

CARE WHERE YOU ARE

ENABLING SINGAPOREANS TO AGE WELL IN THE COMMUNITY





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FOREWORD

By Lien Foundation

LAWRENCE PAUL picked up mountaineering at 64 and, now 68, has summited more than 30 peaks in five countries. He has no plans of slowing down. At 78, Julia Chia makes time for a strenuous weekly game of water polo with a team of *kakis* all in their 60s and 70s. At 93, violinist Julai Tan still entralls audiences with his myriad melodies. His latest gig — performing at Singapore’s National Day Parade, 2018.

Ageing is one of the defining global trends of our time and Singaporeans are living longer and the country ageing faster than almost any other place on earth. Unlike many other nations struggling with poor health outcomes or atoning for financial profligacy, Singapore is ageing from a position of relative strength — we have a largely healthy population and there has been considerable focus in recent years on harnessing the blessings of longevity. Mr Paul, Madam Chia and Mr Tan are fine examples of active ageing and, by all indications, their tribe is growing fast.

Yet, as the pace of ageing picks up, more people will need care. The vast majority in any country, not just in Singapore, would like to be cared for in the comfort of their own homes, rather than in institutions. In decades past, buoyed by the baby boom of the 1950s and 1960s, most seniors had many children to look after them as they aged. But in just 10 years after independence, prompted by a government campaign encouraging smaller families, Singapore’s total fertility rate fell rapidly from 4.7 births per woman

in 1965 to two by 1975. Baby boomers who were part of large families went on to stop at two children of their own.

With today's seniors living well into their 80s, 90s and beyond, with increasingly complex needs that families and domestic workers struggle to cope with, the role of formal long-term care services is expected to grow in the years to come. In 2016, the Lien Foundation commissioned *Safe But Soulless*, a study that took a long hard look at how Singapore cared for some of its oldest, frailest and most vulnerable residents — those who lived in the country's 70-odd nursing homes. Two years on, with *Care Where You Are*, we tackle a larger and more complex issue — how to enable frail, disabled or sick seniors to be well cared for at home and in the community. In the pages that follow, we throw light on the state of professional home care and centre-based care services for seniors, acknowledge strengths, showcase innovations, uncover unmet needs and suggest ways forward. The emerging challenges — with regard to demand and supply of services, care quality and regulation, manpower shortage and, above all, finances — need to be understood, debated and tackled more widely and by more people than is being done today.

There have been some important policy announcements in recent years to help Singaporeans better prepare for rapid ageing and the costs of care.

In 2015, the Government implemented MediShield Life, a health insurance scheme which provides lifelong universal protection against large hospital bills. The same year, it announced a \$3 billion Action Plan for Successful Ageing to enable seniors to remain independent and age in the community. This year, as this report was being finalised, the Government announced CareShield Life, which will help the severely disabledⁱ pay for care. The social insurance scheme is undoubtedly a welcome first step towards lifelong and universal protection from the high costs of long-term care. But concerns have been raised over its strict eligibility criteria, relatively low payouts and the fact that women need to pay higher premiums.

An average of only 13 per cent of seniors use formal long-term care services in the 26 member states of the Organisation for Economic Cooperation and Development (OECD).ⁱⁱ According to a 2017 OECD paper,ⁱⁱⁱ which measured social protection, long-term care costs can be very high and unpredictable, so there is a big case for pooling risks. In fact, in all the countries studied, the cost of home or institutional care for severe needs was equal to or greater than the median disposable income for over-65s. That is almost certainly the case in Singapore too. Although there are no national estimates, the costs of looking after a severely disabled senior at home can be as high as \$3,100 per month^{iv}, before subsidies.

Singapore's social compact of high growth, abundant jobs, self-reliance and financial prudence has served it well so far. However, things may well change as the population ages, the economy slows and costs of living and care rise in tandem with income inequality. Much of the conversation around care financing so far has centred on sustainability and actuarial fairness — that women, for instance, need to pay higher premiums because they spend more years needing care. But solidarity with the less fortunate and inclusion should also be important guiding principles for the care system in a country which now ranks among the wealthiest in the world. Indeed, these two principles form the bedrock of social protection systems in most advanced nations.

We would like to extend our heartfelt thanks to our two tireless researchers, Associate Professors Elaine Ho and Shirlena Huang of the Department of Geography, National University of Singapore, as well as the university's Social Service Research Centre for providing administrative support. A big thank you to the more than 100 sector leaders, workers, academics and civil servants from the Ministry of Health who devoted much time and energy to answering questions for this report, which has been in the works for more than a year.

