronic care should be carefully designed for the long term, with appropriate level of resources, usually low-tech care, and most critically with strong co-operation by patients and their families. Chronic care is a very different care regime from acute care. But when high-tech acute care is mindlessly extrapolated to cover long-term chronic care for the elderly, it is not at all surprising that problems in the US and other countries have arisen.

13. Everyone is searching for a better model to handle long-term chronic care of the elderly. We too are evolving our model. I agree with Mdm Halimah that there are gaps in our current step-down care sector and we must fix them. Fixing them however requires careful thought. Some elements or operating philosophies are better known and appear sound, but we cannot be sure until they are tested through time and actual experience. This calls for carefully-planned experimentation and small-scale pilots, close monitoring and review, and if proven, scaling up. Such initiatives include, among many others:

- (a) Greater emphasis on preventive medicine;
- (b) Better management of chronic diseases at outpatient level;
- (c) Better integration of care between hospitals and step-down care facilities; and
- (d) Right-sting of patient care in more appropriate and lower-cost settings.

14. Many Members have shared their thoughts on this important subject and I thank them. I have noted Dr Lily Neo's comments on possible public-private-people partnership as a model of providing eldercare. Indeed, we should widen participation, both in provision as well as in funding. Ageing of the population is a growing problem, and we should not underestimate its impact. The Japanese are well-known for careful research and wide consultation before they launch any major policy change. Yet, when they launched their national long-term insurance scheme a few years ago, they found that their initial projection of demand and funding needs were off by a wide margin, after just one year of implementation! They have since been trying to curtail demand and raise premiums. This is an important lesson for us who are involved in the planning of eldercare services. Do not underestimate the demand, especially if it is going to be subsidised too generously. Better think through, start small, test the market, rather than rashly committing to any long-term financing that our society may not be in a position to afford.

15. Let us discuss some of the points raised.



## Promoting Healthy Living

16. First, I agree with Dr Lily Neo that we must promote healthy living and healthy ageing. But Singaporeans must participate actively in order to benefit. This is a continuous and often uphill endeavour. But we persevere.

17. Healthy living starts with awareness. This year, HPB will roll out the nurse educator programme. The nurse educators will hold classes at community centres for patients and their families on how to manage their conditions. We will work with PA and the grassroots to promote these programmes.

18. We will leverage on screening. Many MPs did a lot of work promoting community screening in the early years. We are consolidating the programme and raise it to a new level. From this year, HPB will roll out an Integrated Screening Programme. All Singaporeans above 40 will be reminded to go for screening for major chronic diseases.

19. We are embarking on preventive efforts to promote healthy ageing. Last year, we embarked on a pilot "Wellness Programme" at 6 constituencies. This includes a platform for health agencies and service providers to encourage positive changes in seniors' lifestyles and health behaviour.

20. HPB is developing an Elderly Health Promotion Blueprint. It will focus on providing our seniors with the knowledge and skills to keep healthy and live with chronic diseases.

## Improving Primary Care

21. Second, when medical care is needed, primary care is the best first point of contact for chronic-ill and elderly patients, except for genuine emergencies.

22. Good primary care is essential to meet the chronic disease challenge. Medisave can now be used for outpatient treatment of 4 chronic diseases. As noted by Dr Fatimah, half of GP clinics are now participating in this scheme. She asked why the other half are not joining. One main reason is that many of these clinics which



serve corporate clients do not find it necessary to join in. We respect their decisions, whatever they may be. The key is that most Singaporeans are able to have a participating GP within their neighbourhood.

23. Overall, we are pleased with the progress. From April 1, we will extend the scheme to the remaining two major chronic diseases -- asthma and chronic obstructive pulmonary disease, under similar terms. This will benefit up to 180,000 more Singaporeans.

24. Dr Fatimah asked if we would extend the scheme to mental illness. We will keep options open, but for the moment we focus on the key chronic diseases with established treatment protocol and measurable clinical outcome. We also must not forget that Medisave at current contribution rates is only designed for inpatient treatment. Extension to expensive outpatient care is an exception, and we should resist any temptation to broaden its use liberally, or it will surely be depleted prematurely.

25. Mdm Halimah Yacob proposed that we extend the Primary Care Partnership Scheme (PCPS) to cover some chronic diseases. Currently, PCPS covers acute primary health care. (There are now 19,000 patients on the PCPS, with 450 participating GP clinics and 190 dental clinics. Last year, they made 51,000 clinic attendances, for which Government subsidy totalled \$1 million.) Any extension to chronic care will raise the risk of over-consumption and over-servicing. But a case for extension can be made, if we can manage the potential problem of abuse. We will study it carefully.

26. Dr Lam Pin Min and Dr Fatimah Lateef described the problems faced by caregivers of patients with dementia. We have a pilot called the Community Psycho-Geriatric Programme to provide some home-based mental health care. The programme will train GPs and eldercare workers to recognize common mental health problems, and equip them with skills to counsel and care for these elderly.

