The 25th CMAAO Congress and the 43rd Council Meeting

Hotel Royal Cliff Beach and Resort, Pattaya, Thailand
November 18–20, 2007

The 25th CMAAO (Confederation of Medical Associations in Asia and Oceania) Congress and the 43rd Council Meeting was held from November 18 (Sun.) to 20, 2007 in Thailand.

This year’s congress was attended by some 50 representatives of 13 member NMAs. With the re-admittance of the Sri Lanka Medical Association officially decided, CMAAO now has a membership of 17 medical associations. This year’s congress considered plans for events celebrating the confederation’s 50th anniversary in 2008/2009 as well as invigoration of confederation activities. Decisions made concerning CMAAO operations included newly appointing a legal advisor to provide support for legal aspects of future confederation activities; revising the Constitution and Bylaws to renew and strengthen organization; and making efforts to recruit those NMAs that are members of Medical Association of South East Asian Nations (MASEAN), but not yet of CMAAO.

At the Opening Ceremony held on November 19, Professor Dr. Somsri Pausawasdi (Immediate Past President, The Medical Association of Thailand) was installed as the 28th President of the CMAAO (2007–2009) and presented with the CMAAO Presidential Medal by out-going President Dr. Jae Jung Kim of Korean Medical Association.

The Country report session was held on November 19 and the symposium was held on November 20 on the theme “Arts and Science of Longevity.”

Presentations at the symposium were delivered by 8 speakers from NMAs of Hong Kong, Indonesia, Japan, Korea, Malaysia, Singapore, Taiwan and Thailand.
Program

DAY 1: Sunday, November 18, 2007

08:30 – 09:00 Grand Opening Ceremony

09:00 – 09:15 Installation of the President Elect of the CMAAO:
Chairled by Dr. Wonchat Subhachaturas, Chair, CMAAO

09:15 – 10:00 The 8th Taro Takemi Memorial Oration
“60 years of Thai Healthcare under H.M. King Bhumibol”
1. Opening and introduction of the speaker: Dr. Masami Ishii, Secretary General, CMAAO
2. Oration: Prof. Dr. Prinya Sakialaksana
3. Presentation of a commemorative plaque to the speaker: Dr. Jae Jung Kim, President, CMAAO

10:00 – 10:30 Coffee Break

10:30 – 12:00 Professor Boonsom Martin Honourary Lecture “Music Therapy” (in Thai)

12:00 – 13:00 Lunch

13:00 – 16:00 The 43rd CMAAO Council Meeting: Chaired by Dr. Wonchat Subhachaturas
1. Call to Order
2. Roll Call and confirmation of Councilors of CMAAO: Dr. Masami Ishii
3. Welcome Address: President of the MAT, Air Marshal Apichart Koysukhlo
4. Report of the Secretary General
5. Approval of Minutes of the 42nd CMAAO Mid-term Council Meeting held in Singapore (November, 2006)
6. Report of the Treasurer: Dr. Yee Shing Chan, Treasurer
   (1) Financial Statement for 2006–2007
   (2) Budget for 2007–2009
8. Venue and Dates of the 26th CMAAO Congress & 45th Council Meeting (2009)
9. Membership Applications
10. Other Business
   10-1. Proposed amendment of the Constitution & By-laws submitted by the Singapore Medical Association
   10-2. Others
11. Adjournment

18:30 – 21:00 Welcome Reception

DAY 2: Monday, November 19, 2007

09:00 – 10:30 The 25th CMAAO Congress and Assembly Opening Ceremony
Chairled by Dr. Masami Ishii, Secretary General, CMAAO
1. Call to Order: Dr. Jae Jung Kim, President, CMAAO
2. Roll Call: Dr. Masami Ishii, Secretary General, CMAAO
3. Opening Remarks: Dr. Jae Jung Kim
4. Welcome Address: Lord Mayor of Pattaya Adm.
5. Installation of the 28th President of the CMAAO: Dr. Jae Jung Kim
   (Handover of the CMAAO Presidential Medal) Outgoing President, CMAAO
6. Inaugural Address: Professor Dr. Somsri Pausawasdi
7. Presidential Award to be presented to Dr. Kim by Professor Dr. Somsri Pausawasdi

10:45 – 12:00 The 25th CMAAO Congress and Assembly Meeting
Chairled by Professor Dr. Somsri Pausawasdi
1. Approval of Minutes of the 24th CMAAO Congress held in Korea (September, 2005)
2. Report of the Council: Dr. Wonchat Subhachaturas
3. Report of the Treasurer: Dr. Yee Shing Chan
4. Membership Applications
   4-1. Sri Lanka Medical Association
5. Appointment of Standing Committee Members on:
   5-1. Constitution and By-laws: Chairperson and three Members
   5-2. Nominations: Chairperson and two Members
   5-3. Resolutions: Chairperson and three Members
   5-4. Finance: Chairperson and two Members
6. WMA Report: Datuk Dr. N. Arumugam, Immediate-past President, WMA

12:00 – 13:30 Lunch hosted by the Medical Association of Thailand
13:30 – 15:00 The 25th CMAAO Congress and Assembly Meeting (cont.)
7. Reports of Activities of NMAs (Country Report)
15:15 – 16:00 8. Future Meetings
   8-1. The 44th CMAAO Mid-term Council Meeting (2008)  
   (Venue and Dates to be confirmed)
   8-2. The 26th CMAAO Congress & the 45th Council Meeting  
   (Venue and Dates to be confirmed)
9. Other Business
   9-1. Proposed amendment of the Constitution & By-laws by the Singapore  
   Medical Association
   9-2. Membership fee for the Sri Lanka Medical Association
   9-3. Membership fee for the Nepal Medical Association
   9-4. Increase of the membership fee of CMAAO
   9-5. Proposal for collection of registration fee for the CMAAO Mid-term Council Meetings in the future
   9-6. Establishment of the traveling fund in the CMAAO
   9-7. Conversion of some of the CMAAO funds to Japanese yen
   9-8. Any other business
17:00 – 21:30 The Thai Extravaganza Show

DAY 3: Tuesday, November 20, 2006

08:30 – 11:30 Symposium: “Arts and Science of Healthy Longevity”
11:30 – 12:00 The 25th CMAAO Congress and Assembly Meeting (cont.)
   1. Report of the Committees for Approval
   2. Election of the Officers of CMAAO: Dr. Masami Ishii
   3. Closing Remarks: Professor Dr. Somsri Pausawasdi
14:00 – 17:00 City Tour
18:30 – 21:00 Farewell Dinner
Officers, Councillors, Secretary General and Advisors of CMAAO 2005–2007

President:
Jae Jung Kim (Korea)

President-Elect:
Apichart Koysuklo (Thailand)

Immediate Past President:
Eitaka Tsuboi (Japan)

1st Vice President:
Pheng Soon Lee

2nd Vice President:
Somsri Pausawasdi

Chair of Council:
Wonchat Subhachaturas

Vice-Chair of Council:
Ross Boswell

Treasurer:
Yee Shing Chan

Secretary General:
Masami Ishii

Councillors:
Mukesh Haikerwal (Australia)
A.Z.M. Zahid Hossain (Bangladesh)
Sok Khonn Sau (Cambodia)
Yee Shing Chan (Hong Kong)
Ketan Desai (India)
Fachmi Idris (Indonesia)
Yoshihito Karasawa (Japan)
Dong Chun Shin (Korea)
Nai Chi Chan (Macau)
Siang Chin Teoh (Malaysia)
Sudha Sharma (Nepal)
Peter Foley (New Zealand)
Phoebe Lim-Catipon (Philippines)
Chiang Yin Wong (Singapore)
Ming-Been Lee (Taiwan)
Wonchat Subhachaturas (Thailand)

Advisor:
Tai Joon Moon (Korea)
CMAAO

The Confederation of Medical Associations in Asia and Oceania
(Established since 1956)

Official Homepage http://www.cmaao.org/

Current membership: 17 national medical associations
(As of November, 2007)

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<thead>
<tr>
<th>Country</th>
<th>Organization Name</th>
<th>Address</th>
<th>Contact Information</th>
<th>Website</th>
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<tr>
<td>Australia</td>
<td>Australian Medical Association</td>
<td>42 Macquarie Street, Barton ACT 2600, P.O. Box 6090, Kingston ACT 2604, Australia</td>
<td>Tel: +61-2-6270-5400, Fax: +61-2-6270-5499, E-mail: <a href="mailto:ama@ama.com.au">ama@ama.com.au</a>, Website: <a href="http://www.ama.com.au">http://www.ama.com.au</a></td>
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<tr>
<td>Bangladesh</td>
<td>Bangladesh Medical Association</td>
<td>BMA Bhaban, 15/2 Topkhana Road, Dhaka-1000, Bangladesh</td>
<td>Tel: +88-02-9555522, Fax: +88-02-9566060, E-mail: <a href="mailto:info@bma.org.bd">info@bma.org.bd</a>, Website: <a href="http://www.bma.org.bd">http://www.bma.org.bd</a></td>
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<tr>
<td>Cambodia</td>
<td>Cambodian Medical Association</td>
<td>Corner St. 278, Preah Monivong Blvd, Phnom Penh, Cambodia</td>
<td>Tel: +855-17522360, E-mail: <a href="mailto:saint.saly@yahoo.com">saint.saly@yahoo.com</a></td>
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<tr>
<td>Hong Kong</td>
<td>Hong Kong Medical Association</td>
<td>S/F Duke of Windsor, Social Service Building, 15 Hennessy Road, Hong Kong</td>
<td>Tel: +852-2527-8285, Fax: +852-2865-0943, E-mail: <a href="mailto:yvonne@hkma.org">yvonne@hkma.org</a>, Website: <a href="http://www.hkma.org">http://www.hkma.org</a></td>
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<td>India</td>
<td>Indian Medical Association</td>
<td>I.M.A. House, Indraprastha Marg, New Delhi-110 002, India</td>
<td>Tel: +91-11-23370009, 23378819, +91-11-23379470, 23379178, E-mail: <a href="mailto:imedicor@vsnl.com">imedicor@vsnl.com</a>, Website: <a href="http://www.ima-india.org">http://www.ima-india.org</a></td>
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<tr>
<td>Indonesia</td>
<td>Indonesian Medical Association</td>
<td>Jl. Dr. G.S.S.Y. Radulangi No.29, Menteng Jakarta Pusat 10350, Indonesia</td>
<td>Tel: +62-21-3900277, +62-21-3150679, Fax: +62-21-3900473, E-mail: <a href="mailto:pbvisit@idola.net.id">pbvisit@idola.net.id</a>, Website: <a href="http://www.idionline.org">http://www.idionline.org</a></td>
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<tr>
<td>Japan</td>
<td>Japan Medical Association (Secretariat)</td>
<td>2-28-16 Honkomagome, Bunkyo-ku, Tokyo 113-8621, Japan</td>
<td>Tel: +81-3-3942-6489, Fax: +81-3-3946-6295, E-mail: <a href="mailto:jmaintl@po.med.or.jp">jmaintl@po.med.or.jp</a>, Website: <a href="http://www.med.or.jp/english">http://www.med.or.jp/english</a></td>
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<td>Korean Medical Association</td>
<td>Korean Medical Association</td>
<td>302-75 Ichon1-dong, Yongsan-gu, Seoul 140-721, Korea</td>
<td>Tel: +82-2-794-2474 (ext. 120/121), Fax: +82-2-793-9190, E-mail: <a href="mailto:intl@kma.org">intl@kma.org</a>, Website: <a href="http://www.kma.org">http://www.kma.org</a></td>
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<td>Macau Medical Association</td>
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<td>Tel: +853-388388, Fax: +853-788789, E-mail: <a href="mailto:channaichi@yahoo.com.hk">channaichi@yahoo.com.hk</a></td>
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<tr>
<td>Malaysia</td>
<td>Malaysian Medical Association</td>
<td>4th Floor, Bangunan MMA, 124 Jalan Pahang, 53000 Kuala Lumpur, Malaysia</td>
<td>Tel: +603-40411373, Fax: +603-40418187, E-mail: <a href="mailto:info@mma.org.my">info@mma.org.my</a>, Website: <a href="http://www.mma.org.my">http://www.mma.org.my</a></td>
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<td>Nepal</td>
<td>Nepal Medical Association</td>
<td>NMA Building, Siddhi Sadan, P.O. Box 189, Exhibition Road, Kathmandu, Nepal</td>
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<td>Sri Lanka Medical Association</td>
<td>Wijerama House, No. 7, Wijerama Road, Colombo 00700, Sri Lanka</td>
<td>Tel: +94-11-2693324, Fax: +94-11-2698802, E-mail: <a href="mailto:slma@eureka.lk">slma@eureka.lk</a>, Website: <a href="http://www.slma.lk">http://www.slma.lk</a></td>
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<td>Taiwan Medical Association</td>
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<tr>
<td>Thailand</td>
<td>The Medical Association of Thailand</td>
<td>4th Floor, Royal Golden Jubilee Building, 2 Soi Petchburi 47 (Soi Soon Vija), New Petchburi Road, Huaykwan District, Bangkok 10310, Thailand</td>
<td>Tel: +66-2-314-4333, Fax: +66-2-314-6305, E-mail: <a href="mailto:math@loxinfo.co.th">math@loxinfo.co.th</a>, Website: <a href="http://www.mat.or.th">http://www.mat.or.th</a></td>
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Secretariat: JAPAN MEDICAL ASSOCIATION
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REPORT ~
THE HONG KONG MEDICAL ASSOCIATION

