SPEECH BY MR ONG YE KUNG, MINISTER FOR HEALTH, AT THE MINISTRY OF HEALTH COMMITTEE OF SUPPLY DEBATE 2022

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Healthier SG

Mr Chairman

Paying Tribute

1. I want to thank Members for all your questions and cuts, and my Ministry of Health (MOH) colleagues for addressing most of them and stitching up most of the cuts. There is a remaining batch which is mostly on preventive care, which I will address. But Mr Chairman, please allow me to start with a tribute to our healthcare workers.

2. For over two years, they have toiled and fought against the COVID-19 virus, putting themselves in harm's way, undergoing tremendous stress, and even as we speak, they are keeping our population safe, and life in Singapore as normal as possible.

3. At MOH, we have been doing whatever we can to support them– ensuring sufficient Personal Protective Equipment (PPE), prioritising them for vaccinations, decanting as many patients as possible to COVID-19 Treatment Facilities and out of the hospitals, persuading the public to undertake self-recovery if they are infected and experience mild or no symptoms, or imposing the difficult 'no visitor' rule in hospitals.

4. But more than these clinical protections, we must stand up for them, against the abuse they suffer under the hands of a small minority of our population.

5. I thank Members who spoke up for healthcare workers on this. MOH's instructions to the leaders of our public health institutions are clear – we must always protect them against abuse and insults. And this is something that we must also do as a society.

6. There are now good indications that the Omicron transmission wave has peaked and starting to subside. With that, I hope not too long from now, healthcare workers will finally have a well-deserved and lasting respite.

7. The men and women of the healthcare sector are brave, dedicated, committed, big-hearted, professional, and they deserve all the support, respect and understanding we can give.

Laying the Foundation

8. Today, I would like to update Members on a major healthcare initiative to focus on preventive care. It is called Healthier SG.

9. It will address the questions on preventive care from several members – Dr Tan Wu Meng, Ms Ng Ling Ling, Mr Ang Wei Neng, Dr Lim Wee Kiak, and Mr Henry Kwek and others.

10. This is a journey that started more than ten years ago by previous Health Ministers, to focus on health, rather than cure. During this journey, we have built a very robust foundation for the Singapore healthcare sector. The changes I am about to announce are only possible because of all these past achievements.

11. For example, from 2010 to 2020, the capacity and capability of the healthcare system have been strengthened significantly.

12. Acute hospital beds increased by 40%, as we opened three new acute public hospitals – Ng Teng Fong General Hospital, Sengkang General Hospital, Khoo Teck Puat Hospital.

13. Nursing home beds increased by 70%. Senior Care Centres capacity expanded almost four times.

14. The number of doctors and specialists increased by 65% to almost 15,000 now; nurses increased by 45% to 42,000 now. As a result, the number of doctors per thousand population improved from 1.8 to 2.6, and that for nurses has gone up from 5.8 to 7.4.

15. These ratios are similar or higher than most Asian regions and territories, normalised to the proportion of older people in the population.

16. But, they are lower than ratios in OECD countries, as observed by Ms Mariam Jaffar. This is due to a variety of reasons, including the population age profile, model of care in different countries, and also the way Western countries fund, subsidise, and insure healthcare.

17. In terms of policies, we implemented MediShield Life and CareShield Life; we rolled out the Pioneer and Merdeka Generation Packages; introduced the Community Health Assist Scheme (CHAS).

18. In terms of structures, we established three healthcare clusters, centering around Singapore General Hospital, Tan Tock Seng Hospital and National University Hospital, each with significant economies of scale and capabilities.

19. Outcomes have improved. Between 2015 and 2020, there are fewer re-admissions into hospitals within 30 days after discharge, from 11.5% in 2015, to 10.7% in 2020. Response time to cardiac and stroke care at our hospitals has also improved.

20. Across 204 countries in the world, Singapore had the highest life expectancy at birth for men, at 83 years, and women, at 87 years.