We hope this report can help Singaporeans gain a deeper understanding of a complex, multifaceted issue that may affect us all personally someday. We hope it can help policymakers and care providers glean new insights into ground realities and possible solutions to some of the policy dilemmas and practical challenges they face day to day. Above all, we hope it can inspire informed collective conversations on ways to move forward in creating a care system that is more inclusive and effective than what exists today, yet strong and sustainable enough to withstand the demands of a rapidly greying population.¹

Lien Foundation
August 2018

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- i Severely disabled people are unable to perform at least three of six routine activities of daily living (ADL) — feeding, bathing, dressing themselves, getting in and out of bed, using the toilet, and walking or moving about.
 - ii OECD (2017) "Health at a Glance 2017 — OECD Indicators". Retrieved from https://www.oecd-ilibrary.org/docserver/health_glance-2017-en.pdf?expires=1533183821&id=id&accname=guest&checksum=57740E5E0EBE06E88F3EF6A0F68532F3, p.208.
 - iii OECD (2017) "Measuring Social Protection for Long-Term Care". Retrieved from <https://www.oecd-ilibrary.org/docserver/a411500a-en.pdf?expires=1532259494&id=id&accname=guest&checksum=3EC9FEA4491F1631D055A844141A4237>
 - iv *ElderShield Review Committee Report*, p.50. Retrieved from https://www.moh.gov.sg/content/dam/moh_web/careshieldlife/files/ElderShield%20Review%20Committee%20Report.pdf



EXECUTIVE SUMMARY

Enabling Singaporeans to Age Well in Place

THE NUMBER OF Singapore residents aged 65 and above crossed the half a million mark in 2017. In the next year or so, another demographic milestone will be reached when the number aged 65 or older is expected to match the number of children aged below 15.¹ By 2030, these seniors will number nearly a million.² With Singaporeans living longer than almost any other nationality, those in advanced age — 80 and above — have nearly doubled in a decade to more than 100,000. Another 100,000 are in their mid- to late 70s and their ranks are swelling too.³ These numbers have enormous implications for the elderly and their families, as well as for those in the eldercare industry, welfare sector and policymakers.

Even as we work to enable seniors to remain healthy and active for as long as they can, we must be mindful that increasing numbers will need care. According to government estimates made public recently, approximately one in two Singaporean seniors could become severely disabled at some point in their lives, being unable to perform at least three of six routine “activities of daily living” (ADL) — feeding, bathing or dressing themselves, getting in and out of bed, using the toilet, and walking or moving about.⁴ As of 2017, around 34,000 people — or 6.6 per cent of the senior population — were severely disabled, and this group is expected to swell to 69,000 by 2030.⁵

Even as we work to enable seniors to remain healthy and active for as long as they can, we must be mindful that increasing numbers will need care.

GROWING OLD AT HOME AND IN THE COMMUNITY

The Singapore way has been to look to the family and community first to allow people to “age in place” in the familiarity of their own homes. However, as family sizes shrink and foreign domestic workers become more expensive to employ, there will be a growing need for formal day and home care services. This study was commissioned to throw light on the state of formal home-based and centre-based care for seniors in Singapore, acknowledge strengths, identify weaknesses or unmet needs and, where possible, suggest recommendations. It looks at four aspects of community and home care: the overall care landscape, including demand and supply of services; financing; human resource capabilities; and governance.

Providers of home-based and centre-based services formed the biggest group of interviewees for this study. Through focus group discussions and in-depth interviews, we obtained the views of 29 non-profit and 21 private care providers, including most of the largest ones. We also did a thorough literature review and interviewed family caregivers of older Singaporeans, representatives of relevant government ministries and affiliated agencies, academics as well as leaders of ageing-related non-government organisations. A total of 103 individuals participated in this study.

The long-term care landscape is evolving rapidly in fast-ageing Singapore and the Government has been investing in eldercare. In recent years, home-based and centre-based care services have replaced nursing homes as the main mode of formal long-term care, due to concerted efforts by the Ministry of Health (MOH) to quickly shore up capacity in anticipation of growing

demand. According to MOH, as of late 2017, around 14,000 people received subsidised home and community care services, up from 12,000 in 2016. The number filling subsidised nursing home beds, meanwhile, has remained relatively stable at around 10,000 for the past couple of years. This shift away from nursing homes is possible because of a marked increase in community care capacity that lets more seniors age in place in the comfort of their own homes and at neighbourhood day care centres. The capacity of centre and home care places has risen from 2,100 and 3,800 respectively in 2011 to 5,000 and 8,000 in 2017. MOH has said that Singapore is on track to achieve 6,200 places for centre-based care and 10,000 places for home-based care by 2020.⁶ There are, however, no official estimates of the number of home care and day care places offered by private providers.