27. For caregivers in general, we will try to support them more. There are workshops and support groups that teach caregivers coping strategies and provide



information on where to seek help if needed. We intend to expand our supportive efforts. (However, MOH is in no position to grant caregiver's allowance. We will focus on training and counselling caregivers. Any financial assistance that they may need to cope with their expenses will have to come through other agencies.)

## **Integrating Care**

28. Third, I agree with Mdm Halimah, Dr Lily Neo and Dr Fatimah Lateef that we must better integrate the healthcare system with the community to provide appropriate care for the elderly. [Kalyani Mehta] From next month, we will upgrade the Integrated Care Services into an Agency for Integrated Care (AIC). Starting with CGH and NUH, the AIC will equip public hospitals with resources including additional care coordinators. This will cost \$20 million over 4 years. These coordinators will help ensure that patients who are fit for discharge but who have multiple complex care needs, are transferred to appropriate step-down care providers and receive necessary medical and social services.

## **Right-Siting Care and Resources**

29. Another key focus for MOH is to ensure patients get the most appropriate treatment in the right place, or "right-siting".

30. Mdm Halimah and Lily Neo suggested that we subsidise home-based care of the elderly, including home hospice care. At present, there are several service providers offering home-based services to patients who are unable to leave their homes. Last year, MOH provided \$3 million in funding to these providers. We will do more but we are taking a careful approach as the direct home care model is very expensive and manpower-intensive. We need to study the underlying patient needs carefully.

31. Mdm Halimah commented on ElderShield. We have enhanced ElderShield last year. The ElderShield cash payouts help cater to varying needs of the severely disabled, allowing choices for care in the home or in other facilities. Cash is the most

flexible way to help with the cost of long-term care. For those who prefer a higher payout, there are 7 ElderShield Supplements to choose from.

## Expanding Infrastructure

32. We will expand the step-down care infrastructure. Much of this may be care that is not medical in nature. Indeed we should be careful not to “over-medicalise” this sector. We will work with MCYS and other entities to facilitate the development of new services. We envisage that many of these services for the middle-class will be commercially viable.

33. We will ensure that nursing home beds remain accessible and affordable. Mdm Halimah noted the high bed occupancy rate in VWO nursing homes. At the same time, there are 1,000 vacant beds available in private nursing homes. We are tapping on this spare capacity via a portable subsidy scheme. We are currently refining this scheme to extract better value for patients. Separately, we have a pipeline of nursing home sites and will be releasing them via tender in line with demand.

## Developing Manpower

34. Dr Lam Pin Min commented on the manpower strategy to cope with the rapidly-ageing population. I agree with him that current numbers will not be adequate. MOH has extended its Health Manpower Development Programme to cover the step-down care sector, providing them with the opportunity to pursue advanced skills training. In addition, MOH has worked with MOE to train more physiotherapist and other allied health professionals locally. This year, our target is to train 210 physiotherapists, occupational therapists, diagnostic radiographers and radiation therapists. This is a substantial increase from the past. We target to further increase the intakes by another 40% by 2012.

35. Besides stepping up the training of doctors, nurses and allied health professionals, we are putting in place measures to update these professionals with the necessary skills in geriatrics and gerontology, at all levels from primary care to specialists’ training. This includes the offering of more scholarships and developing



relevant training and certification programmes to enhance the competencies of our healthcare professionals. Under the Masters of Medicine (Family Medicine) programme, a posting to Geriatrics Medicine is also compulsory for trainees.

36. We are seeing some results. The intake of specialist trainees into geriatric medicine has increased from only 1 or 2 per year to 7 in 2007. Today, there are over 43 geriatricians in Singapore, almost double the number in 2002. Come May, a new “Diploma of Geriatric Medicine” will equip doctors with the knowledge and skills to better manage elderly patients.

### **Other Issues**

37. Dr Fatimah Lateef asked about the Health and Ageing Issues Workgroup. This is a workgroup formed by REACH last year. It is chaired by Prof Goh Lee Gan and has 10 members. I understand the group has met several times and I am sure they will share their findings and policy recommendations in due course.

### **Conclusion**

38. Everyone wants to live long and live well, without being a burden to the family. In Okinawa, the ladies told me of their top wish: “pokkuri shinu”. “Pokkuri” refers to the popping of a bubble. They want their lives to be fun and happy, and at some stage, just simply “pop” and die in sleep.

39. My father led such a life. He worked hard, loved the family, had no vices and one night, in front of the television went into a coma and drew the last breath a few hours later, surrounded by the family members. I missed him by an hour as I was not in Penang.

40. Not everyone is so lucky. My mother suffered nearly 3 years of cancer pain. We had to try high-tech medicine but when the poor prospects became clear, we went for palliative care and “slow medicine”. She was able to die peacefully at home, in familiar surroundings. This time round, I was able to return to Penang in time and be there as a loved one passed on.



41. As we busy ourselves with our work and our family, we should sometimes take a pause and reflect on how people spend their last moment. Death is not a taboo subject to be left unspoken. In fact, the more we think seriously about death, the more likely we will know how to live life to the fullest and make each moment and each day the most meaningful possible.

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