For Year 2006-2007

Protest against Link Real Estate Investment Trust (Link REIT)

- Unscrupulous rental increase in public housing estates
- Press conference on 3 December 2006
- Rally and march on 14 December 2006

*1 Council Member, Hong Kong Medical Association, Hong Kong (yvonnel@hkma.org).
HA Junior doctors Sit-in (I)
- Fight for equal pay
- Staff exodus
- Pay-rise
- Increase in intake of medical students
- Supporting their sit-in on 23 June 2007

HA Junior doctors Sit-in (II)
- Supporting their protest march on 30 June 2007
- Recent resolution

Medical Students Intake Increase
- Meeting with Secretary for Education in August 2007
- Secretary promised to look into the matter from the perspective of overall supply and demand of medical manpower

Victory with 50% of seats in Election Committee Medical Subsector Election
- HKSAR Legislative Council Medical Subsector Election - December 2006
- Prepared for HKSAR Chief Executive Election March 2007
- Forums
Continuing Medical Education (CME)

Fight:
against allowing parties with vested interests to make CME linked to registration/annual practising certificate

- Medical Council of HK (MCHK)’s unilateral decision and actions
- HKMA’s actions

Therapeutic Misadventures
- Dispensing errors in the Hospital Authority and the private sector

Beijing/Hong Kong Medical Exchange
- Co-organized with Chinese Medical Association
- November 2006
- Theme: Community Health Service & Family Medicine
Primary Care Registry
- Public-private collaboration
- Family doctor concept
- New Territories East as pilot
- November 2006
- Challenged by Medical Council of Hong Kong
- Resolution

Separation of Dispensing from Consultation
- Public opinion poll in late 2006/early 2007
- Conducted by Public Opinion Programme, The University of Hong Kong
- Result: ¾ respondents objected to separation of dispensing and prescription

Dangerous Drugs Register
- Kept in electronic form?
- HKMA vs. Hong Kong College of Family Physicians
- Resolution

Health Maintenance Organizations (HMOs) and Medical Insurance
- Professional autonomy
- Customer service
- Patient care and choice
- to work on core elements of good medical insurance scheme
Healthcare Financing

- Bauhinia Report – June 2007
- Press Conference on 24 July 2007
- HKMA Stand:
  - Pillar 1 vs. Pillar 2
  - Health and Medical Development Advisory Committee (HMDAC) report on public subsidized services
- Contribution vs. savings
- “money to follow the patient” rule

Cultural & Sports Activities

- HKMA Charitable Foundation
- HKMA Orchestra
- HKMA Choir
- HKMA No.1 Band
- Organ Donation Register
- Sports
  1. Family hiking
  2. Joint Professional Tournaments in Badminton, Basketball, Table-tennis and Golf
  3. Sports Night

General

- Council Meetings
- 42nd CMAAO Council Meeting held at Singapore in November 2006
- 57th World Medical Assembly held in Sun City, South Africa, in October 2006
- The Eighth Beijing and Hong Kong Medical Exchange Meeting focusing on “Community Health Services and Family Medicine” was successfully held in Hong Kong last year
- 12 monthly HKMA News
- 12 monthly CME Bulletins
- bimonthly Hong Kong Medical Journal
Surveys
- drug dispensing
- judicial review
- MCHK composition
- LINK Management
- Primary Care Registry
- Visiting Medical Practitioners Scheme
- the new CME Online website and bulletin

Representation of HKMA in the Statutory Governing Body of MCHK
- 7 elected representatives
- also representatives in:
  1. Ethics Committee
  2. Education & Accreditation Committee
  3. Health Committee
  4. Licentiate Committee
  5. Credentials Sub-Committee of the Licentiate Committee
  6. Exemption Sub-Committee of the Licentiate Committee
  7. Review Sub-Committee of the Licentiate Committee
  8. Preliminary Investigation Committee

END
~ Thank You! ~
INDONESIAN MEDICAL ASSOCIATION

Ihsan OETAMA*1

Country Report

Indonesia Medical Association activity

National

- The 26th General Assembly, held in Semarang on Nov.29-Dec.2, 2006, Dr. Fachmi Idris was installed as the president of the Indonesian Medical Association for the period 2006-2009, and Dr. Prio Sidiqratomo as vice-president/president-elect.
- Opening Ceremony was conducted at Presidential Palace
- Dr. Datuk Arumugam, President of WMA was invited to speak on this occasion.

Indonesia Medical Association activity

National

- January 2007: Plenary session of the IMA, followed by a workshop to compose the IMA’s grand strategy, that is:
  a. Vision: Producing Indonesian doctors with global competency with a high regard for humanity values.
  b. Mission: To enhance the dignity and well being of a doctor in creating a healthy society.
- IMA’s Grand Strategy:
  - To strengthen organisational infrastructure (central, regional, branch)
  - To promote the competency and ethics of a doctor in Indonesia, according to the competency and ethical standards of Indonesian medical system.
  - Creating an integrated medical service system.
  - Formulating an IMA image as an active medical profession organisation in health issues.
  - Have a good working relations regionally and internationally.
  - Members welfare.

*1 Chairman, International Relations, Indonesian Medical Association, Jakarta, Indonesia (pbidi@idola.net.id).
Indonesia Medical Association activity

National
- February 2007: The IMA is active in helping the victims of the five-yearly big flood that hit Jakarta, by providing clean water needed, working together with the Banting Technology Institute.
- May 2007: Present at the Constitutional Court in a Judicial Review seminar for the Law of Medical Practice, in which none of the articles are not beneficial for practicing doctors.
- June 2007: Signing of an MoU between the IMA and Indonesian Pharmacy Organisation about Medicine Promotion Ethics, witnessed by the Minister of Health, and the chairman of the Indonesian Medical Council.
- June 2007: Conducting the medical Check up for governor candidates in the Jakarta Election.

Indonesia Medical Association activity

National
- August 2007: Workshop to formulate the idea of forming a General Practitioner Society, regarding the Law of Medical Practice that is not beneficial to general practitioners.
- October 2007: Attending the WMA General Assembly in Copenhagen.

Indonesia Medical Association activity

National
- October 25, 2007: the 57th Anniversary of the Indonesian Medical Association. Launching of Doctor for the Nation Program, followed by a seminar about the Indonesian Medical History, and Medical Education to face the Globalization Era.

Indonesia Medical Association activity

International
- January 2007: Meeting with the BASICS (Basic Support for Institutionalizing Child Survival), a USAID project to fight needless childhood deaths, to develop an increase in immunization coverage in Indonesia.
- Visit Singapore Healthcare Providers initiated by the Singapore Tourism Board, with the purpose of regulating seminars on both sides.
- Meeting with JIBIC (Japan Bank for International Cooperation) who is planning to assist certain universities to increase products of the medical schools.
**Indonesia Medical Association activity**

**International**

- March 2007: MoU with AMDA (Association of Medical Doctors in Asia) for rebuilding and maintaining a health facility in Bantul, a disaster struck area in Yogyakarta Province
- April 2007: UPLIFT International offered a grant to study in the University of Washington, which will be for nine months.

**Indonesia Medical Association activity**

**International**

- June 2007: another visit by JBIC, talks about the possibility of providing University of Indonesia with a modern teaching hospital.
- June 2007: another meeting with UPLIFT. Talks about IMA participating in a program to teach children in religious schools to live clean and healthy, like for example teaching children to have breakfast, which is their rights.
- June 2007: Signing of MoU for cooperation between IMA and STB
Grand Design 2007 Published by the JMA

The JMA recently published a policy analysis document titled “Grand Design 2007” based on the discussions with the JMA Research Institute study group on the future of Japanese healthcare. This grand design lays the analytical foundations for state finances overall in order to give direction to the reconstruction of the health insurance system and discusses total analysis of national finance to see how healthcare as the core of social security should be treated in the future. Based on these two pillars, we are trying to evaluate the current healthcare provision system to find most appropriate way of how the environment to ensure quality healthcare should be provided and discuss the most appropriate way of the cost sharing by the Japanese people for healthcare. Of these, the general statement will be published in English translation in the JMA Journal of the Japan Medical Association in installments, and we encourage you to read it.

The 27th General Assembly of the Japan Medical Congress

The General Assembly of the Japan Medical Congress met in Osaka in April 2007. Its themes were “life, people, and dream,” and 25,000 people attended it. The General Assembly meets once every 4 years. Its first meeting was in 1902, and this year was its 27th meeting. The General Assembly now has a tradition of over 100 years. During the period of this General Assembly, the officers of the Korean Medical Association in charge of scientific affairs visited Japan and conducted an exchange of opinions with JMA officers including myself.

JMA Research Institute Celebrates 10th Anniversary

This year the JMA Research Institute, the JMA think tank, celebrates the 10th anniversary of its foundation, and an event was held in April to mark the occasion. Dr. Michael Reich, Taro Takemi Professor of International Health at the Harvard School of Public Health, and Mr. Keizo Takemi, then Vice Minister of Health, Labor and Welfare, joined Dr. Yoshihito Karasawa, President of JMA for a panel discussion on healthcare. People interested will also find this content published in the JMA Journal.

WMA Medical Ethics Manual

In 1999 the WMA reached agreement to publish its own medical ethics manual, and the English version was accordingly completed in 2005. Individual national medical associations have been preparing translations of this English version in their own national languages and distributing them at a national level to people involved with healthcare and legal affairs. The Japanese version is the 13th produced. Copies were donated to the 160,000 members in Japan and to all current medical school students. We understand that it is widely used as a textbook in ethics training provided to clinic and hospital staff in Japan.

Indonesia Tsunami Recovery Support Project

The JMA collected over 60 million yen or 500,000 US$ in donations for Indonesia to assist with recovery from the 2005 Indian Ocean earthquake and allocated this sum through the Asian Medical Doctors Association or AMDA towards the establishment of a healthcare center in the suburbs of Jogjakarta, Indonesia. Dr. Ishii, as

*1 Vice-Chair of Council, World Medical Association. Vice-President, Japan Medical Association, Tokyo, Japan (jmaintl@po.med.or.jp).
CMAAO Secretary General, visited Indonesia last March in order to exchange memorandum of understanding with the Indonesian Health Ministry and the Indonesia Medical Association.

CMAAO Country Report
Kazuo Iwasa, MD
Vice President, Japan Medical Association
Vice-Chair of Council, World Medical Association
November 19, 2007

Grand Design 2007
Policy analysis document on the future of Japanese health care was published by the JMA.

This grand design...
- lays the analytical foundation for state finances overall in order to give direction to the reconstruction of the health insurance system.
- discusses total analysis of national finance to see how health care as the core social security should be treated in the future.

The Grand design in English translation is available in the JMA Journal.

The 27th General Assembly of the Japan Medical Congress

Opening Ceremony
Scientific Session
- Venue: Osaka, April 2007
- Theme: "Life, people, and dream"
- Participants: 25,000 people
- The General Assembly has a tradition of over 100 years.