More help facilities, schemes and programmes are also appearing, with newer, more sophisticated models emphasising greater continuity of care. Under the Integrated Home and Day Care (IHDC) programme, for instance, people who normally use centre-based care but sometimes find themselves unable to leave home can now have care delivered to their homes temporarily, while those who receive home-based care are encouraged to switch to centre-based services when they become more mobile. MOH is also working

The shift away from nursing homes is possible because of a marked increase in community care capacity that lets more seniors age in place in the comfort of their own homes and at neighbourhood day care centres.

with the Housing & Development Board (HDB) to create purpose-built “Active Ageing Hubs” offering integrated eldercare services in new estates. These one-stop centres provide seniors with a range of services, from day care and rehabilitation to grocery delivery. At least 10 future HDB estates will have these hubs by 2020.⁷

In recent years, the private sector has stepped in to fill gaps in eldercare, especially for middle-class and better-off Singaporeans seeking a wider range of options and more exclusive care. Innovative private providers have brought about the on-demand “Uberisation” of home care by dispatching care workers employed on flexible terms and using online platforms and mobile applications. Private providers are expected to play a bigger role as the number of seniors soars.

Community and home care also receives substantial support from the charity sector. Numerous voluntary welfare organisations (VWOs) have responded to needs among the elderly by rolling out services and programmes, especially for lower-income seniors. VWOs have also begun collaborating with private providers. Our study found that forging partnerships makes for an efficient means of achieving economies of scale and specialisation while ensuring that the goals of providing holistic and continuous care are met.

Nonetheless, certain concerns remain. Despite more schemes to promote awareness, many seniors and their caregivers appear not to have a good understanding of how the eldercare system works and are not sufficiently aware of the various funding schemes to tap on to pay for care. Care providers

themselves sometimes find the administrative frameworks of the sector a challenge as they try to work out appropriate arrangements for clients while bearing costs in mind. The complexities faced by caregivers, and the resources and time needed to make sense of an array of care services, cause some to forgo help from the Government and care providers.

As of Financial Year (FY) 2016, the most recent for which figures are available, preliminary estimates show that the Government spent \$800 million on long-term care, up by a third from \$600 million in FY2015. This includes both capital and recurrent costs of building and running nursing homes, centre-based care, and palliative and home care services.⁸ Despite a substantial rise in long-term care spending in recent years, this still amounted to only 8 per cent of the overall healthcare budget and 0.19 per cent of Singapore’s Gross Domestic Product for the year. By comparison, advanced nations from the Organisation for Economic Cooperation and Development (OECD) spent an average of 1.4 per cent of their GDP on the sector in FY2014.⁹ While the importance of enabling seniors to age at home is acknowledged, government spending on home-based and centre-based care only increased from \$200 million in FY2015 to \$240 million in FY2016.¹⁰ This accounted for a third of the \$800 million long-term care budget and 2.5 per cent of the overall \$9.8 billion healthcare budget for the year.

Public spending on home-based and centre-based care was \$240 million in FY2016, accounting for 2.5 per cent of the overall healthcare budget for the year.

IS CAPACITY GROWING FAST ENOUGH?

According to government estimates, around 6.6 per cent of seniors aged 65 and above — or 34,000 people — are severely disabled.¹¹ This group is likely to need long-term care services the most. Despite ramped-up capacity, there are still only around 28,000¹² nursing home, day care and home care places, even if a single day care place can be used by several clients at a time. This figure excludes the capacity of private providers who serve self-funded home and day care clients, which is not tracked, as such services are not licensed.

