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At the Helm of Local Healthcare

Health Minister Gan Kim Yong on the silver tsunami, residency programme and finding the right balance

At the Helm of Local Healthcare

By Dr Toh Han Chong, Editor

Mr Gan Kim Yong has been serving as Singapore's Minister for Health after being appointed to the position in May 2011. Cambridge-educated Minister Gan began his career in the civil service at the Ministry of Trade and Industry and Ministry of Home Affairs. In 1989, he joined NatSteel Ltd, and eventually rose to become its Chief Executive Officer and President in 2005. He also led the Ministry of Manpower (MOM) from 2008 to 2011.

Singapore's population demographics have been changing rapidly over the years, bringing about various problems related to healthcare. In an interview conducted last month, Minister Gan shares the Ministry of Health's (MOH) plans to prepare the local healthcare system and the Singaporean society for these imminent challenges.

Pondering healthcare financing

Dr Toh Han Chong – THC: Minister Gan, thank you very much for granting us this interview in spite of your busy schedule, especially with the recent haze and dengue outbreak. Minister for National Development Khaw Boon Wan announced that "as the chief supplier of homes, the Housing Development Board should set the price of public housing, rather than take its cue from the resale market". As local public hospitals provide most of the hospital and specialty care in Singapore, would MOH do the same for healthcare?

Minister Gan Kim Yong – GKY: Healthcare has some similarities with housing, but we are also quite different for obvious reasons. Housing is a big-ticket item which you have to make decisions about once or twice in your lifetime. But healthcare is something that you may not be able to choose when or how you receive it, but yet it is important. You may need healthcare services quite regularly when you are young and more regularly as you get older.

One key similarity among public healthcare institutions – hospitals and polyclinics – is that they still play an important role in moderating healthcare costs. To start off, our hospitals are the main provider for subsidised patients. When the hospitals set their medical fees, they have to keep in mind the affordability issue, especially for subsidised patients. For private patients, public hospitals provide a more affordable alternative as compared to the private service providers, so that private patients have more options to choose from. In that way, public healthcare institutions do play an important role in moderating healthcare costs.

At the same time, we do look at how we can enhance greater transparency, so that patients can make informed decisions about their own healthcare needs. In 2004, MOH started publishing healthcare bill sizes, to encourage more transparency and education for the patients, so that they can decide what type of healthcare services they need and where to seek them. With this information at hand, patients are able to make better healthcare decisions. I think greater transparency and better education for the patients will help in managing healthcare costs.

THC: 80% of primary healthcare are provided by GPs, and the private medical specialist sector is growing in this country. How can we provide more transparent information for bill sizes on cost of treatment and procedures in the healthcare sector famous, for its asymmetry of information?

GKY: I think many people are familiar with polyclinics, and therefore the fees they charge are quite transparent. Anyone can gain access to healthcare services at polyclinics, so they are an alternative. Even in the private primary healthcare sector, GPs are also quite moderate in their charges. After introducing Community Health Assist Scheme (CHAS) a few years ago, we have built a bridge between the public and private primary healthcare sectors, so that eligible patients will also enjoy subsidies from consultations with private GPs. As patients now have options and choices, the key then is to give them information. The specialists in our hospitals, or Specialist Outpatient Clinics (SOC), also provide possible alternatives when patients who need those services are referred by the polyclinics, and given counselling on the costs when they seek specialist treatment. This is a form of education for the patients.

THC: Some of us, who were trained in England under the National Health Service, saw how GPs were the gatekeepers for the medical needs of designated communities and families. Do you ever forsee that GPs would have a bigger role in a geographical- or community-centric way, or do you think we should stay with the philosophy of having the freedom to choose one's primary care doctor?

GKY: I think we need to calibrate the balance very carefully. On one hand, we want to make sure that there is some gatekeeping, so that we will not inadvertently encourage overconsumption of healthcare

Photos: Ministry of Health

services, which could then escalate the overall healthcare costs for the country. But at the same time, we do want to allow individuals to make their own healthcare decisions, and take responsibility for the healthcare services they want to seek.

If you want to access public specialist healthcare in association with hospitals today, they would be able to access subsidised healthcare if they have referrals from the polyclinics or GPs on CHAS. The doctors are then able to assess whether the patients really need specialist care. That way, we gate keep and ensure the right setting for the patients.

If they do not need specialist care, they are encouraged to stay in primary care, and benefit from the subsidies either from CHAS accredited clinics or polyclinics. If they do need specialist care, the doctors in CHAS or the polyclinics will make the necessary referrals, and they would be able to enjoy subsidised hospital treatment.

THC: One of the cost discrepancies in local healthcare is that for a long staying patient in B2 or C class ward in a tertiary hospital, it may be cheaper than for the patient to move to a step-down care facility because of the costing structures and subsidies that have been created. How do we resolve this so that the tertiary hospitals are not clogged up?