21. After 10 years of foundation laying, plus a pandemic crisis, it is time for us to take the next big step. There is urgency to this, because in the next 10 years, long after the COVID-19 dust has settled, we will have to tackle our biggest healthcare challenge since our nation began – the deteriorating health of the population.

Anticipating the Challenge

22. Dr Lim Wee Kiak asked what is driving cost increases. Deteriorating health is driving cost increases. What then in turn drives deteriorating health? Two major driving forces.

23. First is ageing. Currently, about one in seven residents in Singapore are seniors aged 65 and above. By 2030, that number goes to one in five. An older person is more likely to fall sick or suffer from severe illnesses than a young person – it is a fact of life. We see this in our parents, in grandparents, and in time, we will feel it ourselves.

24. Second driving force which is quite aside from age, Singaporeans young and old are generally getting less healthy, even after adjusting for age.

25. For example, in 2017, about two in ten has high blood pressure. In 2020, this has become about three in ten.

26. There are more of us with high cholesterol – from about three in ten to four in ten.

27. Fortunately, for diabetes, the prevalence rate has been constant, likely due to our efforts in the War on Diabetes.

28. More of us are getting obese. From 2017 to 2020, the obesity rate has gone up from under 9% to over 10%, undoing many years of progress.

29. The first factor of ageing is due to the march of time, and there is very little we can do about it. The second factor of deteriorating health is due to the will of people, there is plenty we can do something about.

30. Because deteriorating health is mostly a function of lifestyle – too sedentary, too much device time, too little exercise, too much sugar, salt and fat in our diet; and putting off looking after our health until it is too late.

31. And indeed, living unhealthily is often more carefree and often more enjoyable. But we do not realise that we are paying for these instant gratifications by instalments, with our long-term health – bit by bit – until we realise the snowballing cost later in life.

32. So, a young person who is obese, or has high blood pressure or high blood sugar may feel alright now, but he may be a walking ‘time bomb’. When he is older, there is a high chance of him being struck with a heart attack, stroke or require dialysis.

33. When these illnesses strike, they are painful. They snatch away from us quality of life and happiness. They will burden family members and loved ones, emotionally and financially.

34. For this generation of seniors, many have several children, who can all chip in to help take care of them. Even so, it can be quite taxing.

35. But people around my age, slightly older, slightly younger, we have fewer children and we are likely to live longer. That means when we are in our 80's and 90's and if you are lucky, 100s, and fall very sick, are unable to walk, change, eat, shower, our children will be in their 50's or 60's and hopefully, they will be able to take care of us.

36. Beyond the immediate family, sickness across the population imposes a huge burden on the healthcare system, and on our taxpayers.

37. We heard this sobering piece of data during the Budget debate that Minister Lawrence Wong mentioned, that Government healthcare expenditure tripled over the last ten years, and based on the current trajectory, it will again more or less triple in the next ten years, to about $27 billion in 2030.

38. By then, healthcare budget may well be larger than that for defence and education.

39. To make healthcare affordable, the Government will have to continue to subsidise healthcare. That is the key reason why additional revenue from GST increases is needed.

40. Even so, the two percentage-point increase in GST may not be sufficient given the rate at which healthcare costs are increasing.

41. That is why we also need to control costs. We have been doing so through bulk buying of drugs, using cost effective treatments, better clinical procedures, right siting patients, and moderating the buffet syndrome caused by healthcare insurance.

42. But the more fundamental way to tackle cost is at its roots. That is, to make us healthier. It won't reverse the impact of an ageing population, but it can reduce the rate of increase, and 'bend the cost curve' downwards in the long run. It will still slope upwards but we can bend it downwards.

Making Good Health Easier

43. How are we doing this? Let me explain.

44. Many doctors that I have spoken to often wondered: How did a patient become so stricken with chronic illnesses? Why didn't he make lifestyle adjustments when he was younger? Why did he leave it till too late?

45. I can relate to the inaction. When I was younger, in my 30's and 40's, you feel almost invincible, you will never fall sick. I didn't feel the need to take care of my health too. Then a doctor friend of mine kept nagging me to go for health screening. Since he is my friend, I listened to him.