JMA Research Institute celebrates 10th Anniversary
The JMA Research Institute celebrates the 10th anniversary of its foundation, and the event was held in April to mark the occasion.

Panel discussion on healthcare
- The discussion is published in the JMA Journal.

WMA Medical Ethics Manual
- 1999: The WMA reached agreement to publish the medical ethics manual.
- 2005: The English version was published.
- 2007: The Japanese version was completed as the thirteenth language version.

Copies of the Japanese version were donated to 160,000 JMA members and all the current medical students.

Indonesia Tsunami Recovery Support Project
The JMA collected over 500,000 US$ in donation for Indonesia to assist with recovery from the 2005 Indian Ocean earthquake.

The donation was used through the Asian Medical Doctors Association (AMDA) to establish a healthcare center in the suburbs of Jogjakarta, Indonesia.
Government’s Plan to Develop ‘Medical Industry’ and Revision of Medical Law

In 2005, the Korean government launched its strategic plan to develop the medical sector into a core future industry in Korea and has continued with follow-up measures to support the plan. The measures include diversification of for-profit-business of hospitals, establishment M&A procedures for hospitals, development of high-tech medical industry complexes and promotion of private health insurance. These measures require institutional support in the form of an all-out revision of the Korean Medical Law, which was last revised 30 years ago. KMA agrees in principal to the government’s direction of active medical area promotion but at the same time emphasizes that measures to prevent negative impact on underprivileged people should come first. KMA also expresses concern that the government’s plan is focused only on the hospital-level and doesn’t include strategies to strengthen financial structures of clinic-level medical services. Moreover, the plan cannot become fundamental measures because it fails to address issues such as improvement of regulations, review of underestimated physician fee and increase of social health insurance contributions. Regarding the proposed bill of the Medical Law revision, KMA clearly opposes it, as some provisions impose too heavy legal obligations on physicians and should be dealt in the area of medical ethics. The bill also drafted a new stipulation banning on false keeping of medical records. False keeping of medical records can be dealt with within the concept of “fraud” on the current criminal law and reckless establishment of another penal stipulation may result in overuse of administrative disposition. KMA is planning to further keep a keen eye on the proceedings of the bill and continue to express its stance to the government.

Criticism on Government’s Plan to Enforce Generic Prescribing

The government announced the plan to urge physicians to issue generic prescribing as a way of reducing health expenditure. One of the biggest cost increases in Korean health care is prescription medications. On average, medications accounted for over 30% of the total health insurance expenditure in 2005. KMA warned the government that rushed enforcement of generic prescribing without proper infrastructure and stringent institutional requirement to ensure the safety and quality of generics would harm people’s health. It was found in 2006 that some bioequivalence test results of generics were fabricated by the inspecting institutions. As a result, their marketing approvals were cancelled. The Korea Food and Drug Administration (KFDA) is currently re-inspecting the bioequivalence of generics previously approved. However, notwithstanding this circumstance and KMA’s concern, the government went ahead with a pilot program of generic prescription starting with the National Medical Center (NMC) in September 2007. Another concern of KMA is generic substitution. Generic substitution may undermine the relationship between doctors and patients. Doctors face difficulties in treating patients, because changes in medication can influence compliance with the course of treatment. During the first 2 months of the pilot program, only 29% of the patients subject to generic prescribing

*1 Executive Board Member, Korean Medical Association. Professor, Department of Preventive Medicine, College of Medicine, Yonsei University, Seoul, Korea (intl@kma.org).
have been actually prescribed by generic names. KMA believes this low rate of compliance is a clear reflection of the concerns Korean physicians have about this new approach. KMA will continue to monitor the re-inspection process of KFDA to ensure the safety and quality of generics and keep members and the public informed about the risk of hasty enforcement.

**Controversies over a Bill on Medical Malpractice Law**

The National Assembly Sub-committee on Legislation passed a draft bill on Medical Malpractice Law in August 2007, imposing the burden proving no-fault on physicians. Efforts to legislate a Medical Malpractice Law have existed for 20 years in Korea, but an agreement was never reached due to its strong ramifications on the behavior of physicians, the quality of medical services and thus on the entire health care system. The 2007 draft bill reflected opinions of civil groups to a great extent in the following controversial issues: 1) imposing the burden of proving no-fault on physicians and 2) changing arbitration to a voluntary process. (Medical malpractice arbitration committee will be established, but whether to bring individual cases to the committee depends on patients’ decisions. This means that patients can file a lawsuit without going through an arbitration process)

KMA expressed clear opposition to this draft bill. Imposing the burden of proving no-fault on physicians will result in passive and defensive medical treatment and avoidance of specialties which involve a high possibility of medical malpractice among trainee for residency.

This bill failed to be submitted to the plenary session of the National Assembly and was automatically annulled with the end of the term of the National Assembly this year. However, the lawmaker who proposed this bill is expected to introduce the bill again next year. KMA will continue to make clear its stance and concerns on the bill to lawmakers and the public. It plans to draft a separate bill which defines the burden of proving no-faults based on general principles and maintains an obligatory process of arbitration.

**Preparation for 2008 WMA General Assembly**

The KMA will host the 2008 World Medical Association (WMA) General Assembly in Seoul next year (The Shilla Hotel) from October as a part of celebrating its centennial anniversary. With the assembly only one year away, KMA is pulling an all-out effort for the successful hosting. Promotional materials (video, poster and leaflet) were presented at the 2007 WMA Copenhagen General Assembly held last month, which attracted participants’ attention from various countries. At the assembly, the proposed theme for the scientific session “Health and Human Rights” was approved. The preparation committee is now working on a detailed program and inviting renowned speakers for each session. A photo exhibition displaying the history of KMA and medical societies is planned in parallel with the Assembly. It will become an opportunity to look back on the traces of the medical development in the last century and to set future priorities and strategies for the next century.
1. Government’s plan to develop ‘medical industry’ and revision of Medical Act

1) The Government’s strategic plans for developing ‘medical industry’
   - Objective: medical industry as one of the future core competence of Korea
   - Follow-up measures: diversification of for-profit-business of hospitals, establishment of procedures for M&A among hospitals, development of high-tech medical industry complex, institutionalization of private insurance and etc.
   - These measures require the revision of the Medical Act of Korea

2) KMA’s stance
   - In principal, it agrees to the Government’s direction to intensively foster medical area.
   - Concerns on negative impact on underprivileged people
   - The plan is focusing only on hospital-level
   - The plan cannot be fundamental measures unless it doesn’t deal with improvement in regulations, increase of social health insurance contributions, etc.

2. Criticism on Government’s plan to enforce generic prescribing

1) Rush enforcement of generic prescribing
   - The Government urges physicians generic prescribing as a way of reducing health expenditure
   - KMA’s concerns
     - Not proper infrastructure: Cases of fabrications of bioequivalence test results and re-inspection by Korea Food and Drug Administration (KFDA) of bioequivalence for generics
     - generic substitutions

2) Pilot program of generic prescribing
   - The Government applied a pilot program of generic prescribing starting with National Medical Center (NMC) in September 2007
   - About 30% of the patients subject to generic prescribing have been actually prescribed generically.
   - KMA’s further measures
     - continue to monitor the re-inspection process of KFDA
     - keep members and public informed about the risk of rush enforcement of generic prescribing system
3. Controversies over a bill on Medical Malpractice Law

1) Background

- Establishment of Medical Malpractice Law has been proposed and reviewed over twenty years in Korea, but agreements were never reached.

- The preliminary committee on legislation, National Assembly of Korea passed a bill on Medical Malpractice Law in August 2007.

3. Controversies over a bill on Medical Malpractice Law

2) Controversies over the bill

- Imposing the responsibility of proving no-fault on physicians → This might result in passive and defensive medical treatment and tendencies to avoid specialties of highly exposed to medical malpractice.

- Process of arbitration on voluntary basis → This means that patients can file a lawsuit without going through an arbitration process first.


1) Overview

- Date: October 15(Wed.)~18(Sat.)

- Place: Hotel Shilla, Seoul, Republic of Korea

- Main Program:
  - Council Session, Scientific Session, Assembly Ceremonial Session, Plenary Session of Assembly

- Theme of Scientific Session: "Health and Human Rights"

- Social Events:
  - Welcome Reception hosted by the President of Korea, Dinner hosted by KMA, City tour, Dinner hosted by WMA


Cheong Wa Dae (Presidential Residence)

Hotel Shilla and Main Meeting Room

Glimpse of Seoul- Royal Palace

Glimpse of Seoul- Central Area for Commerce

5. Tobacco cessation campaign

   Education Programme for physicians
   - Provision of education to physicians to help and guide tobacco cessation of patients and physicians themselves
   - Promoting awareness of importance of physicians' role in tobacco cessation
   - Series of workshops for physicians rotating provinces
   - KMA will diversify and expand the programme in 2008 to provide education opportunities to more members

Thank you.
New Zealand’s health sector has been radically transformed over the past decade and a half. Successive governments with different perspectives and ideologies have made huge structural changes. The current Labour-led Government, headed by Prime Minister Helen Clark, is now 2 years into its third 3-year term, and is in a phase of consolidation rather than implementing new initiatives. This Government now faces a strong challenge from the main Opposition party, which is leading in the polls.

Over the past 15 years democratically-elected regional hospital boards have been set up, abolished and replaced by commercial companies, and then re-introduced. New Zealand now has 21 District Health Boards (DHBs) which are responsible for providing government-funded health care for the population in their region. DHBs focus on planning and delivering health services, running hospitals, overseeing primary health care services and delivering some public health programmes.

Adequacy of funding at District Health Board level is a continuing concern, with some running continual deficits and/or cutting services to meet budget constraints. The continuing inability of many DHBs to meet their commitments in respect of patient access to secondary and tertiary services continues to be of great concern. This is particularly so in relation to first appointment with specialists, and the long waiting times for many elective procedures. The situation is further complicated by the returning of many patients from hospital waiting lists to the care of their GP. This lack of timely access to the care they need causes great distress to many New Zealanders and their families.

Care in the private secondary health sector is available to those with health insurance or the means to pay. More than 50% of elective surgery takes place in the private sector, as funding restraints and restricted waiting lists mean only the most urgent cases get priority in public hospitals. A major issue has been the removal of subsidies, in some regions, for patients of private specialists who require laboratory tests. The NZMA believes this is inequitable and unfair both to the patients and private specialists.

Medical registration in New Zealand is controlled by the Health Practitioners Competence Assurance Act 2003, which brought together all registered health practitioners (such as doctors, nurses, dentists, midwives and physiotherapists) under the same registration, competency and disciplinary procedures. The Act has the primary aim of protecting the public. Of great concern to the NZMA is the fact that although the Act permits regulations to be made which would allow for elected members to the Medical Council of New Zealand (MCNZ), to date, the Minister of Health has not done so. For the MCNZ to work effectively it must have the respect and confidence of the profession, and that will not happen while there are no directly elected members.

The medical workforce in New Zealand continues to be under extreme stress. The high fees and resulting debt levels incurred by medical students in training lead to many newly-qualified New Zealand doctors seeking higher-paid positions overseas. Other problems include:

- Increasing demand
- Ageing workforce
- Doctor dissatisfaction and morale leading to retention issues
- Insufficient medical student places (self-sufficiency is needed)
- Student debt
- Long lead time to train doctors
- Generational changes in work-life balance expectations
- Inappropriate reliance on overseas trained doctors (OTDs)

Many of New Zealand’s practising doctors

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*1 Chairman, New Zealand Medical Association, Wellington, New Zealand (nzma@nzma.org.nz).
trained elsewhere in the world—currently 42% are from overseas countries. Doctor shortages in some regions and notably in rural areas continue to place extra demands on the profession. Specialities such as obstetrics, psychiatry and general practice are particularly short. The Government has established a Medical Training Board to find solutions to workforce problems. The NZMA has long called for a comprehensive strategic plan for the medical workforce which will address both the short and long term need for medical practitioners in New Zealand.

Seven years ago the Government released its Primary Health Care Strategy, based on capitated funding to general practices which enrol their patients as members of a Primary Health Organisation (PHO). PHOs receive public funding through District Health Boards. This was the biggest shake-up of the primary health sector for half a century.