Although community and home care places have doubled in recent years, there are indications that capacity may still be falling short of need. The Agency for Integrated Care (AIC), which coordinates Singapore's long-term care services, for instance, received 7,800 referrals for day care services in 2015, when only 3,500 day care places were available.¹³ There were 5,000 places available in 2017¹⁴, but this still fell short of the 2015 demand, and the need has likely increased since then. Of course, not all referrals result in the take-up of places, since families can make alternative care arrangements such as by hiring a domestic worker, and not all seniors attend day care on a daily basis. Yet, the need expressed through referrals and the number of day care places available may well be significant. There is no wait list for home care services currently. The median waiting time for general day care is about 20 days while that for dementia care is about 35 days. Waiting time depends on factors such as capacity as well as family's preferences and availability.¹⁵

Respite care is also a pressing concern. It is available across Singapore at about a dozen centres run by VWOs, but applications must be submitted at

least five working days in advance. Even then, respite care is mainly provided until about 8pm, and rarely on Sundays or for elderly who are bed-bound.¹⁶ Options for overnight respite care (for periods of seven to 30 days) for the elderly who require higher levels of nursing care are more limited and offered mainly by private nursing homes. Applications must be submitted six to 12 weeks in advance if applicants are seeking subsidies, although it takes about a month to process referrals.¹⁷ Respite care provided by VWOs is cheaper than private options, but is still expensive and can prove a financial burden for families just above the cutoff for government subsidies. Respite care costs are also not covered by Medisave. Enlarging the capacity of respite care and offering higher quality options will benefit both care recipients and their caregivers.

While it is important to increase eldercare capacity in a carefully calibrated manner, supply represents only part of the picture. Cost issues also need to be solved.

CAN I AFFORD TO PAY FOR ELDERCARE?

As this report was being finalised, MOH unveiled CareShield Life, an expanded form of ElderShield, which will offer payouts starting at \$600 per month for life (for claims made in 2020; to be reviewed periodically). Severely disabled Singaporeans with at least \$5,000 in their Medisave accounts will also be able to make cash withdrawals of \$50–\$200 per month for their long-term care needs. Medisave, part of the Central Provident Fund, was originally set up in 1984 to defray hospital bills. Allowing cash withdrawals from Medisave for long-term care is a radical departure from past policy. A new safety net, ElderFund, will

provide the severely disabled who are needy up to \$250 per month. The schemes will become operational in 2020¹⁸ and undoubtedly offer better and stronger social protection to a small but vulnerable segment of society — the severely disabled.

However, the overall impact of the recently proposed changes can only be judged in time to come. As of 2017, about a third of those aged 40 to 84 years old had not purchased the basic ElderShield scheme. CareShield Life will be optional for older cohorts; how many will join the scheme remains to be seen. Women, in particular, may choose not to join despite premium subsidies and incentives from the Government, given that they have to pay higher premiums to cover more years of care than men. Moreover, seniors who are already severely disabled will not be able to join CareShield Life. Overall, too, the eligibility criteria are stricter and payouts appear lower than other national long-term care insurance systems in countries like Japan, South Korea and Germany.¹⁹ The criteria have been kept relatively strict to keep premiums affordable — and ensure financial sustainability in the long run — but this might mean that seniors who need home-based or centre-based care but are not severely disabled will not qualify for CareShield Life payouts.

Of currently enrolled ElderShield policyholders, only a third have purchased additional private insurance protection, known as ElderShield Supplements.²⁰ Even with the more generous CareShield Life payouts

Many Singaporeans will be potentially under-insured for long-term care. There does not appear to be a high level of public awareness towards private long-term care insurance.

anticipated, some families will be financially stretched without supplementary insurance. Many Singaporeans will be potentially under-insured for long-term care. There does not appear to be a high level of public awareness towards private long-term care insurance. Restrictive criteria requiring beneficiaries to have some degree of severe disability may have deterred people from purchasing supplementary protection under the ElderShield scheme.

We therefore recommend a graduated payout tied to the number of ADLs a senior is unable to fulfil, rather than the current threshold of three ADLs. Greater public and private financing for preventive care and rehabilitative treatment to delay or even reverse frailty would also better prepare Singapore for ageing. Insurance for acute care, primary care and long-term care should be approached as a continuum. Bringing the different types of insurance together would bring us closer towards an integrated eco-system of healthcare and long-term care for better protection and fiscal sustainability.

The study also found that co-payment is a key concern for families. Costs may deter families from using formal long-term care services. An earlier local study found that only about half of those referred to day care or home care services in 2011 and 2012 used the services, with levels falling to a quarter after six months.²¹ Perceived affordability was a strong consideration for those who decided against using available services. Recently published estimates show that home and community care services for the severely disabled can cost about \$3,100 per month before subsidies if one uses IHDC facilities, including transport and consumables, which is more expensive than the \$2,400 median nursing home fees at charity-run nursing homes for the same group of elderly.²²

There are no official national figures for Singapore on the total cost of formal long-term care, or how much is paid out of pocket. It was estimated that in 2015, families paid 40 per cent of the total cost of long-term care services out of pocket, while the Government paid 42 per cent in the form of means-tested subsidies targeting lower-income families and grants to providers who run these services. Charity dollars and ElderShield payouts accounted equally for the rest.²³ For families whose means-tested subsidy status qualifies them for only 30 per cent subsidies or none at all²⁴, the co-payment burden can be considerable and a deterrent to using community and home care. The full cost of using day care and transportation to centres, for example, can amount to nearly \$2,500 per month. A family of three with a household income of at least \$7,803, just above the eligibility cutoff for means-tested subsidies, would have to spend nearly one-third of its income on eldercare.