46. After tests, he found that I have quite high levels of cholesterol. Based on my risk level, he performed further tests and found a very small calcium deposit in one of my heart arteries. On his advice, I started taking some medication, adjusted my diet, essentially nothing very austere; I have to cut down on chilli crabs, prawns and sotong . Not a very huge sacrifice as Mr Pritam Singh is acknowledging. I can still eat them once a month, I just don't eat them every week or every other day. Eat in moderation, certainly not deprivation.

47. My readings are now fine, and more importantly, because of early intervention, I have probably averted a major heart bypass surgery when I become old, or worse, a heart attack that may kill me and distress my family and my loved ones.

48. We usually associate better healthcare with fascinating medical technology or heroics in the operating theatre. Those are important but good health is more likely to come from an accumulation of the humdrum and the mundane.

49. Because as the saying goes, "prevention is better than cure."

50. We need to, as Mr Ang Wei Neng and Mr Henry Kwek said, maintain health, rather than treat sickness. That is why we are not called the Ministry of Sickness, we are called the Ministry of Health.

51. The measures must be taken early, when the person is still healthy. It must identify the risk factors in our lives that will erode our health slowly and quietly, and then address these factors. It must be done in homes and community, not in hospitals or clinics.

52. It is best centred on family doctors – in polyclinics and General Practitioner (GP) clinics – and less on surgeons and specialists in hospitals. Family doctors must then become the most important anchor of our healthcare system.

53. This new strategy centered around primary care is called Healthier SG.

54. We have worked out the broad plan but still finalising the details. Over the next few months, we will be consulting different stakeholders, Singaporeans from all walks of life, GPs, healthcare workers, and community partners to gather their input and views.

55. MOH will then flesh out the details in a White Paper and table it in this House for debate. Today, I will outline five key components of the Healthier SG strategy.

Making Singapore Healthier

56. First, mobilise our network of family physicians, family doctors.

57. Studies have shown that people who go to only one family doctor consistently, are generally healthier. They have fewer visits to the emergency department, and have fewer episodes of hospital stays.

58. This is because the doctor and his care team know you well, can better detect early signs of any problems timely and accurately. The family doctor can do for you what my friend has done for my chronic conditions. They can be what Dr Tan Wu Meng described, as the “coordinating physician”.

59. However, only three in five Singaporeans have a regular family doctor.

60. The other two tend to doctor-hop, go to doctor A for hypertension medicine , doctor B for cough and cold and get a medical certificate (MC). So there is no one family doctor who knows our overall health condition and family health history well enough, to be able to see the link between different care episodes, even across different family members.

61. We now have a golden opportunity to bring as many of our family doctors as possible into this long-term national public health programme – and that opportunity is made possible by COVID-19.

62. When we needed more people to get vaccinated against COVID-19, I personally wrote to the GPs and TCM practitioners, and asked them for help. They heeded the call and explained the need for vaccinations and persuaded many of their patients to take the jab.

63. GPs are nodes of trust. Throughout the pandemic, they served as the first port of call for people who fell sick and suspected that they might been infected by COVID-19.

64. Then during the Omicron wave, GPs took on an even greater role – they assessed the severity of patients coming to them, placed them on home isolation if they have mild symptoms and low risk, and then supported their recovery, often by telemedicine.

65. Therefore, they demonstrated that rest and recovery at home are appropriate for many ailments, and that telemedicine does work.

66. Our COVID-19 response would have been inadequate, even crippled, if not for the contributions of our family doctors. They have been a key component of the national crisis response.

67. MOH has been working in partnership with GP clinics for some time, started by my predecessors. They are part of our CHAS programme. They also serve as Public Health Preparedness Clinics during pandemics. COVID-19 has deepened that partnership, and now we can leverage on it to implement Healthier SG.

68. We can leverage GPs to attend to more patients, not for coughs and colds, but devoting time to provide preventive care. MOH will support this, by building up the clinics’ capabilities, such as in telemedicine and IT systems. We will work with GPs to develop the skills of clinic healthcare team, and forge partnerships with hospitals to deliver more integrated team-based care.