The New Zealand Medical Association supported the broad proposals of the Primary Health Care Strategy as having the potential to improve the health of New Zealanders and their access to primary health services. The Government has progressively rolled out increased funding to all age groups, which has enabled patient co-payments to be reduced. We have fought hard to retain the principle that GPs be able to set their own fees, and charge a co-payment if necessary (as the government funding does not cover the entire cost of visiting a GP). The control of GP fees is shaping up to be a major election issue.

The NZMA continues to publish the New Zealand Medical Journal, which has been online only since 2002. The NZMJ is the premier scientific medical journal for the profession in New Zealand, and continues to publish well regarded research on a wide variety of medical topics.

The NZMA provides the Code of Ethics for the profession in New Zealand, and has been reviewing the Code this year.

The NZMA works closely with the NZ Medical Students’ Association, recognising that students are the future of the profession. The NZMA also has a Doctors-in-Training Council, which represents the interests of junior doctors and medical student members.

Other NZMA initiatives include:
- Around 50 submissions on a wide variety of issues.
- Running a successful Trainee Forum, with participation from registrars from many of the Medical Colleges.
- The establishment of a Leadership Fund to support participation in leadership activities.
- Settling the largest multi-employer collective employment agreement ever to be negotiated in New Zealand (representing GPs as employers of practice nurses).
- Launching a new publication—the NZMJ Digest.
- Producing a member resource on the Commerce Act, to enable medical practitioners to develop an understanding of competition law and practise safely within the confines of the law.

It has been another busy and challenging year for the NZMA. We place a high value on advocacy for the health of the population and support for professional conditions. Continuing liaison with health sector policy makers, representation on consultative bodies, preparation of submissions on health-related legislation and advocacy about the introduction of new initiatives continue to keep members actively engaged in improving health care for all New Zealanders. We continue to work closely with other medical organisations both within the country and at an international level.
SINGAPORE MEDICAL ASSOCIATION

Yik Voon LEES*1

COUNTRY REPORT

Presented by
Dr LEE Yik Voon
Honorary Treasurer, 48th Council
Singapore Medical Association

Membership

✧ As at 30 September 2007, total membership of the Singapore Medical Association stood at 4,917.
✧ This represents 68% of all 7,288 registered practitioners in Singapore.

48th SMA Council 2007/8

President
Dr WONG Chiang Yin
1st Vice President
Dr CHONG Yeh Woei
2nd Vice President
Dr TOH Choon Lai
Honorary Secretary
Dr Raymond Chua Swee Boon
Honorary Treasurer
Dr LEE Yik Voon
Honorary Asst Secretary
Dr WONG Tien Hua
Honorary Asst Treasurer
Dr Abdul Razakjri OMAR

Members
Dr Tammy CHAN Teng Mui
Dr CHIN Jing Jih
Dr LEE Pheng Soon
Dr TAN Sze Wee
Dr TOH Han Chong
Dr Bertha WOON Yng Yng
Dr YEO Sow Nam Alex
Dr YUE Wai Mun

Conventions & Seminars

13th SMA House Office Seminar
✧ Held on 21 April 2007.
✧ Attended by more than 100 graduating House Officers.
✧ Talks included "Morning Ward Rounds", "Changes", "What Makes a Good House Officer" & "Medical Indemnity".

*1 Honorary Treasurer, 48th Council, Singapore Medical Association, Singapore (sma@sma.org.sg).
Conventions & Seminars

38th SMA National Medical Convention
- Theme: "Breaking New Barriers in Pain Management".
- Aims:
  - Raise awareness of pain medicine as multidisciplinary.
  - Provide forum to discuss pain objectively and openly.
  - Update fellow colleagues on current trends.
- Keynote address by Mdm Halimah Yacob,
  Member of Parliament and Chairman of the
  Government Parliamentary Committee (Health)

- Special lecture on "Chronic pain: Is it a disease entity? IASP's role" by Prof Troels Staehelin Jensen, President of the International Association for Study of Pain (IASP)
- Plenary session on "Impact of pain in Asia and how we cope", with presentations from Australia, Singapore, China, Japan and Malaysia
- Medical symposium on "Breaking new barriers in pain management", with presentations on pharmacological and interventional approaches to cancer pain, arthritis, headaches, back and neck pain, neuropathic pain, and opioids and NSAIDS for chronic pain.

- Lunch symposium on "The use of COX-2 inhibitors in NSAID intolerant patients"
- Workshop on "Dealing with Opioids in chronic pain" and "Acupuncture and needling"
- Public forum on "Overcoming pain with the latest medical breakthroughs". Chinese translations were also provided to cater to the large number of Mandarin-speaking public who attended.

Flu Pandemic Workshops
- Held over 3 weekends from August to September 2007.
- Attended by almost 700 participants.
- Jointly organised by Ministry of Health, SMA and College of Family Physicians Singapore.
- Aim of workshops was to support GPs who would continue to manage the sick in the community during a pandemic.
Conventions & Seminars

- Presentations included:
  - latest updates on avian influenza situation and the
    systems and operational procedures that will come into
    effect in the event of a pandemic
  - practical steps on how to prepare clinics to handle
    suspected cases
  - personal protective equipment and mask-fitting
- GPs were also encouraged to sign up for the Primary
  Healthcare Response Framework. In event of a pandemic,
  GPs will continue to provide clinical assessment and anti-
  viral treatment when needed or make referral to hospitals
  for further treatment. Participating GPs and their clinic
  staff will receive same level of protection as healthcare
  workers in public sector and will be provided with anti-
  viral drugs for treatment purposes.

11th SMA Annual Ethics Convention

- 19 & 20 October 2007
- Theme: "Managing Risks in Medical Tourism & Aesthetics
  Practices"
- Opening Ceremony on 19 October 2007 was held in
  conjunction with the Launch of the Medical Protection
  Society (MPS) Educational Services.
- Following the acquisition of Cognitive Institute in March
  2007, MPS Educational Services is expanding their risk
  management and training portfolio, allowing them to
  offer more educational programmes to MPS members
  around the world.

Conventions & Seminars

- Presentations on 20 October 2007 included:
  - "Managing Risks in Medical Tourism and Aesthetics
    Practices"
  - "Enhancing Communications and Informed Consent in
    Medical Tourism & Aesthetics Practices for Better
    Doctor-Patient Relationships"
  - "Ethical Issues in Aesthetics Practices"
  - "Dealing with Medical Tourism Overseas – The Do’s and
    Don’ts"

SMA Lecture 2007

- 24 October 2007
- SMA Lecturer 2007: Professor Woo Keng Thye
- Theme: "Physician Leadership". Highlights included:
  - Fundamental advantages a doctor has over others in
    leadership positions, including the study and
    understanding of human nature.
  - Essential qualities in a strong leader, with examples
    from Art of War by Sun Tzu
  - The importance of change and exiting leadership.

AST Course on Medical Ethics,
Professionalism & Health Law

- Compulsory requirement for exit certification
  from specialist training.
- Equip trainees with necessary communication
  skills & working knowledge of clinical ethics &
  local health statutes.
- Help trainees develop more systematic &
  professional approach to common ethical &
  medico-legal issues in Singapore.
Monthly/Bimonthly Publications

- Singapore Medical Journal
- SMA News
- Sensory (bimonthly)

Withdrawal of SMA Guideline on Fees

- SMA announced the withdrawal of its Guideline on Fees (GOF) at its AGM on 1 April 2007 with immediate effect.
- The decision was made by the 48th SMA Council after it received indications that the GOF might contravene Section 34(2)(a) of the Competition Act, and also after the Council had sought advice from 5 of its Honorary Legal Advisors.

The GOF was first introduced in 1987 with the aim to:
- Protect patients from being overcharged and to equip them with knowledge on medical procedures in the hope that with improved knowledge there would be lesser cases of misunderstandings.
- Help doctors with an indication of the current rates and how much to charge their patients.

In the meantime, SMA will be conducting surveys on clinic charges and professional fees of GPs and specialists and will publish the data before its next AGM in 2008.

The defunct SMA Tent Card, which provided a display of consultation charges under the GOF, will be re-issued with blanks for doctors to fill in their own clinic charges and professional fees.

SMA is also working with the Law Society of Singapore to jointly re-issue a separate advisory entitled "Best Practices Guidelines for Court Attendance and Preparation for Medical Practitioners". This advisory will be circulated to members of SMA and Law Society, for the purpose of promoting good work relationships between medical and legal practitioners.

SMA Medical Students’ Assistance Fund

- To help poorer medical students with their basic living expenses. Fund set up in partnership with the National University of Singapore’s (NUS) Yong Loo Lin School of Medicine and with support of NUS Development Office.
- Recent survey by NUS Medical Society found that about 21%, or 250 medical students in the NUS undergraduate course, have a monthly household income of less than S$3,000. Another 26% come from households that earn between S$3,000 to S$5,000 a month.
- A NUS medical student needs at least S$4,410 a year to survive day-to-day (transport, food, books, etc), or S$367.50 a month.
Social Concerns

- While there are a number of bursaries, financial assistance schemes and loans which can help pay for tuition fees, basic living expenses are not always covered.

- Some students have managed by giving tuition but at the expense of their own studies.

- Fundraising activities include appealing for monetary donations from SMA members, hospitals and charitable foundations, as well as selling SMA Christmas cards.

- SMA will also be engaging medical students more actively through NUS Medical Society, e.g. SMA has offered SMA student memberships to final year students, mentorship scheme, inviting students to SMA events, etc.
Striving for Medical Reconstruction Fund

The increase of aging population, numbers qualify for serious injury and the introduction of new medical technologies have all contribute to the annual 8–10% medical expenditure growth rate. The financial difficulty is extremely urgent. However, the Bureau of National Health Insurance has strengthened its control over health care facilities. The model it uses to control the payment system contradicts with market mechanism and has led to a twisted and restrained future for the health care development.

In 2005, the health care expenditure counted for 6.16% of GDP in Taiwan. This is significantly low compare to 8% in OECD countries and 15.3% in the U.S.A. There is no doubt that Taiwan is offering high quality health care services with insufficient resource. Nevertheless, health care facilities face a discounted payment system. This will danger the health care system if it induces the health care facilities to collapse and the providers to break down.

In order to maintain the health service quality, improve peoples’ habit of accessing health care services and health care system default, hold the public health system together, assure patients’ right to access health care services, we have been striving for the government to budgeting the “medical reconstruction fund” for 2 years. The main purpose is to add the budget to the unbalanced global budget payment system. The premier has finally agreed our appeal for 50 billion dollars “medical reconstruction fund” budget in September of 2007.

Insurance Certification—IC card

Taiwan introduced National Health Insurance in 1995. With the need of informationize, insurance
certification evolved from paper into IC card in 2004 and the first stage registration and uploading was implemented at the same time. In order to increase the accuracy of medical information, reduce the consumption of medical resources, monitor health care facilities that patients access and assist in the implementation of various prevention measures, the Bureau of National Health Insurance in Taiwan adopted a disciplinary and rewarding method to request health care facilities to cooperate with second stage registration and uploading in 2007. The main contents include primary and secondary diagnosis, medication, physician orders, fees...etc. However, Taiwan Medical Association continues to negotiate with Department of Health and the Bureau of National Health Insurance not to force the implementation by using disciplinary way due to the suspicion from different facets such as: facilities’ settlement, ability to handle information and the doubt of service quality, ethics, privacy, legal and practical operation. We are still continuing our talks with other parties in order to reduce the impact this has caused to health care facilities.

**Taiwan Medical Association Signed a Memorandum of Understanding with the Argentina Medical Association**

Taiwan Medical Association signed a bilateral Avian Flu cooperative memorandum of Understanding with Dr. Jorge Carlos Janez, President of the Argentina Medical Association, in April of 2007 based on the standpoint of “diseases without borders.” The main purpose is to bring NGO’s participation in international epidemic prevention into play through both organizations’ interaction and cooperation with the hope to assist people and government from both countries to completely prevent avian flu from happening again.

**Taiwan Medical Association’s Representative Made a Keynote Speech in 2007 World Medical Assembly**

Dr. Heng-Shuen Chen from the Taiwan Medical Association was invited to be the speaker of 2007 World Medical Assembly Scientific Session on the topic “e-Health Solutions for Systems in Development.”

