

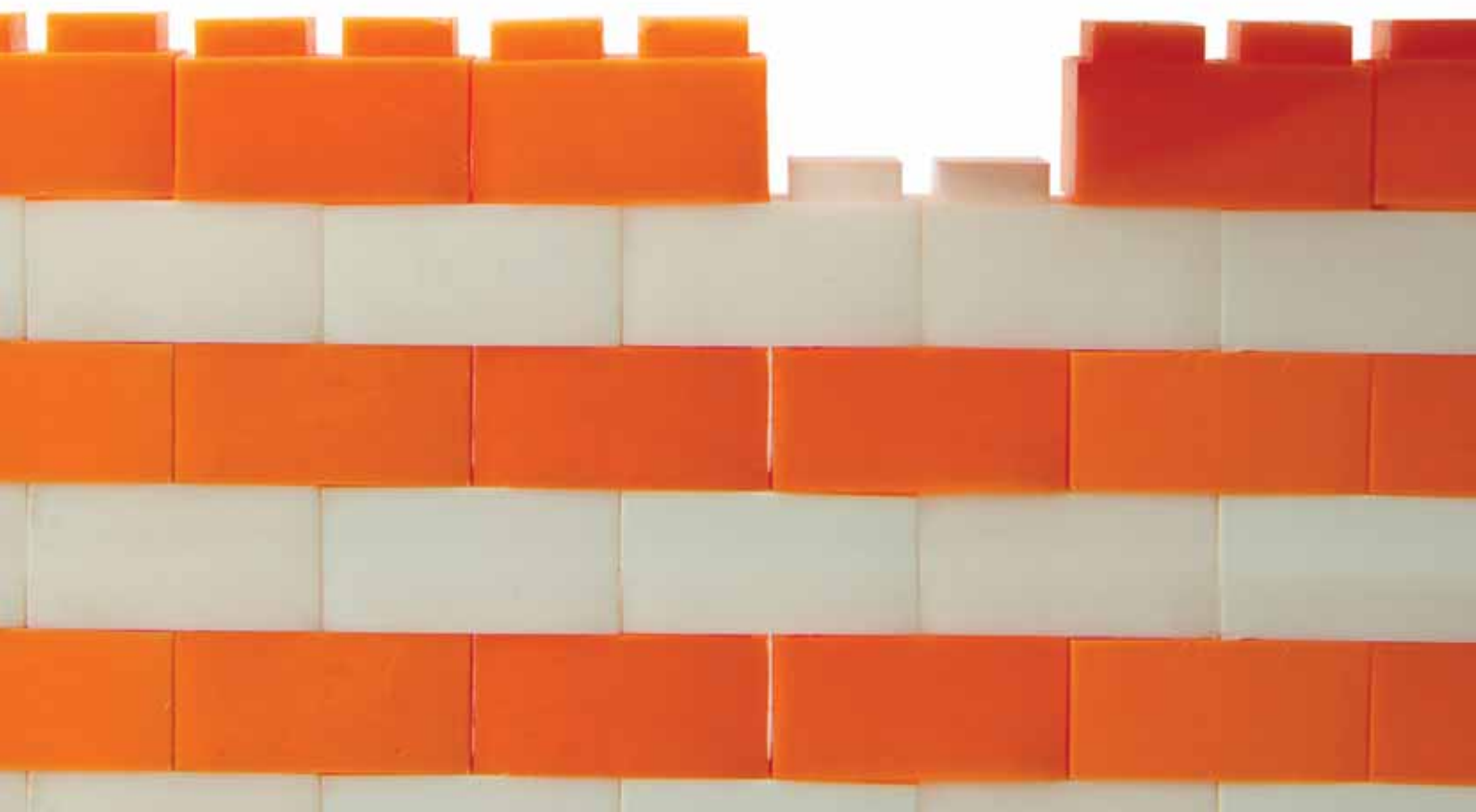
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Bridging the Gaps in Local Healthcare



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With the rapidly ageing population in Singapore, it is important that the healthcare system adapts to meet its changing needs. Melinda Elias and Alicia Tan identify some gaps in local healthcare, and suggest ways to bridge them.