69. The second component of Healthier SG is healthcare plans. Seeing our family doctor for preventive care is different from the occasional visit to the clinics when we do not feel well.

70. It means regular scheduled check-ins – at least once a year – so that the family doctor can assess your overall health condition, conduct necessary health screenings, track your results, administer vaccinations if need be, and advise you on adjustments in lifestyles to help you achieve your health goals.

71. And this is especially useful if you are at risk of developing a chronic condition, like diabetes. A care plan can help prevent it. To support residents to follow through with the care plans, we need to make them accessible, attractive, maybe even rewarding.

72. We will conduct public and stakeholder consultations to work out these proposals and incorporate them in the White Paper.

73. I am very sure there will be no shortage of ideas, and we have heard several today from Members. I don't think we can implement them all but we will try to put together a package that is compelling, attractive, and which we can afford.

74. So perhaps some ideas. Preventive care consultations with family doctors and recommended health screenings could be made free or cost only a very nominal sum. Just to assure Dr Tan Yia Swam this does not mean GPs won't be paid, they will just be reimbursed elsewhere. Perhaps we can claim higher CHAS benefits for drugs if we go to the same doctor; perhaps we can tap on MediSave more for our care plan; perhaps we can offer insurance premium discounts or vouchers if we diligently follow our care plans or even better still, show good outcomes. These are all possible ideas. But by enrolling into the Healthier SG, the resident will commit to see one family doctor, and adopt one care plan.

75. Our third component is that we then need community partnerships. Preventive care plans involve lifestyle adjustments, which need to happen outside of the clinics, and in our living environment. Doctors have a name for these, they call these 'social prescriptions', as opposed to drug prescriptions.

76. We therefore need the support of agencies such as Health Promotion Board, Agency for Integrated Care, People's Association, SportSG, National Parks Board, and community partners that oversee various social services. They run various activities and programs in the community which we then get family doctors to tap on.

77. So one analogy. If we have a major illness and we go to the doctor, the doctor often refers us to a few specialists or therapists. But in a preventive care plan, the family doctor may refer us to a *qigong* class, to a brisk walking group, or a community farming club, for example.

78. We already have such collaborations on the ground, some Members have mentioned it, in Queenstown, and in Tampines. We need to roll out such initiatives across every town, to make good health not just a matter for doctors in clinics, but for all of us in everyday life and places.

79. That brings me to the fourth component. Once the first three components are in place, we will roll out a national Healthier SG enrolment programme.

80. That's when I mentioned, by enrolling into Healthier SG, a resident will commit to see one family doctor and adopt one care plan.

81. The national enrolment programme will be coordinated by our three healthcare clusters. Each will look after a region of up to about 1.5 million residents, and work with the family doctors and other partners in the region to reach out to as many residents as possible.

82. We will probably start with people in their 40's and older, because that is when chronic illnesses may start to set in. We will have to build up the participation base progressively.

83. When HPB rolled out the latest season of the National Steps Challenge, it recruited 900,000 participants. We hope Healthier SG can be even more successful than that.

84. I want to specifically highlight the importance of this collaboration between healthcare clusters and the family doctors. It is a very important nexus, because the family doctors will receive support from hospitals, in looking after residents with more complex needs. Hospitals after discharging a patient can refer them back to the family doctor. This is exactly what we did during COVID-19. It works and there will be seamless co-ordination and continuity of care.

85. We have taken a geographical approach to enroll residents because this will cater to the needs of the great majority, because today, about nine in ten residents will visit a family doctor or hospital near their home.

86. Nevertheless, individuals will have choice. You can choose whether to enrol or not. You can choose who to enrol with, even doctors who are far away from your home. There is a variety of reasons why some Singaporeans may decide to do that. Because the clinic may be nearer to your workplace, near your parents' home, or is a friend that you have known for many years.

87. And finally the last component, we need the necessary support structures to make Healthier SG work. And this is actually no small matter.