Dr. Chen gave a detail introduction on Taiwan’s medical technology, such as IC card, telemedicine, the development and research in telemedicine in recent years, and how to combine other information systems to promote health care quality...etc.
2006 Excellent National Professional Organization

- Aggressively participate in cooperative plans with the Department of Health of Taiwan and WMA.
- Undertake physician clinics global budget task.
- Establish "Medical Dedication Award" to cite for physicians' exceptional contributions to the health care.
- Assist DOH to draw up the "Patient Safety Guidelines" as a reference to patients and families.

Medical Reconstruction Fund

- Every year, a 8~10% growth of medical expenditure due to population aging, advanced medical technology development and many other factors was noted in Taiwan.
- In 2005, health care expenditure around the world:
  - Taiwan: 6.16% of GDP
  - OECD countries: 8% of GDP
  - USA: 15.3% of GDP
- The discounted payment system had great impacts to the health care system.
- 50 billions NT dollars (1.3 billions USD) of "medical reconstruction fund" has been proposed.

Insurance Certification - IC Card

- National Health Insurance in 1995
- First stage in 2004
  - Patient visit data registration and uploading was implemented by IC cards
- Second stage in 2007
  - Patient visit registration and uploading of all claim data, including primary and secondary diagnosis, medications, physician orders, fees...etc

Memorandum with the Argentina Medical Association

- Diseases have no borders
  - In April of 2007, TMA signed a bilateral Avian Flu cooperative memorandum with the Argentina Medical Association.
  - Invite both GO and NGO to participate in this cooperative prevention program

Keynote Speech in 2007 World Medical Assembly

- Dr. Heng-Shuen Chen from the Taiwan Medical Association was invited speak in the 2007 World Medical Assembly Scientific Session
  - "e-Health Solutions for Systems in Development.”

Mental health gatekeeper program

- All 13,000 primary care physicians were invited to be gatekeepers of suicide prevention.
- Mental health collaborative care systems for primary care physicians and mental health workers
  - Depression management
  - Dementia screening
Towards Healthy Longevity

CHOI Kin*1

Geriatric population in Hongkong

- 1996 10.2% population >65
- 2001 11.2% population >65
- 2031 24.0% population >65

Geriatric Medicine in Hongkong

- 1973-74 Dr. Chan Sik sent to UK to observe British Geriatric Service
- 1975 First geriatric unit in Princess Margaret Hospital
- 1979 Geriatric included in curriculum in HKU
- 1981 Founded HK Geriatric Society
- 1994 First Geriatric Medicine Professor in CUHK – Jean Woo

Life after 80

- Life expectancy of woman after 80 in HK is 11 years
- Life expectancy of men after 80 in HK is 8.4 years
- Over 85 spend 13 days a year in hospital
- 75-79 year old spend 6 days a year in hospital
- 65-69 year old spend 2 days a year in hospital

*1 President, Hong Kong Medical Association, Hong Kong (yvonne@hkma.org).
Elderly Health Services

- 18 Elderly Health Centers by Department of Health
- Annual Enrolment fee $110 for >65
- Health assessment, physical check up, counseling, curative treatment and health education
- 18 visiting health teams for vaccination in community and residential care settings to increase health awareness & self-care ability

Residential Care Facilities 2003

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>Total capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hostels</td>
<td>7</td>
<td>113</td>
</tr>
<tr>
<td>Home for aged</td>
<td>78</td>
<td>7343</td>
</tr>
<tr>
<td>C &amp; A Homes</td>
<td>87</td>
<td>11999</td>
</tr>
<tr>
<td>Self-financed homes</td>
<td>36</td>
<td>3112</td>
</tr>
<tr>
<td>Long stay care homes</td>
<td>4</td>
<td>770</td>
</tr>
<tr>
<td>Contract Homes</td>
<td>5</td>
<td>504</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>7</td>
<td>1776</td>
</tr>
<tr>
<td>Private Old Age Homes</td>
<td>573</td>
<td>45926</td>
</tr>
<tr>
<td>Bought place scheme</td>
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<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>70943</td>
</tr>
</tbody>
</table>

Financial assistance to elderly citizens of Hong Kong

- Normal OA Allowance  65-69 $625
- Higher OA Allowance >70 $705
- Normal disability 100% $1120
- allowance loss of work capacity
- Higher DA +24 hrs attention $2240
- Diaper allowance On diapers $900
- Diet allowance Special diet $795

Community Support Service

- Neighborhood Elderly Center 114
- Health education, information, referral center on community resources, volunteer development, social and recreational activities, meal services, counseling, reaching out and networking, support services, drop in services

Community Support Services

- 60 Social Centers for the Elderly
- Organize Social and Recreational services
- Information giving regarding elderly welfare services
- Organized group activities
- Will be upgraded to Neighborhood Elderly Center

Community Support Services

- 40 District Elderly Community Centers
- Community support services at district level
- Community education, case management, support team for elderly, information and referral centers on community resources, volunteer development, care giver support, meal and laundry services, social and recreational activities. Provide support and training to other elderly service unit
<table>
<thead>
<tr>
<th>Community Support Services</th>
<th>Community Social Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 40 Support teams for the elderly</td>
<td>• 50 Day care center for 2957 elderly</td>
</tr>
<tr>
<td>• Based in District Elderly community centers</td>
<td>• Center based care and support services in day-time for frail and demented elderly</td>
</tr>
<tr>
<td>• Provide social networking services and outreaching services to vulnerable elderly</td>
<td>• Personal care, nursing care, rehabilitation training, meal and transport</td>
</tr>
<tr>
<td>• Telephone contacts and home visits</td>
<td></td>
</tr>
<tr>
<td>• Escort to clinics and household chores</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Social Services</th>
<th>Community Social Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Home Help Services for disabled elderly and families incapable of looking after themselves.</td>
<td>• 60 Integrated Home Care Service Team</td>
</tr>
<tr>
<td>• Bathing, feeding, household cleaning, purchase and delivery of daily necessaries, laundry service, escort service to hospital and clinics, meal services</td>
<td>• Multidisciplinary Team approach – nursing care, personal care, rehabilitation service, social work service.</td>
</tr>
<tr>
<td></td>
<td>• Planned and coordinated package of home care and community care service tailor-made for individual service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Social Service</th>
<th>Senior Citizens Card Scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 18 Enhanced Home and Community Care services</td>
<td>• Proof of Age to elders</td>
</tr>
<tr>
<td>• Similar service to IHCST</td>
<td>• Facilitate access to concessions, discounts, priority services offered by government, public companies, private and commercial establishment</td>
</tr>
<tr>
<td>• Will be upgraded to IHCST</td>
<td>• &gt;65 years old are eligible</td>
</tr>
</tbody>
</table>
**Elderly depression**

- WHO: depression will be the second most important cause of disability world wide, after ischemic heart disease, by 2020.
- World wide prevalence of depression in the elderly 9-35%, 13% of community dwellers, 43% of nursing home residents

**Screening for depression**

- US Preventive Service Task Force:
- Overall, screening and feedback reduced the risk for persistent depression
- Compare with usual care, screening for depression can improve outcomes, particularly when screening is occupied with system changes that help ensure adequate treatment and follow up

**Screening for elderly depression**

- 1424 patients over 65 were offered a psychiatric interview when they were seen in a primary care practice in Hong Kong
- 31 patients were diagnosed with dementia and excluded from the study
- 25 patients were excluded because they were known to have depression
- 4 patients were excluded because of deafness and difficulty in communication

**Prevalence of depression in the elderly in Hong Kong**

- 9.6 % of elderly interviewed were diagnosed with major depressive disorder
- 7.4% of male interviewed were depressed
- 10.7% of female interviewed were depressed
- Chinese version of GDS-15 could be used for screening of elderly depression and AMT-10 for dementia

**The Problem with Dementia**

- World prevalence
  - 65-69 1.5%
  - 70-74 3.5%
- HK Prevalence
  - 60+ 4%
  - 70+ 6.1%

**Cholinesterase inhibitor**

- Cholinesterase inhibitor
- Cost-effectiveness
- Memantine
- NICE guideline
- Advocate for our elderly patients
Fall Prevention

- 30% of community dwelling elderly fall each year
- 20% of falls require medical attention
- <10% of falls result in fracture
- Together with accidents and suicide, falls rank the sixth leading cause of deaths in Hong Kong

Environmental hazards

- Furniture: unstable &/or of inappropriate height
- Beds/toilets – inappropriate height
- Uneven stairs & inadequate or no railing
- Steps and kerbs at entrance
- Cracked and uneven sidewalks
- Obstacles on the floor e.g. wires, cords
- Slippery floors and bathtubs
- Poor lighting or glaring

Community Geriatric Assessment Team

- Occupational therapist to look at the environment.
Towards Healthy Longevity in Indonesia

Czeresna H. SOEJONO,*1 Purwita W. LAKSMI

The population is aging. By the year 2050, 12 countries are projected to have more than 10% of oldest-old population. They include not only countries in Europe, but also in Asia Pacific region. Furthermore, five countries will have 10 million or more people over 80 years old, including China, India, the United States, Japan and Indonesia [United Nations Information Centre].

In 2005, there are 16,440,500 people age 60 years and older in Indonesia and it is estimated that the number will increase to 19,079,800 people or 8.15% of total Indonesian population in 2010 (BPS, 2005).

Many diseases and disabilities will then ensue, ranging from infection, hypertension, diabetes mellitus, instability, immobility, osteoporosis, and fracture to depression, dementia, overactive bladder and insomnia. The health problems are thus inevitable. Elderly people are bound to place an enormous personal and socioeconomic burden on their families and society, unless prompt action is undertaken to quickly develop better prevention and treatment programs for many of the physical and mental ailments associated with old age. Compared with younger patients, older patients have longer and more frequent hospitalizations and their illness severity is greater. Cost of hospitalization are higher in elderly patients compared to younger adults.

Geriatric patients are elderly patients with certain characteristics: coincidence of multiple health problems in one person, tendency for polypharmacy, decreased or limited physiologic reserves in multiple organ system, decreased functional status, atypical presentation of illness, and usually have malnutrition condition and psychosocial problems. Thus the approach to the elderly person requires a perspective different from that needed for medical evaluation of younger persons, which called comprehensive geriatric assessment (CGA).

Traditional medical evaluation typically focuses on the medical care of disease-specific and life-threatening illnesses, while less attention is given to functional outcomes such as physical and cognitive functioning which may be critical determinants of the quality of life, physical independence, cost of care, and prognosis among elderly patients. CGA extends beyond the traditional medical evaluation to include assessment of cognitive, affective, functional, social, economic, environmental, and spiritual status, as well as a discussion of patient preferences regarding advance directives. In addition, to improve clinical outcomes of hospitalization, CGA are conducted by interdisciplinary team to include doctors from kinds of specialties, nutritionists, pharmacists, gerontological nurses, therapists (physical, occupation, and speech), and social workers.

The health care system of geriatric care consist of hospital-based care which include acute care and sub acute care and community-based care which include nursing home care and home care services. Acute care setting is comprehensive inpatient care designed for someone who has an acute illness, injury, or exacerbation of a disease process, while sub acute care setting is designed for someone who no longer required acute care services and did not need (or want) long-term care placement, but who was not yet sufficiently recovered from his/her acute illness to return home and still requiring medical management and/or functional rehabilitation within the skilled nursing facility. The interdisciplinary process of discharge planning in acute care unit serves to identify patients who will need nursing home placement or home care services, to estimate the patient’s hospital length of stay, to educate the patient and family about the patient’s diagnosis, prognosis, and choices for discharge location, and to review medications, home safety, and the promotion of self-care.

Bearing in mind the imminent health problems in the elderly, it is important to make it possible to deliver the right care, in the right place, at the right time, by the right practitioner and to organize

*1 Indonesian Medical Association, Jakarta, Indonesia (pbidi@idola.net.id).
The long and winding road to the establishment of geriatric care in Indonesia has begun since 1966 when one of the pioneers of our geriatric care, R. Boedhi Darmojo, MD, studied gerontology and geriatric medicine abroad. This was followed by the first national symposium on geriatric medicine 10 years later. In 1994, three hospitals (Ciptomangunkusumo Hospital, Jakarta; Kariadi Hospital, Semarang, Central Java; Sardjito Hospital, Yogyakarta) were appointed by Ministry of Health to be the pioneer hospitals which serve integrated geriatric care. But it was not until 1996 when geriatric medicine became part of the curriculum and being taught to internal medicine residents/undergraduate students and the Indonesia Medical Gerontology Association being established under bow the Indonesia Medical Association.