Thinking about the “System” in Our Healthcare System

By Melinda Elias

The Singapore healthcare system is *not* in a state of crisis. Life expectancy increased to 79.6 years for males and 83.4 years for females in 2011, from 76.6 years and 81.6 years respectively eight years prior. Infant mortality rates fell to a low of 2.0 per 1,000 in 2010. Singapore is on par with the health outcomes of high-income countries and has achieved these outcomes at a fraction of what these countries have spent on healthcare.

This is a remarkable achievement. However, although it may not be immediately evident, there are signs that if Singapore is to continue to achieve such good outcomes at relatively low costs, certain changes to the healthcare system may need to be made. Population ageing and an expanding population with a high burden of chronic diseases will add cost strains to the system. This year, the Government has already projected a doubling of healthcare spending from the current \$4 billion to \$8 billion a year, over the next five years.

While the ageing process is outside the purview of government action, the greatest increment in rising costs is driven by policy actions on the changes over time in health spending for people of a given age, which is of benefit given that it tends to be costlier.

In the short term, most ill health suffered by patients will be from chronic diseases, which can be prevented. Yet not all health interventions provide the same value for money, in terms of health improvements per unit of

expenditure. The increasing costs of healthcare, coupled with increased longevity, suggests that perhaps we need to also come to a better understanding of the limits of our system of care and of Medicine.

Nowhere is this more apparent than in end-of-life care. Research on the costs of dying shows that a large proportion of healthcare costs over the lifetime of the individual occurs in the last year of life, particularly the last few weeks before death.

Our healthcare system, which is institution- and physician-centric, is ill-suited to effectively deal with chronic diseases and general frailty. The culture of Medicine and its pursuit to prolong and “save” lives makes it hard for healthcare professionals to accept dying as a natural part of a person's life cycle. Most societies also do not feel comfortable talking openly about death and dying. However, evidence from the US shows that those who have such conversations tend to live longer (despite less aggressive treatment). Their caregivers are also three times less likely to suffer from major depression. Having conversations with cancer patients at their last week of life can also defray costs to the tune of US\$304 million a year.

In a 1998 study¹ published in the *Singapore Medical Journal*, 44 cancer patients, aged between 24 and 84, were surveyed to find out their preferred place of terminal care. 52% of the patients interviewed preferred

to die at home instead of the hospital. Particularly, 62% of patients aged 65 years and above wanted to die at home. Of the 44 cancer patients surveyed, 71% of male patients compared to 52% of female patients preferred to die at home. 2006 data² from the Registry of Births and Deaths for elderly aged 65 years and above showed that most elderly deaths occurred in hospitals (57%), followed by at home (31%), and while the proportion of deaths at home increased with age and deaths in hospital decreased in age, significantly more elderly women died at home compared to men. This mismatch suggests that the utilisation of hospitals may be more consistent with the system of care, socioeconomic and cultural factors, and not necessarily with preference.

Taking a more holistic view stresses the need to place emphasis on evidence and on optimising the health system as a whole. It also requires us to look at the issue at a broader level to work on: a shift in the mix of skills; improving coordination of care; developing primary, long term and social care services and support structures; improving economies of scale and stewardship functions; developing clear guidelines; and promoting partnerships with the private sector and communities, among other things. Health promotion will be important so as to promote greater responsibilities for self-care on the part of the population.

We need to come to a more realistic appreciation of the limits of Medicine and the inefficiencies in our

current system of care. This will allow us to focus our energies on obtaining a greater net impact from our public expenditure across our healthcare system (including acute care, prevention and end-of-life care) so that our system can be robust enough to sustain us as our population continues to age. **SMA**

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Voices from the Heart

By Alicia Tan

Many say, "Wow, you must have a heart of gold to become a social worker." Ten years ago, I would probably have said yes, but ten years on, I would say a big heart alone is not enough to sustain one. Hospital social work is not a job for the faint-hearted...