88. Manpower is a big part of this. Ms Mariam Jaafar asked for our workforce transformation plans. Let me share briefly.

89. We need to build up and optimise our primary and community care workforce further. Today, a fifth of doctors and nurses are in primary and community care. By 2030, we will need to increase this to at least a quarter.

90. Besides growing the numbers, we will further build up the competencies and skills of our healthcare workforce.

91. For doctors, family medicine should feature even more strongly in the curriculum of our medical schools. We now encourage new graduates not to become a specialist and do their residency straightaway. But be exposed more broadly in medicine and build up confidence in dealing with chronic illnesses. Postgraduate training in Family Medicine is also being strengthened.

92. For nurses and other healthcare professionals, the potential for skills upgrading is even greater. We need to broaden inter-disciplinary training and empower them to practise at the highest level of their licences.

93. For example, once we roll out Healthier SG, I expect preventive care efforts to be implemented in community and these efforts can be led by nurse clinicians and pharmacists, not necessarily by doctors. I foresee Healthier SG opening up many new job roles for our healthcare workers.

94. Finance is another major support system. We have been funding our healthcare clusters, largely by their workload, such as the number of treatments, number of surgeries and operations.

95. We will change this to a capitation model, where healthcare clusters get a pre-determined fee for every resident living in the region that they are looking after.

96. Under the new system, the absolute budgets of each healthcare cluster will not be affected. In fact, the budget will go up a little bit. What will change is the basis of calculating the budgets.

97. Appropriate surgeries, procedures and treatments will always be provided when required. But with this shift in the basis of funding, there will be a natural incentive for hospitals to try to keep residents healthy through preventive care.

98. Complementing this new basis of funding is a set of health outcomes. Some salient indicators are quality of care, uptake of healthy lifestyles and habits, prevalence of chronic illnesses, cost effectiveness of treatments etc.

99. The last critical support structure is IT. Family doctors in the frontline of Healthier SG will need good system and data support. They must have access to patients' medical records. They must have the IT tools to track the patient's conditions and progress over time.

100. They must also be able to share the records with other healthcare providers. We want to work towards a scenario that no matter where you are receiving care, for example, at the GP or dental clinics, polyclinics, hospitals, specialist outpatient clinics, nursing homes, eldercare centres, the same data can be retrieved to support your care.

101. That is why MOH has been enhancing and rolling out the National Electronic Health Record (NEHR) system.

102. We then need to ensure such data sharing is secured and users take greater responsibility for data access. We would need new legislation to govern this and we intend to put in place a Health Information Bill in the next couple of years.

103. Mr Chairman, let me now say in few words in Mandarin.

104. 主席先生，接下来的几年里，我们会大刀阔斧地推动医疗护理领域的改革。我们关注的是预防性医疗，原因有两个。第一、人口老化。因为年纪一大，难免有更多的病痛。第二、新加坡人其实我们越来越不健康了。该多的不多，该少的不少：活动量太少，运动太少。电子配备用得太多，糖，盐，油吃得太多。所以患有各种慢性疾病的人也就更多了。如果我们不改变生活习惯，未来的十年，病痛会大量地增加。

105. 如果你生病，生活素质就差了。你在退休后，本来想尝试一些新的事物，或者想和家人共享天伦之乐，但却因为疾病缠身，不能够实现自己的愿望。我们一旦生病，原本简单的日常作息，或者医药费等等，现在都得依赖家人、孩子、孙子，给他们带来额外的负担。此外，医疗体制的压力也更重了，政府医疗开支也将越来越吃不消。

106. 庆幸的是，很多慢性疾病，其实是可以避免的。大家都听过 "预防胜于治疗"。中医师也常常说，"病从浅中医"。但这需要在没生病之前，就开始在生活和饮食上做一些调整。未雨绸缪的道理，用在保健其实是最适当的。

107. 所以我们接下来的首要目标就是协助大家保持健康，不是生病后才来医。在任何医疗体制内，调养、治病，缺一不可。但在人口老龄化的情况下，我们需要在两者之间取到一个新的平衡，多注重预防性的调养和医疗。