The charity sector remains crucial in supporting and funding long-term care. Our study estimates that about two-thirds of the 170 care providers in Singapore are VWOs. While the Government provides them grants to run many of their long-term care

While the Government provides VWOs grants to run many of their long-term care schemes and programmes, long-term care is not cheap and there has been a persistent gap between the real cost of service delivery and the “norm cost” set by MOH to determine subventions.

schemes and programmes, long-term care is not cheap and there has been a persistent gap between the real cost of service delivery and the “norm cost” set by MOH to determine subventions. Norm costs, which are MOH’s observed average costs of running services, are typically lower than what VWOs say are the real operating costs of delivering services. The gap varies for different types of services and is particularly large for home care. For example, according to one provider, charity dollars offset 29 per cent to 41 per cent of the full costs of various home care services for lower-income families even after accounting for government subsidies. To make up the shortfall, VWOs expend substantial time and resources to raise donations.

WILL THERE BE ENOUGH TRAINED WORKERS?

There are no official estimates of how many workers there are in the home and day care sector. However, as of March 2017, there were 8,300 direct care staff in the long-term care sector²⁵. They worked in nursing homes, day care centres for seniors and in providing professional home care services. This number is expected to grow to 12,000 by 2020²⁶ — a jump of about 45 per cent in three years. This seems like a daunting task.

Providers estimate that around 70 per cent of direct care workers, including doctors, nurses, therapists and nursing or therapy aides, are foreigners with many working in “support care” roles, assisting nurses or therapists and the sector is still plagued by relatively high turnover rates.

The Ministry says it is on track to meet the additional manpower needs by

2020. In a bid to attract new workers and retain existing ones, MOH has also worked with care providers to raise salaries of both local and foreign staff by around 30 per cent, in tandem with salary increases in the public acute care sector since 2012.²⁷ It extended some \$200 million to participating providers in the sector over the last six years to raise long-term care workers' salaries.²⁸ Attrition rates have come down in the sector from 17 per cent to 14 per cent in recent years.²⁹ However, salary levels for support staff, in particular, continue to be much lower than what is offered for similar jobs in Hong Kong, Japan, South Korea and Australia.

Our study also found that the sector needs to improve pathways for training and career advancement, and raise productivity through technology and job redesign to make working in the sector more sustainable. Sharpening care competencies is particularly important in the area of home care. Currently, home care providers that do not receive subventions mostly set and monitor their own standards, for example, in the areas of certification of workers and protocols for escalating situations that arise during home care. Clearer safeguards are needed for home care and these should include accreditation standards for all providers and workers in the sector, as well as expecting all home care workers to be trained and certified before being deployed into the community.

It should also be mandatory for labour agencies and employers to send foreign domestic workers for eldercare training if they are looking after a senior with advanced dementia, mobility or medical care needs. These helpers must also be made aware of their right to refuse to perform medical

procedures that they are not trained to carry out, even if requested to do so by their employers. Public education for employers is also crucial. A multi-dimensional approach, bridging the different ministries involved, employers, labour agencies and training centres, is required for the different aspects of eldercare to be addressed holistically.

IS THERE AN URGENT NEED FOR MORE REGULATION?

Unlike nursing homes and childcare centres, home-based and centre-based care is not licensed in Singapore. All providers that receive government subventions are subject to certain mandatory service requirements stipulated by MOH, including care processes and staff qualifications. It is worth noting that private sector involvement has grown rapidly in recent years and there are at least 60 private providers offering services, mostly in home care. Currently, only two private home care providers receive government subventions and are therefore subject to MOH's service requirements.³⁰ Licensed care professionals — such as doctors, nurses or physiotherapists — are regulated by their respective professional bodies. However, disciplinary action for professional misconduct is taken only against the individual, rather than his or her errant employing agency. A private provider can simply replace one poor worker with another and carry on.

We need to strengthen the regulatory environment of eldercare, particularly in home care where more private providers are entering the market.