GKY: We have been addressing this in the last one or two years by reviewing the financing structure of intermediate and long term care in community hospitals and nursing homes. This is to address the issue of gradient so that long term care is also affordable for individuals. It is important to ensure that they do not end up with a perverse incentive to stay in a high-cost environment because there are more subsidies. As such, we have looked at how we restructure subsidies, and how they can be sustainable in the long term.

When we increase hospital subsidies, we also have to make sure

that subsidies for step-down care are also adjusted so that there is an incentive for patients to step down. But it is also important for us to work with hospitals to discharge patients who no longer need hospitalisation, so that resource-intensive acute beds can be freed up for those who really need them. In addition to building capacity for step-down care, we need to work with the hospitals to facilitate the seamless transfer of patients to step-down care providers. Our move towards regional healthcare systems is an important step in this direction. For example, Tan Tock Seng Hospital (TTSH) and Ren Ci Hospital are next to each other and work very closely with each other. Patients can be easily transferred to Ren Ci, and if their condition deteriorates, they can be readmitted to TTSH. The new Jurong Hospital is designed with an adjacent community hospital, and Khoo Teck Puat Hospital has a community hospital nearby as well. This will be the new concept for hospital constructions to facilitate integration of care.


Minister Gan visiting a hospital

THC: Singapore's healthcare financing 3M framework of Medisave, MediShield and Medifund has stood for affordability and efficiency. But over time, it may need to be tweaked as the 3M system only covers 15% of total healthcare expenditure, are there ways to improve the 3M system, to potentially reduce the burgeoning health cost burden on employers, patients and their families, on a background of soaring healthcare costs and cost of living?

GKY: While the 3M framework ensures that healthcare is affordable, one important element is individual responsibility. For MediShield, insurance premiums are paid through savings or Medisave, which is an individual savings account too. The 3Ms play a very important role, despite the fact that it is not a large component. I think the 3M framework has served us well, and will probably continue to do so for the next five to ten years, but we cannot remain status quo. We need to continue to adapt and tweak the framework to ensure it meets the needs of the changing landscape, especially our ageing population. As such, we are looking at reviewing the 3Ms: Medisave, MediShield and government subsidies, including Medifund. In addition to the 3Ms, subsidies are a very important component too. Even as we enlarge the 3Ms and subsidies, we have to tweak the system to ensure the funding goes most.

One area we need to think about is how we can enhance risk pooling through MediShield, make it more effective, and provide wider coverage and stronger support. As MediShield is funded through Medisave premiums, we must make sure that the premiums remain affordable. The Government has introduced GST vouchers for Medisave and helped with MediShield premiums. We also want to see how we can make Medisave more useful for individuals, and there have been many suggestions on how we can be more flexible with its use.

Today, Medisave is primarily targeted at helping individuals pay their share for inpatient bills (alongside MediShield and subsidies), and we have also liberalised it to pay for outpatient treatment for chronic diseases and some cancer treatments. The key then is that if we want to expand it further, the current Medisave structure is sufficient. Do we need to enhance the current Medisave savings, or can we tweak it so that it is more flexible in some areas but less so in others? There are many discussions going on, and we are taking views from the public as well.

As we expand, we need to keep in mind that the amount of savings is a finite pool. We need to think how best to use that money, stretch the dollar and emphasise the impact on helping individuals so that they can afford healthcare services. The Medisave review is ongoing, and we will announce when it is completed.

Medifund is for the lower income. Among the middle income population, they may have to pay for very expensive treatments but they have no choice. For those instances, Medifund has the flexibility to meet the needs of the middle income. Hospitals have their own funds to ensure that all their patients can afford healthcare treatment. We need to work together, through the 3Ms and subsidies, to make sure healthcare is affordable. The landscape is changing and evolving and you need to continuously review our

3Ms and subsidies framework to make sure it is still relevant and effective.

Addressing future challenges

THC: There have been major initiatives to build new hospitals both in the public and private sector. How are we going to staff them adequately with nurses, doctors and allied health professionals?

GKY: It's a major challenge, absolutely. It is easier for us to put plans on paper or even to implement the building of infrastructure, but the key challenge is how we can make sure that we have enough manpower to staff them, as you rightly put it. Therefore, a major part of our Healthcare 2020 plan actually focuses on manpower development.

Hospital constructions are quite straightforward: you need to make sure they are well designed to meet our needs, and are efficient and cost effective. The key challenge is how to staff them with nurses and doctors. In our projections, we will need about 32,000 healthcare professionals by 2030, including allied health professionals, nurses and doctors, and an additional 9,000 supporting staff. The numbers are very huge, so we need to take a few strategic approaches.