108. 所以我们将展开‘健康SG’这个策略。这是一个全国性，通过替国人提供健康检查，改进生活习惯的保健策略。我们会鼓励中年的国人，向你们的家庭医生报名。过后，家庭医生会和政府医院合作，一起帮你预防疾病、一起保持身体健康。医生也会定期帮你做健康检查，定期打免疫针。他们会跟社会伙伴，包括与人民协会和新加坡体育理事会合作，帮你改善饮食习惯、戒烟、多做运动。

109. 但预防性的医疗，意味的是你没有病痛也要去看医生，接受检查甚至辅导。这其实不是我们新加坡国人的习惯，觉得无端端去看医生做什么。所以要鼓励大家这么做，要有一些推动力。所以，接下来的几个月，卫生部会通过公众咨询，收集建议，来制定一套有吸引力，而我们负担得起的配套。也许配套里可以说，预防性的身体检查，可以免费或只收很低的费用。也许拿药时，可以用更多的保健储蓄去付费。也许当你按家庭医生的护理计划保持身体健康，终生健保的保费会下降。这个道理跟汽车保险一样，你的汽车没有遇到车祸，没有修理，保费就逐渐下降，道理一样。

110. 我们设计了这个配套后，就会草拟一份 ‘健康SG’ 白皮书，呈上国会，然后进行辩论。拟定政策方向后，有了医院，医生，民众的支持和配合，大家都可以过得更健康、生活也更充实，年长者可以快快乐乐地安享晚年。

Strengthening Social Compact

111. Mr Chairman, a central issue of the Budget this year has been the increase of GST, because we need to meet the rising healthcare expenditure of an ageing population.

112. Healthcare expenditure will increase, because we are committed to make healthcare affordable to those who are sick, by heavily subsidising healthcare bills.

113. After subsidy, there is still a remaining sum that needs to be paid. We can cover most of that through MediShield Life. And then there is still a smaller remaining sum, which the patient can pay through his MediSave. And if there is still a small sum that the patient cannot afford, he can apply for MediFund.

114. Subsidy, MediShield, MediSave and MediFund - that is in essence the S+3M framework – a multi-layered safety net for healthcare. It will continue.

115. However, it is important to understand that spending on health is quite different from spending on say, education, which is always forward looking, molding the future of Singapore.

116. Healthcare spending is critical and essential, but mostly about treatment - trying to restore a sick person back to where he was in the past, and often imperfectly.

117. Sometimes we hear comments including in this House that healthcare spending is an investment in our people. If we are honest with ourselves, we know it is not the same as education. It is driven by deteriorating health that can be prevented, and often about paying for the unwise lifestyle choices of our past.

118. But there is a component in our healthcare spending that is forward looking and about investing in our future, and that is preventive care.

119. Healthier SG will grow that component. What we are saying here is that as healthcare spending inevitably grows in the coming years, let us have the discipline to always set aside enough to invest in keeping our people healthy for the future.

120. Our multi-layered safety net in healthcare, embodied in the S+3M policy, will always be universal. That is we will not have a situation which happens in other countries, where a patient comes to the hospital and gets turned away because he is unable to pay, or a lack of medical insurance. We will not let that happen.

121. That universality will now expand in coverage, beyond medical treatment, to preventive care and population health.

122. The more well-off and better-informed are already taking better care of their health, with coaches, therapists, personal doctors, and diet plans. We want to extend these interventions to the broad population, which will benefit most, those with lower incomes, who do not have the time, resources or wherewithal to do this.

123. I have been lucky to have a highly trained and well-meaning doctor friend who nagged me and helped me. We hope everyone in Singapore will have such a friend too – a family doctor to advise or even nag us to do what is right for our long-term health and for our family. We want to make it easier and affordable for everyone to stay healthy.

124. We will have a fuller debate on Healthier SG in the house later this year when we present the White Paper. I seek the support of members to translate Healthier SG into a healthier Singapore population. Thank you.