I remembered the time when I was called back during an intensive care unit call and there was a mother wailing nonstop outside the operating theatre. The mother told me her son had slipped into a coma after complaining of a headache earlier. She demanded that I tell her that her 15-year-old son would live... I was speechless.

I remembered the time when I did a home visit, and when I stepped into the elderly patient's house, I saw tons of bed bugs crawling all over. He shared how he laid in his bed helpless at night when the bugs fell on him from the ceiling... I was heartbroken.

I remembered the time when I found my elderly patient crying for help as he lay in his urine and faeces at his home for a whole day. He pleaded for me to pull him up but I did not have the strength to do so... I was helpless.

I remembered the time when I met an elderly couple who brought their 51-year-old physically and mentally disabled son out at 5 am to wait at the hospital for his appointment at 1 pm. The mother had poor memory and was hard of hearing, and she feared that her son would miss his medical appointment... I was flabbergasted.

As a medical social worker, I have met many people from different walks of life. There are the elderly who require assistance but refuse to accept any, and there are families who can afford the medical charges but demand assistance. While handling a whole spectrum of cases, I have experienced a roller coaster of mixed emotions and struggles as many unexpected firsts happened in my life.

Throughout this journey, I would often ponder our social situation and wonder what else could be done to help, like how much the elderly in need would appreciate if we could offer handyman services or fumigation services to improve their home conditions? Could there be schemes that provide assistive devices like spectacles and hearing aids, which would improve the elderly's quality of life? How could we build on activities in day

care centres which include reminiscence and memory training, which could be continued at home so that family members could better engage the elderly? For example, in Singapore, the Montessori approach is mainly used in the curriculum of childcare centres. Would local day care and senior activity centres consider integrating this concept when planning activities for the elderly to improve engagement and affect? After all, Montessori-Based Dementia Programming is already being used in some day care centres and nursing homes in the US.

As social, cultural and political forces shape social services provisions for those in need, we could consider adopting the person-centred care (PCC) approach by Tom Kitwood¹ which *Values* the elderly by promoting their rights and entitlements, regardless of age, cognitive impairment or dependency needs. Treat them as *Individuals* as we appreciate that they have a unique histories and personalities, physical and mental health, and social and economic resources, which will affect their response to ageing and dependency. Look at the world from the *Perspective* of the elderly in need of care, recognise that each person's experience has its own psychological validity, that people act from this perspective and that empathy with this perspective has its own therapeutic potential. Last but not least, recognise that all human life is grounded in relationships and people need an enriched *Social* environment to meet their needs for human contact and foster opportunities for personal growth. (In short, "VIPS".)

PCC has been commonly used in the UK, the US and Australia in planning and providing for the care of people with dementia. Though the model was designed for people working with dementia, its concept is very apt as it highlights the importance of focusing on the person with the need for such care. Many tools, approaches to care and activities have stemmed from this approach and we could use them as reference to help us improve our care provisions. For example, dementia care mapping is used to assess the care practice and develop person-centred care for residents in a centre. Essential lifestyle planning, which is a guided process for learning how someone wants to live and developing an individualised

plan to help make it happen, has also been developed. TimeSlips, a way of improvisational storytelling, invites people with dementia to express themselves and connect with others to meet their needs for social interaction. In Australia, the government of Victoria has developed a guide on implementing person-centred practice in their health services.

All said, if we treat all the elderly as Very Important Persons (VIPs) in the PCC way, they would be able to age gracefully and truly enjoy their golden years. **SMA**

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Alicia is a principal medical social worker at Singapore General Hospital. She sits on the Alzheimer's Disease Association Management Committee and is also a member of the Person-Centred Care Steering Committee. The views expressed in this article are her own.