Now, the Indonesia Medical Gerontology Association has 15 branches all over Indonesia (Medan, Padang, Pekanbaru, Palembang, Jakarta, Bandung, Semarang, Solo, Yogyakarta, Malang, Surabaya, Denpasar, Makasar, Manado, Banda Aceh) with 7 branches as center of education which teach geriatric medicine to undergraduate students and 4 branches which also teach geriatric medicine to internists who want to be internist-geriatricians. The contribution to the community-based geriatric care is through training of PUSAKA personals.

Indonesia still lack of human resources concerning that there are only 15 internist-geriatricians until now who have to serve more than 10 million elderly people. We are also lack of facilities of geriatric care, research and training in geriatric medicine for internists, GPs, nurses, and layman. Lastly, government support and health care insurance support system are all still needed to make better health management, as well as international collaboration to exchange information and experiences vital to the advancement of health and research in geriatric medicine in Indonesia.

TOWARD HEALTHY LONGEVITY IN INDONESIA

CZERESNA H. SOEJONO, MD, PhD
Internist-Geriatrician

INDONESIA MEDICAL ASSOCIATION
INDONESIA MEDICAL GERONTOLOGY ASSOCIATION

The population is aging...

- In 2050:
  - 12 countries will have >10% of oldest-old population
  - 5 countries will have >10 million people age >80 (China, India, USA, Japan, Indonesia)

United Nations Information Centre, 2000
**Elderly in Indonesia**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>PEOPLE AGE &gt;60</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>16,440,500</td>
</tr>
<tr>
<td>2010</td>
<td>19,079,800</td>
</tr>
</tbody>
</table>

\[ \approx \]

8.15% of total population

Indonesia Bureau of Statistics

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**Number of Elderly and Toddler Estimation in Indonesia**

- **Population (millions)**
  - Age 0-1
  - Age 60+

- **Years**
  - 1980
  - 1990
  - 2000
  - 2005
  - 2010
  - 2015
  - 2020

---

**Comprehensive Geriatric Assessment (CGA)**

- CGA different from traditional medical evaluation
- Include assessment of cognitive, affective, functional, social, economic, environmental, and spiritual status
- Discussion of patient preferences regarding advance directives
- Conducted by interdisciplinary team

---

- Coincidence of multiple health problems in one person
- Tendency for poly-pharmacy
- Decreased or limited physiologic reserves in multiple organ system
- Decreased functional status
- Atypical presentation of illness
- Usually have malnutrition condition and psychosocial problems

---

**Geriatric Patient**

Medical assessment different from younger adult

COMPLETE GERIATRIC ASSESSMENT
Health Care System of Geriatric Care

Hospital-based Care
- Acute Care
- Sub Acute Care

Community-based Care
- Nursing Home Care
- Home Care

It is important to deliver the right care, in the right place, at the right time, by the right practitioner and to organize good insurance health care financing program.

Geriatric Care in Indonesia -1

<table>
<thead>
<tr>
<th>YEAR</th>
<th>ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1966</td>
<td>R. Boedhi Darmojo, MD, studied gerontology and geriatric medicine abroad</td>
</tr>
<tr>
<td>1976</td>
<td>The 1st national symposium on geriatric medicine</td>
</tr>
<tr>
<td>1994</td>
<td>3 hospitals became pioneer to serve integrated geriatric care</td>
</tr>
<tr>
<td>1996</td>
<td>- Geriatric medicine became part of the curriculum</td>
</tr>
<tr>
<td></td>
<td>- Indonesia Medical Gerontology Association was established</td>
</tr>
</tbody>
</table>

Geriatric Care in Indonesia -2

- Indonesia Medical Gerontology Association has 15 branches all over Indonesia

7 branches as center of education to teach geriatric medicine to undergraduate students

4 branches also teach geriatric medicine to internists who want to be internist-geriatricians

Geriatric Care in Indonesia -3

- Contribution of Indonesia Medical Gerontology Association in Indonesia
  - Conducts training for nurses and GPs from primary health care annually
    - Conducted training of PUSAKA personals (community-based geriatric care service)
    - Conducted training in hospital-based geriatric care for internists, medical rehabilitation consultants, and psychiatrists from 52 hospitals (of 427 hospitals all over Indonesia)

Geriatric Care in Indonesia -4

- Contribution of Indonesia Medical Gerontology Association in Indonesia
  - Conducted training of PUSAKA personals (community-based geriatric care service)

Geriatric Care in Indonesia -5

- Contribution of Indonesia Medical Gerontology Association in Indonesia
  - Conducts National Geriatric Annual Scientific Meeting
  - Will hold the 3rd Asia Pacific Geriatric Congress, Nov 13-16, 2008 in Bali
Geriatric Care in Indonesia -6

Still lack of...
- Human resources
  - Only 15 internist-geriatricians who have to serve >10 million elderly people
- Geriatric care facilities
  - Only 4 hospitals with Acute Geriatric Care
  - Only 1 hospital with Day Hospital Facilities

Conclusion
- Indonesia is facing a new epidemic: geriatric giant
- Geriatric Care in Indonesia is still far from ideal
- Indonesia needs so much support from the Indonesian Government and International Collaboration to improve Geriatric Care toward healthy longevity in Indonesia

Geriatric Care in Indonesia

Still lack of...
- Training in geriatric medicine for internists, GPs, nurses, and layman
- Public facilities that elderly friendly
- Government support
- Health care insurance support system

On-going process...
- Research in geriatric medicine
- International collaboration

MAIN TOPICS
- Biology of aging, role of stem cell and successful aging
- EBM in geriatric: applicability of valid and importance study in geriatric medicine
- Dementia care in homecare setting
- Caloric restriction and its role as anti aging
- Osteoarthritis in the 21st century: growth factors, exercise and medications
- Immunology of aging and infection
- Complimentary and alternative medicine to overcome pain problems
- ...... and much more

ASIA PACIFIC GERIATRIC CONFERENCE, BALI 13 – 16 NOVEMBER 2008
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☑ Gorgeous congress location
☑ Bali...countless times voted as “World’s Best Tourist Island”
☑ Registration fee (USD 390 only) include buffet lunch, coffee break, cultural dinner and full day sight seeing program
☑ Range of accommodation options within walking distance to congress venue. Convenience budget hotel range from USD35/night.

See you in Bali .........

Asia Pacific Geriatric Conference
13 – 16 November 2008
Discovery Kartika Plaza Hotel
Bali, Indonesia

Contact:
Email: apgc@pharma-pro.com
isma@pharma-pro.com,
Web: www.apgcbali.com

APGC
ASIA PACIFIC GERIATRIC CONGRESS
GERIATRIC GIANTS: THE NEW EPIDEMIC IN THE 21st CENTURY

Thank You
Health Policy toward the Longevity Society in Japan

Takashi HANYUDA

Introduction

With regard to the rights of Japanese citizens to life and health, Article 25 of the Japanese Constitution, promulgated in 1947, stipulates that:“(1) All people shall have the right to maintain the minimum standards of wholesome and cultured living” and “(2) In all spheres of life, the State shall use its endeavors for the promotion and extension of social welfare and security, and of public health.”

Based on Article 25, various social welfare related laws such as the Living Protection Law, Child Welfare Law, and Physically Handicapped Persons Welfare Law, as well as social insurance related laws such as the National Health Insurance Law, National Pension Law, and Unemployment Insurance Law, were established one after the other in the past 60 years. These laws have contributed tremendously to the stabilization of people’s livelihoods, preservation of life, and maintenance and enhancement of health.

Since that time, the living conditions in Japan have improved with high economic growth and changes in industrial structure; moreover, with the nationwide spread of public health endeavors such as vaccinations and medical examinations, Japan came to have the world’s highest longevity. In 1947, the average life expectancy for men in Japan was 50.06 and for women 53.96; in 2006, the average life expectancy for men was 79.00 and for women was 85.81—and increase of around 30 years for both men and women over a half century.

According to World Health Organization (WHO) data, Japan is also ranked Number 1 in the world for healthy life expectancy.

People living into their eighties and beyond has become a reality, and so the important challenge for the future is to not simply extend life—in other words, a quantitative response—but to devise and implement measures for improving Quality of Life (QOL)—in other words, a qualitative response.

Attitude towards “Healthcare”: from consumption to investment

National healthcare expenditure in Japan has grown from 513 billion yen or 4 billion US$ in 1961, when the universal healthcare system was established, to some 33.1289 trillion yen or 2,760 billion US$ in 2005. Behind this increase in healthcare expenditure are a range of factors including population growth, aging of society, and advancement of healthcare; however, with the long-term stagnation of the Japanese economy in the wake of the collapse of the so-called economic bubble, the Japanese Government in recent years has continued to strongly move to restrict healthcare expenditure.

Approximately one-quarter of funding for national healthcare expenditure is provided through public funds, and this has led to the constriction of benefits and restriction of healthcare expenditure.

However, according to Organization for Economic Cooperation and Development (OECD) data, in 2004 Japan’s total healthcare expenditure was 8% of percentage of GDP, which places Japan nine points below the OECD member country average of 8.9% with a ranking of 22 out of 30 countries. In other words, low expenditure in healthcare compared with the country’s economic strength supports the improvement of citizens’ health.

With the growth in public expenditure to cover increasing healthcare expenditure, healthcare is now frequently discussed in terms of “consumption.” However, as Japan becomes an increasingly aging society with fewer children, it is
imperative that both the government and the general public develop an awareness of healthcare as a useful “investment” for advancing the health of citizens, thereby maintaining and improving the nation’s vitality.

From Secondary to Primary Preventative Measures

With the improvement in living conditions, raising of living standards, and changes in dietary habits over the past decades, disease composition in Japan has also changed tremendously. From a time when tuberculosis and respiratory tract infections were the most common diseases, today cancer, cerebral stroke, and heart diseases are the cause of death in some 60% of cases. These diseases are also known as “lifestyle related diseases,” with clinical and epidemiological research clearly showing the influence of individual people’s lifestyles on their health.

Measures that take this situation into consideration recognize the importance of focusing on primary prevention through improving people’s lifestyles rather than on secondary prevention that centers on conventional health checkups aimed at early detection and diagnosis of diseases.

The WHO Ottawa Charter for Health Promotion states that health is an important resource for both individuals and society as a whole, and proclaims the necessity of improving and promoting health.

In Japan, too, the Health Promotion Law was promulgated in 2002 with the aim of establishing an infrastructure for actively promoting health improvement and disease prevention through national consensus.

Moreover, a new law to ensure healthcare for the elderly will come into force in April of 2008, implementing new measures for preventing lifestyle related diseases by, for example, requiring “health check-ups and guidance for specific diseases” to be provided for all people in Japan with healthcare insurance as a means of preventing and treating metabolic syndrome in particular.

In this way, Japan’s health policies are shifting from secondary prevention-centered measures to primary prevention focusing on preventing diseases from developing, and there is furthermore a gradual shift towards measures and policies that focus on “health promotion” that actively raises health levels.

Establishment of the Lifelong Healthcare Service Program

Lifelong healthcare services in Japan have been systemized centered on medical check-ups, with Maternal and Child Healthcare for children younger than school age, School Healthcare for children of school age, Occupational Healthcare for people during their working years, and Elderly Healthcare for seniors.

However, different ministries, departments, and agencies administer each of these healthcare services and they are implemented independently; consequently, health information for any individual person is not managed in an integrated manner. These systems have been organized as lifelong healthcare services, but they cannot be said to be operating appropriately overall if no system for managing health information over a lifetime is maintained.

The quality of individual citizens’ health is expected to improve as a result of the implementation of healthcare services such as health check-ups, education, and guidance tailored to people’s lifestyles as well as the detection of changes in health through integrated management of health data. To this end, it is vital that objective evaluation indicators be developed for viewing the accumulation of “Capital of health” through these services.

The cooperation on coordination of allied health personnel is imperative for the development of comprehensive and effective health services. It is hoped that local medical associations, which have developed various community-based health services over their long histories, will make systematically contributions in response to these needs.