First, we increase the local intake of students training to be healthcare professionals. Lee Kong Chian School of Medicine is taking in their first batch of about 54 students this year. We hope that, in a steady state, it will increase to about 150. Taking into account Yong Loo Lin School of Medicine and Duke-NUS Graduate Medical School as well, we are looking at a steady state of about an enrolment of 500 medical students every year. That is a significant increase from 350 today. They are also increasing the capacity to train nurses, and allied healthcare as well.

In addition to changes to the local education pipeline, we are also looking at midcareer conversions, especially during recessions when some are thinking about changing career paths. They will then be able to consider nursing or allied health as a profession. We have introduced quite a number of professional conversion courses for those from other professions who want to join the healthcare sector. This will provide new manpower from the existing local workforce.

The third area, which we are working very hard on, is extending the working life of healthcare workers. For many healthcare workers who have reached the retirement age of 62, we offer them reemployment to 65 or beyond. I was told that nine in ten of those who were given the offer took it up and continued to work. In healthcare particularly, experience is valuable, especially those who are senior with many years of experience. We really want to find ways to keep them as long as they are healthy, physically capable of working and want to do so. Many hospitals are putting in place flexible arrangements where they allow part-time workers to attend to family needs and also work.

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We are also looking at how to attract Singaporeans trained overseas. The preemployment grant has a scheme which was recently extended to dentistry as well, which supports Singaporeans as they study dentistry overseas, so that they can come back to serve.

I think that the implementation of all these schemes will help us to meet our manpower needs. It is also important for us to raise the profile of and correct the misconceptions of the healthcare sector, in nursing, allied health and so on. Recently, we have launched a campaign to reach out to the general public, to change their perceptions of the healthcare sector and promote our recruitment drive with the tagline: "Care to Go Beyond". It takes effort to project the right perceptions of healthcare sector: that it has many opportunities, career pathways and so on. We also need to regularly review and adjust remuneration packages, and make sure that they are competitive with the private sector. I think many of the healthcare workers in the public sector work beyond salaries. They look upon their work as contributions to public service, and this is one area we need to continue to emphasise, to maintain good quality healthcare manpower. Despite all these efforts in place, meeting manpower needs is still a very challenging task.

We also need to continue introducing measures to improve productivity through technology, equipment and so on. For example, teleconsulting is an area we are exploring. We aim to minimise the need for on-site consultations by having telephone consultations. Or could we advise patients to be seen by a nurse, if they are not seen by a doctor? Even for equipment, we want to invest in patient mobility aids like hoists and so on, so as to reduce the need for additional manpower. These are the efforts that are ongoing to reduce overall manpower costs to look after patients.

THC: I just completed an Internal Medicine ward round before this interview. Many of the inpatients are 70-, 80- or 90-year-olds admitted for frequent falls, disabling strokes, chronic heart conditions and infections. It's unsettling to see that the support system in their family and communities is lacking and hence, they end up in

Minister Gan going from door to door to distribute N95 masks during the recent haze

tertiary hospitals again and again. How are we going to meet the challenges of the silver tsunami?

GKY: I think there are quite a few different aspects. First, given the rising number of elderly people, changing lifestyles and longer lifespans, we do expect an increasing number of the elderly who need healthcare support, whether it is hospital beds, primary care or nursing homes, and so on. Capacity-wise, we are building and expanding facilities to meet the demand. We are also recruiting manpower, as I mentioned. We also announced some time ago that we are going to build 100 eldercare facilities in the community all over Singapore, including nursing homes and day care facilities. We have also enhanced a few schemes, including the Seniors' Mobility and Enabling Fund, to provide subsidies to the elderly who need support and hope, like mobility devices, consumables or expensive items like diapers. We want to keep the elderly in the community as much as possible, where they can be looked after by their families.

We also need to enhance home care support. Home nursing is one sector that we're trying to develop, but I'll say that there is a lot of work to be done. This area is less developed because we've focused a lot on institutional care – hospitals and so on, and now we're pushing on with nursing homes and community hospitals. But we really need to raise the capacity of home nursing significantly

Caregiver training is also one aspect we need to push for. The Agency for Integrated Care is working very hard to help train caregivers, whether they are domestic helpers or family members, so that they are able to look after the elderly at home. It is a lot of work, because some commonsensical precautionary measures may not be so obvious. But once we train the caregivers, they will be able to prevent falls and other accidents from happening at home.

We've also rolled out this Enhancement for Active Seniors programme, which retrofits existing HDB flats with grab bars, ramps and so on, to facilitate mobility and prevent falls. All these put together, coupled with public education programmes, will minimise the need to go to the hospital for accidents and so on. Many of our healthcare institutions – hospitals and polyclinics – are quite heavily involved, together with the Health Promotion Board, in reaching out via public education and sharing with the community what are the do's and don'ts at home to protect the elderly.