Concluding Remarks

In order to create a system that maintains and improves the “Capital of health” for citizens over their lifetimes, it is vital that not only are the laws and ordinances that form the foundation for individual healthcare services revised in a comprehensive manner, but that a framework for comprehensively providing health insurance and healthcare be secured. To achieve this, financial support is imperative and many issues must be resolved.
In particular, as mentioned above, the Japanese Government in recent years has been eagerly working to contain social security expenditure, especially healthcare expenditure. Consequently, insufficiencies have arisen in the absolute numbers of doctors and other health professionals, whose responsibility it is to protect the health of the public, and reviews of these and other “burdens” that have resulted from reforms that have gone too far are now being discussed.

Considering the situation in Japan, where the aging of society is progressing at an unparalleled speed, environmental improvement measures such as the enhancement of healthcare services and spread of new medical technologies based on a stable financial foundation for enhancing health insurance and healthcare are imperative.

In other words, by enhancing the health capital of citizens through measures such as these, it becomes more possible to extend the age up until people can work and to encourage employment. This in turn leads to increased GDP and tax revenue and contributes to the establishment of a financial foundation.

Transforming the inherently unstable aging society with fewer children into a stable society by creating “positive” cycles such as this is regarded as the response that Japan is demanding.

As mentioned at the beginning, Article 25 of the Japanese Constitution stipulates that the nation has a mission to endeavor to improve and advance social welfare, social security and public health.

Considering the improvements in living standards in Japan that accompanied the remarkable economic development and changes in the social environment, such as the strengthening of people’s awareness of their rights, it is imperative that the national government take a stance of promoting social welfare, social security, and public health at a consistently higher level.

References

Ottawa Charter for Health Promotion
First International Conference
on Health Promotion Ottawa
21 November 1986 - WHO/HPR/HIP/85.1

Advocate

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

Improving Lifelong Healthcare Services by the Health Insurers

- The new law requires the health insurers health check-up and health guidance for preventing lifestyle related diseases such as diabetes.

- Increase of 20% in the medical check-up rate

  Current situation: 66.4% for those who have a health checkup in 2007.

The Constitution of JAPAN

Article 25

All people shall have the right to maintain the minimum standards of wholesome and cultured living.

In all spheres of life, the State shall use its endeavors for the promotion and extension of social welfare and security, and of public health.

Thank you for your attention!
Long-term Care Act in Korea

Dong Chun SHIN*1

1. Introduction

2) The need to establish Long-Term Care Act

- Korea is one of the fastest aging society among OECD countries with 7% of its population over 65 years old and the rate is expected to reach 14.3% by the year 2018.
- Over 90% of senior citizens are found out to suffer from more than one chronic diseases and half of them are suffering from more than three diseases (Korea Institute for Health and Social Affairs)
- Need for institutional support to cope with rapid aging and people’s need
  ➢ Long Term Care Services will start in July 2008

2. Contents of Long-term care Act

1) Recipients and requirements

- The system will apply to people over 65 years and people less than 65 with senile diseases

2) Type of services

- Home care benefits: To help beneficiaries do physical or housekeeping activities, take a bath, assist with medical treatment, provide trainings for recovering physical functions

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*1 Executive Board Member, Korean Medical Association. Professor, Department of Preventive Medicine, Yonsel University, Seoul, Korea (intl@kma.org).
2. **Contents of Long-term Care Act**

2) **Type of services**

- Facility care benefits: admission of the elderly to facilities offering training for recovering physical functions
- Financial benefits:
  - Compensation for families of a recipient who have no option but to receive care from their families due to geographical limited access to institutions providing long-term care services or due to disasters and so forth.
  - Special compensation for undesignated convalescent facilities for providing services

3) **Procedure to get services**

Submission of application form → Determining whether to provide services or not and the level of services (Judging Committee) → Sending of approval sheet to applicants for care level and plans for standard care → Agreement about care benefits

4) **Financial resources**

Social health insurance (contributions) + Government aid (funded from tax) + co-payment of recipients

---

2. **Contents of Long-term Care Act**

5) **Parties involved**

- National Health Insurance and Corporation (NHIC): overall management and operation (collecting contributions)
- The Elderly Care Committee: establishment of main policies and plan (decision on contribution rate, criteria for special benefits)
- Medical Institutions: designated by NHIC to provide long-term care services
- Service Providers: Care managers and care providers

---

3. **Limitation and Challenges**

1) **Limitations in population coverage**

- According to the LTC executive committee’s research, about 15% of the senior population is in need of LTC by 2008.
- The Government plans to assist only 3.4% of them to minimize its expenses. Seniors who have serious illnesses will be prioritized to get covered by the LTC and this low population coverage may bring complaints and unsatisfaction among people eligible for the services.

2) **Limitations in financial resources**

- Korea is expected to suffer shortage in service centers and home care services in 2008. The Government is planning to fund this shortage leveraging from the public sector.
- The government encouraged hospitals to specialize in the elderly care with financial supports at the beginning of the LTC and this motivated many insolvent hospitals to specialize in the elderly care as a result.
  - Saturation in the number of senior hospitals

3) **Exclusion of medical services**

- Elderly patients suffering from multiple chronic diseases (such as senile dementia) need to be admitted in hospitals or nursing homes.
- However, elderly patients in serious conditions have difficult time in getting necessary services from nursing homes, as they provide very limited medical services.
- The collaboration should be properly arranged between nursing homes and physicians so nursing homes can provide better medical services.
3. Limitation and Challenges

4) Future plans

➢ Promotion of disease prevention and senior life improvement
  : Most recipients of the LTC are in mild condition and preventing them from getting worse will go a long way in reducing of additional expenses

➢ Expansion of community-based care management
  : Korea’s long-term care services are mainly focused on facilities and equipment. Development of community-based care management including elder house call program, day-care center, or group homes"
Towards Healthy Longevity

Siang Chin TEOH*1

*1 Immediate Past President of Malaysian Medical Association, Chairman of Medical Association of South East Asian Nations (MASEAN), Kuala Lumpur, Malaysia (coolhealth@gmail.com).
ACHIEVEMENTS: 50 YRS SINCE 1957:
The life expectancy at birth:
- 1957: males 55.8 years and females 58.2 years
- 2006: Males to 71.6 years and females 76.8 years
Maternal mortality rate declined significantly from 320 to 30 per 100,000 live births.
Similarly, the infant mortality rate had fallen from 75.0 to 5.1 per 1,000 live births in 2005.
Malaysia’s rate: 5.1 per 1,000 live births
Singapore: 3 per 1,000 live births
United Kingdom: 5 per 1,000 live births
U.S.: at 8 per 1,000 live births
Indonesia 28 and Thailand 18 per 1,000 live births

Cross Cultural Multi-racial / religious Population

Physical access: 90% of the population within 5 km of a static health facility

BETTER ACCESS TO CARE

Reaching to the rural poor
outreach services such as mobile clinics, riverine services, the flying doctor service, mobile health teams and dental clinics

Starting: from Cradle
IMPROVE MATERNAL HEALTH
Immunization:

DPT (for diphtheria, whooping cough and tetanus) in 1958.
BCG (for tuberculosis) in 1961.
Oral polio and measles vaccines in 1972.


Overall coverage of childhood immunizations has been sustained above 90%.

Special Focused Public Health Areas

- Outpatient care
- Water supply and environmental sanitation
- Nutrition
- School health services
- Health promotion and education
- Oral health
- Women's health
- Elderly health
- Adolescent health
- Community mental health
- Children with special needs

Higher Technology & better skills

INSTITUTE OF MEDICAL RESEARCH

MEDICAL BIOTECHNOLOGY

Minister of Health Dr Soi-Lek CHUA
Focus on Personal care

Health Education

Healthy Heart Campaign

HOME CARE

SELF CARE

CHALLENGES:
- Spending on Health Care
- 3.2% of GDP (Public 1.8% Private 1.4%)
- Health Resource Funding / Allocation Issues

| Table Four: Distribution of Health Resources in Malaysia 1999 |
|-----------------|-----------------|-----------------|
|                 | Hospital Public | Hospital Privat |
| Admissions      | 1,500,000       | 500,000         |
| C.T. Scan*      | 19              | 67              |
| Specialties*    |                 |                 |
| - Medical       | 33%             | 67%             |
| - Surgical      | 34%             | 66%             |
| - G&O           | 20%             | 80%             |

Source: Eight Malaysia Plan. Pg 486

We now have a situation where 75% of the admissions are still to the govern- hospitals, but 75% of the specialists are in private hospitals. The distribution indicates that high tech facilities are much easier to avail in the private sector over-stretched government sector.
NATIONAL HEALTH FINANCING SCHEME

Health financing schemes in a context of uneven income distribution and rapid urbanization. The current levels of inequality raise health problems that cannot be solved without a comprehensive health strategy. Introduction of a health financing scheme requires a comprehensive and diverse range of options for achieving equity, sustainability, and performance in the health sector.

MALAYSIA VISION FOR HEALTH

THE 3 P's:
1. PERSON OR POPULATION?
2. POPULAR OR PROPER POLICIES?
3. PROVIDER AND POVERTY

Thank You
Towards Healthy Longevity

CHIN Jing Jih*1

Outline

- Concepts of successful aging
- Ageing population in Singapore
- Strategies in Singapore

Concepts of successful ageing

Structure of successful aging:
Rowe-Kahn or MacArthur Model
Rowe JW and Kahn RL (1998)

*1 Council Member, 48th Council, Singapore Medical Association, Singapore (sma@sma.org.sg).
Continued engagement with life
Rowe JW and Kahn RL (1998)

- Close social relationships
- Involvement in activities that are meaningful and productive
- Use of valued skills and abilities

Successful aging

- Combination of 3 elements or domains
  - complete concept of successful aging
- But success – a matter of degree and some may be limited in one domain while enormously successful in others.
  - To succeed is to flourish, not necessarily to attain perfection, and there are degrees of success; less than perfection is NOT failure.

Evolution of theories on aging

- Disengagement model ➔ disengagement from life, relationship and life itself
- Baltes model ➔ what individuals can do to cope with age-related losses in functional level and reserves
- Riley model ➔ what society can (and hence should) do to enable active and productive old age
- Rowe-Kahn model ➔ what individuals can do for themselves to maintain vitality in old age

Successful aging:

- 356 men and women aged 65-95 years measured prospectively in 1984 and followed to 1990.
- Successful aging was defined as:
  "minimal interruption of usual function, although minimal signs and symptoms of chronic disease may be present."
  - needing no assistance nor having difficulty on any of 13 activity/mobility measures plus
  - little or no difficulty on five physical performance measures.

Successful aging:

- Predictors and associated activities.
- Strawbridge WJ, Cohen RD, Shema SJ, Kaplan GA.
  - After adjusting for baseline successful aging, sex, and age, 1984 predictors of 1990 successful aging included:
    - income above the lowest quintile
    - ≥ 12 years of education (OR = 1.67, 95% CI 0.98-2.04)
    - white ethnicity (OR = 2.12, 95% CI 0.63-4.86)
    - Absence of diabetes (OR = 0.10, 95% CI 0.01-0.89)
    - Absence of COPD (OR = 0.41, 95% CI 0.17-0.97)
    - Absence of arthritis (OR = 0.43, 95% CI 0.26-0.71)
    - Absence of hearing problems (OR = 0.48, 95% CI 0.25-0.90)
    - Adjusting for all variables, behavioral and psychosocial predictors included:
      - Absence of depression (OR = 1.94, 95% CI 1.10-3.32)
      - Having close personal contacts (OR = 1.82, 95% CI 1.05-3.18)
      - Often walks for exercise (OR = 1.77, 95% CI 1.00-3.23).
    - Cross-sectional comparisons at follow-up revealed significantly higher community involvement, physical activity, and mental health for those aging successfully.
Definitions and predictors of successful aging: a comprehensive review of larger quantitative studies.
- Mean reported proportion of successful aging was 35.8%.
- Multiple components of successful aging were identified, although 26 of 59 included disability/physical functioning.
- Most frequent significant correlates of successful aging were:
  - Age (younger-old)
  - Non-smoking
  - Absence of disability, arthritis, and diabetes.
- Moderate support was found for:
  - Greater physical activity
  - More social contacts
  - Better self-rated health
  - Absence of depression and cognitive impairment
  - Fewer medical conditions.
- Gender, income, education, and marital status generally did not relate to successful aging.

CONCLUSION:
Despite variability among definitions, approximately one-third of elderly individuals were classified as aging successfully. The majority of these definitions were based on the absence of disability with lesser inclusion of psychosocial variables. Predictors of successful aging varied, yet point to several potentially modifiable targets for increasing the likelihood of successful aging.

Compressed morbidity

The Ageing Population in Singapore

Singapore: population projections

Elderly population aged 60 and above

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>Per cent of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>170,400</td>
<td>7.5</td>
</tr>
<tr>
<td>1990</td>
<td>246,900</td>
<td>9.1</td>
</tr>
<tr>
<td>2000</td>
<td>341,000</td>
<td>10.5</td>
</tr>
<tr>
<td>2010</td>
<td>505,600</td>
<td>13.8</td>
</tr>
<tr>
<td>2020</td>
<td>818,600</td>
<td>21.3</td>
</tr>
<tr>
<td>2030</td>
<td>1,055,000</td>
<td>26.8</td>
</tr>
</tbody>
</table>

Old Dependency Ratio*
(Singapore)

<table>
<thead>
<tr>
<th>Year</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>11.5</td>
</tr>
<tr>
<td>1994</td>
<td>14.4</td>
</tr>
<tr>
<td>2010</td>
<td>21</td>
</tr>
<tr>
<td>2030</td>
<td>48</td>
</tr>
</tbody>
</table>

* Number of elderly persons to 100 adults of working age

Ageing population: how fast?

- Proportion of Elderly
  (Residents aged 65 years and over)
  
<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>8.4%</td>
</tr>
<tr>
<td>2030</td>
<td>18.7%</td>
</tr>
</tbody>
</table>

- Old-Age Dependency Ratio
  (Population aged 65 years and over divided by population aged 15 to 64 years)

<table>
<thead>
<tr>
<th>Year</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>11.8 per 100</td>
</tr>
<tr>
<td>2030</td>
<td>29.5 per 100</td>
</tr>
</tbody>
</table>

1 Department of Statistics, Singapore (2005)

Ageing population: how fast?

Projected growth in the global population aged 60 years and older, 1995-2025

Healthy Longevity:
Strategies in Singapore

Strategies

- Primary prevention (“well elderly”):
  - Health promotion and disease prevention
  - Preservation of function, self-esteem and social role
  - Continuing social engagement
  - Postponement of retirement
- Secondary prevention:
  - Emphasis on chronic care, esp. vascular diseases
  - Prevention of IHD, CVA
  - Attention to mental health issues
- Tertiary prevention:
  - Integration of acute, intermediate and chronic care
  - Development of rehabilitation services

Primary prevention (“well elderly”)

- Health promotion and disease prevention
- Preservation of function, self-esteem and social role
- Continuing social engagement
- Postponement of retirement (age), with adjustments in roles, duties and wage-expectations
- Healthy psychological attitude
**MYTH #1**

“I’M ALREADY 65 YEARS OLD, SO WHY BOTHER, I’M GONNA DIE SOON ANYWAY.”

**But the TRUTH is......**

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Life Expectancy at Birth (yrs)</strong></td>
<td>75.3</td>
<td>78.1</td>
<td>78.4</td>
</tr>
<tr>
<td><strong>Life Expectancy at Age 65 (yrs)</strong></td>
<td>15.7</td>
<td>17.0</td>
<td>17.2</td>
</tr>
</tbody>
</table>

---

**MYTH #2**

“SUCCESSFUL AGING IS ALL ABOUT LONGEVITY.”

**But the TRUTH is......**

- It is not how long, but how well, one lives that ultimately matters
  - Medical illness
  - Physical function
  - Psychological well being
  - Social engagement

---

**MYTH #3**

“TO BE OLD IS TO BE SICK.”

**But the TRUTH is......**

- Although the population is aging, seniors are getting healthier than before
- Need to distinguish age-related changes from disease
What happens in “normal” aging

• Changes experienced are gradual and insidious (never abrupt)
• No restriction in basic physical and mental function
• Not the cause of disease (or death)

MYTH #4

“It’s all in the genes. I can’t do anything about how I age.”

But data shows that ……

• As one grows older, the contribution of genes become less and less significant
• It is the way you live, ie environmental factors (NOT the genes that you are born with) that chiefly determines the quality of how you age

MYTH #5

“It’s too late to do anything about my health.”

But the TRUTH is……

• It’s never too late to start!
• With cessation of smoking, the risk of disease falls with time and can approach that of non smokers
  – Heart disease: FIVE years
  – Stroke: TWO to FOUR years
  – Lung Cancer: FIFTEEN years

MYTH #6

“You can’t teach an old dog new tricks.”
But the TRUTH is……

- Seniors can, and do learn new things and learn them well
- Trained seniors can do better than untrained young people

“…as long as I can stay abreast of events, learning new ways of working, then I can draw on my wealth of experience, data which I can use to make a contribution which a younger fellow, more active but less experienced, cannot come to the same conclusion…”

Secondary prevention

- Emphasis on chronic care, esp vascular diseases
  - prevention of IHD, CVA
- Attention to mental health

Chronic and primary care

- General or family practitioners
- Doctors in Home or Domiciliary care
- Doctors in Long term Residential or Aged Care
- Master of Medicine (family Medicine)
- Graduate Diploma in Geriatric Medicine
- Continuing Medical Education Programmes in Geriatric Medicine

Tertiary prevention

- Integration of acute, intermediate and chronic care
- Development of rehabilitation services

Geriatric Medicine Departments in Singapore

- Located in acute hospitals
- Inpatient services – acute services, taking patients directly from Emergency departments
- Outpatient services – based on geriatric syndromes
  - Geriatric assessment clinics
  - Dementia / Memory Clinic
  - Continence Clinic
  - Falls & balance Clinic
  - Palliative Care Clinic
  - Geriatric Pain Clinic
Approach in Geriatric Medicine

- Problem-based > age-based, with stress on functional status and quality of life
- Syndromes:
  - Impaired cognition
  - Incontinence
  - Instability
  - Immobility

Geriatric Medicine Departments in Singapore

- Tan Tock Seng Hospital (since 1988)
- Alexandra Hospital (since 1994)
- Changi General Hospital
- Singapore General Hospital
- National University Hospital

Intermediate Care: Community Hospitals

- Focused on rehabilitation and convalescent care (immediate post-acute care)
  - Physiotherapy
  - Occupational therapy
  - Speech and swallowing therapy
  - Palliative care
- 5 community hospitals

Facilities in the Community and Long-term Care

- Community:
  - Social day care
  - Rehabilitative day care
  - Dementia day care

- Institutional:
  - Nursing homes
    - Voluntary (government-subsidised)
    - Private
  - “old folks’ home” or “Sheltered home”

Challenges in Singapore

- Seamless integration
- “Right-siting” of care
- Funding mechanisms
- Community perceptions
- Staffing & communications

Multi-dimensional approach

- Biomedical
- Psychological
- Social
- Ethical & Legal
Caution

The need to avoid inappropriate discrimination and biases both in attitude and in allocation of healthcare resources towards those deemed NOT to be ageing successfully.

Thank you

Acknowledgement: Dr Lim, Wee Shiong for contributing some of the slides used in this presentation.
Towards Healthy Longevity

Liang-Kung CHEN**

[Image: Towards Healthy Longevity]

World’s fastest aging country

WHO definitions:
- Aging society: elderly population 7%
- Aged society: elderly population 14%

Aging speed: years required from 7-14%

85 years
1940-1975

115 years
1965-1990

Population aging in east Asia

1. Similar population aging speed
2. May share common cultural background
3. An integrated healthcare system for older people is often lacking
4. Geriatrics development is mostly lacking

Population aging

Life expectancy

Life prolongation of elderly

71.6%

Life expectancy

44.1%

*1 Taiwan Medical Association, Taipei, ROC (intl@tma.tw).
Health expenditure

Longer longevity...

Disability can be postponed

Health care for the elderly

Healthcare system reform

Geriatrician training

Promoting quality care for older people

- Longer longevity
  - Disability compression
  - Disability expansion
  - Dynamic equilibrium

- Postpone disability
  - Elderly friendly health care system
  - Integrated services
  - Continuing care

- Number of Chronically Disabled People Aged 65 and Over in the United States: 1980 to 1990

- Disability is related to poorer health

- Older age is related to more disability

- Geriatrician
- CME Service delivery
- Family Support
- Medical Care
- Social Care
- Intermediate care
- Long-term care
- Community resources

- National Health Research Institute
- National Taiwan University Hospital
- Chang Gung General Hospital
- Mount Sinai Medical School
- Veterans Affairs System
- Taipei Veterans General Hospital
- Taichung Veterans General Hospital
- Kaohsiung Veterans General Hospital
- British Geriatrics Society

- Comprehensive Geriatric Assessment
- Multidisciplinary team approach
Longevity of Thai Physicians

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*2 Professor, Dean of the Faculty of Medicine, University of Srinakarintaviroj, Bangkok, Thailand.
[Thailand]

Longevity of Thai Physicians

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*1 Professor, Department of Preventive and Social Medicine, Faculty of Medicine, Chulalongkorn University, Bangkok, Thailand (fmedpss@nd.chula.ac.th).
*2 Professor, Dean of the Faculty of Medicine, University of Srinakarintaviraj, Bangkok, Thailand.

Background and rationale

- Physicians are supposed to be health team leaders
- Their tasks are 3Ds - difficult, dirty and dangerous
- No previous systematic studies on Thai physicians’ health – notion that they were short-lived
- Opportunity: CCME (under TMC) has physicians’ database and periodically updated; occupational medicine physicians are interested in physicians’ health and health hazard exposures

We're Thai physicians short-lived?
Target population

- Total 30,000+ doctors
- Growth rate 1,500 doctors/yr
- Increased female physicians
- Death rate 60-100 doctors/yr

Thai physician health promotion program

- Phase I: Thai physician health study (2 years)
- Phase II: Longevity of Thai physicians (1 year)
- Phase III:
  - Intervention and Health Promotion (1 year)
  - Dissemination to Public (3+ years)

I: Thai physician health study

3 projects
2. Cross-sectional survey of Thai physicians’ health and risk factors

Death rate of Thais 1998-2002

Life expectancy of Thais 1998-2002
Were Thai physicians short-lived?

II: Longevity of Thai physicians

- Quantitative study – survey
- Qualitative study – in-depth interview

Quantitative study – survey

- 983 questionnaires (responded 327) to 840 males (responded 272) and to 143 females (responded 55)
- Age 68 - 93 years (75.1 ± 4.86)
- Majority were married suggesting that their spouse were also long-lived
- ½ still provided clinical services, ¼ did charity work, ¼ did more than one volunteer work, some did several jobs

Majority were not obese : BMI 16.53-34.16 (23.97±2.88); only 8 had BMI over 30
4/5 had disease – one or more – top 5 were HT, DM, IHD, DLP, BPH
Majority did exercise – walk
Majority did not drink alcohol or drank occasionally
Majority practiced religious activities regularly
Majority had hobbies

Qualitative study – in-depth interview

Financial stability – saving and invest while young
Increase positive lifestyles – exercise, proper diet, etc.
Decrease negative lifestyles – smoking, DUI, etc.
The mind-set to be non-attachment
To be mentally ready to die
Physicians as role model – practice and advice
family/friends/patients/ relatives/society

III: Intervention and Health Promotion & Dissemination to Public

- Funded by Thai Health Promotion Foundation
- Direct to public – mass media, conference, publications, internet www.thaihealthy.org
- Indirect to public
  - Physicians as means, role model, and multipliers
  - Physicians & health care personnel as means, role model, and multipliers
  - Government expands pension system and encourages individual savings
Boundary partners

- Thai Medical Association
- Thai Health Promotion Foundation
- Thai Medical Council and CCME
- All Royal Colleges of Thai physicians
- Medical Schools & students
- Medical Societies & Associations
- Public & private hospitals
- Other health personnel councils & associations

Love to share and network with other countries’ Medical Associations