It is also very important to shift the paradigm of Singaporeans: that ageing does not need to be a burden, and that it does not need to be a negative. As a person ages, it can be fulfilling, rewarding and fruitful. Stay active, stay happy, look after your health from young, and continue to be engaged in the community. Seniors are as important to the society as they have a wealth of experience. If they remain active, they can also contribute positively to society, but not necessarily in an economic sense. For example, the elderly can help look after grandchildren, and they can also look after one another in a day centre. We need to shift this mindset that the elderly is a challenge, a tsunami, a problem, and take it as an opportunity for us to age graciously and build an inclusive society by looking after the old at home or in the community, and if necessary, in the institutions. That is the positive message I hope this article can help us spread.

Training the next generation of doctors

THC: Could you comment on the transformation of our long-held British training system into an American residency system? There has been a bit of angst and pain in operations, execution and culture. Singapore has preserved the British medical training system for decades and produced high quality doctors, and a highly regarded healthcare system.

GKY: Broadly, in terms of policy concept, we need to ensure that medical training in general is structured to ensure our trainees are exposed to different aspects of Medicine, and that they are adequately trained, monitored and tested, and graduate with competence in skills and knowledge.

We recognised the need for more structured programme. Even the UK system, as I understand, is

morphing into one that is more structured as well. As such, this shift is part and parcel of the development of medical knowledge training. We do recognise that any move is painful because it is new, and there is a lot of uncertainty. It is no different when we changed the school education system, whether it is the Primary School Leaving Examination or the Integrated Programme. Whenever we change the system, there is always anxiety. However, I am quite confident we can manage this process well, because we have the best brains. Our healthcare professionals are all highly educated and intelligent people, and are used to managing crises and the unknown in hospitals and clinics, so I'm very confident we have the people to manage this process.

We also do not have the luxury to drag the transition on for a long period, because every cohort that misses out is a cohort that will not benefit from the new system, and so we need to transit the systems as soon as is practicable. It is also quite challenging to run multiple parallel systems, so the necessary resources and support need to be provided to the various specialties so that they are able to do the transition smoothly.

The transition will be carried out in two phases: some specialties will move first, followed by the more complicated ones. We have to manage the process as much and as best as we can, recognising and understanding the anxiety of people on the ground, both trainers and students. What we can do is to step up opportunities for dialogues between MOH, students, professionals and institutions so that there is greater understanding of what is to be expected and reduce uncertainty and unknowns as much as possible. I have also met student groups, residents and undergraduates who are graduating and moving into the residency programme, to better understand their concerns. Very often, you find that once you clarify with them, they are more settled and assured. If we, the ministry, work together with institutions and student bodies, we can reduce the amount of anxiety.

Concluding thoughts

THC: We realise your job requires you to work 24/7. Do you have time to relax? If you do, what do you do for leisure?

GKY: Well, I try to balance my workload and personal time. My strategy is really to try to integrate them. For example, if I have a chat with a group of doctors and medical students, and look at it as a job, then I would find it very stressful. But not if you look at it as friends meeting up, getting to know each other – if I could have coffee with friends, there's nothing wrong with having coffee with students and doctors.

Nowadays I have breakfast regularly with residents – a very simple breakfast of coffee, tea, and maybe fried noodles with fishcakes – and I chat with them, about how old they are and how many children they have. If you look at that as work that you have to wake up early for, then it is very stressful. But if you look at it as breakfast with friends, you will enjoy the breakfast and enjoy the chat. If you can find a way to integrate leisure into work, then it is not work anymore, and you enjoy while you do those activities.

I learnt this when I was in MOM. We had a lot of tripartite discussions and negotiations between the unions, the Government and the employers. We found that it is more effective when these discussions were done in an informal setting, whether it is over a meal or on the golf course, and we could discuss the issues in a more relaxed mood.

THC: Is there any personality who you admire greatly and has inspired you?

GKY: Many people, so I'd rather not highlight anyone. My teachers in school, for example, have influenced me greatly: how to conduct myself, how to serve the people – that it's not just about grades. Serving in a uniformed group also teaches how to bring the group together and how to bond with people in the group – these are the things you learn when you are young.

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When you grow up and start working, you learn from your superiors how to deal with business. Before I joined the public sector, I worked in a company called NatSteel. Working with the top management of the board at NatSteel was very satisfying as they had very clear business ethics. There were certain things we would never do to be fair to our partners, even if the opportunity arises, we shouldn't try to take advantage of them. Always remember that they are partners, and we are in business with them, so we share with them whatever we have, go into the business together, and succeed together. Even if we fail, we fail together. Each individual chips in whatever way they can, to ensure the business does well. This is the philosophy I acquired as I went along. SMA