As the role of community and home care increases, the sector will also become more diverse with a greater variety of eldercare services and players. We need to strengthen the regulatory environment of eldercare, particularly in home care where more private providers are entering the market but the vast majority are not subjected to MOH's service requirements.

The proposed Healthcare Services Act (HCSA), to replace the existing Private Hospitals and Medical Clinics Act (PHMCA), is therefore welcome.³¹ We recommend that the new legislation extends regulatory mechanisms to home-based and centre-based care specifically, including over all private providers regardless of whether they receive government subsidies or serve self-funded clients. Both clinical care and social care should also be incorporated into the regulatory considerations, in line with the transfer of social care functions from the Ministry of Social and Family Development to MOH. Singapore needs to develop a more robust governance framework over licensing, training and accreditation, auditing on-the-job capabilities, and the quality of care delivered by non-profit and private providers to clients.

Singapore can draw on examples from other countries to consider how to improve governance in the eldercare sector. We suggest that the United Kingdom (UK), which regulates healthcare and long-term care (including social care and all private providers), could be suitable for Singapore to consider. No country has a perfect model, but an OECD report in 2013 highlighted the UK's comprehensive legislation and quality assurance structure.³² There are two regulatory mechanisms in the UK that Singapore can consider: long-term care legislation; and the institution of independent bodies for regulatory and complaint functions.

While the proposed HCSA could potentially address legislation for long-term care, unlike the UK, Singapore does not have independent bodies auditing and adjudicating eldercare. Making regulation and complaints independent and separate from policy development and funding will enhance transparency and confidence in these processes. The UK's regulatory framework also emphasises informed consumer choice, including through making public the ratings given by accreditation agencies and giving care recipients greater control over the type of care and financing they prefer.

LOOKING AHEAD

The need for formal care services will grow as families shrink in size, trained domestic workers become more expensive and the population ages. We need to deliberate more and devise sustainable solutions for long-term care financing. Primary and preventive care programmes to delay frailty and avoid institutional care should also be strengthened. In addition, mandatory minimum care quality standards must be set for centre-based services and home care. Our recommendations in the report address concerns that cut across centre-based, home-based, integrated care models and transitional care. We hope the insights in this report will be taken into account as the Government's proposed Masterplan on Home and Community Care mentioned in the Action Plan for Successful Ageing takes shape, and the wider Healthcare Masterplan 2020 is reviewed.📍

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1

CARING FOR THE ELDERLY IN THE COMMUNITY AND AT HOME

Sharp rise in elderly population presents both opportunities and challenges for all

PICKING UP MARBLES with a pair of chopsticks is no easy feat but 92-year-old Madam Kang handles this activity with finesse at a senior day care centre that she attends from 9am to 4pm four times a week. She enjoys meeting the other seniors and taking part in the many activities organised at the centre. Madam Kang is one of many older people in Singapore who attend a day care facility, usually run by voluntary welfare organisations (VWOs) and located in residential neighbourhoods. Some centres, like the one she attends, focus on social activities for those who are still mentally alert and physically able, while others cater to those who need dementia care, rehabilitation and basic nursing services. Madam Kang lives with her daughter and son-in-law. On the days when she is not at the day care centre, she stays at home and is looked after by a foreign domestic worker.

Madam Kang is one of the 517,000 people aged 65 and above in Singapore who currently comprise 13 per cent of the population.¹ The country expects to have more than 900,000 people aged 65 and above by 2030.² The number in advanced age — 80 years old and above — nearly doubled in a decade, from 56,466 in 2007 to 101,276 in 2017, and their ranks are expected to swell too.³ These numbers have enormous implications for the elderly and their families, as well as for those in the healthcare industry, welfare sector, and policymakers. Older Singaporeans, like Madam Kang, who develop one or more health issues as they age, need a range of support from their families, the community and the authorities. Families who can afford it will rely, as many already do, on live-in help in the form of foreign domestic workers. Others will struggle with their caregiving responsibilities and to pay the bills

for elderly family members who require day care, treatment and rehabilitation for illness, or nursing and palliative care for those most frail and ailing.

Singapore's life expectancy at birth is 81.3 years for men and 86.1 years for women, which is among the highest in the world. Singaporeans can also expect to remain healthier for longer than elderly people elsewhere. Yet, it is estimated that about a decade of their later years — 9.3 years for men and 10.9 years for women — may be spent in an unhealthy state.⁴ Demand for community and home care is growing, as indicated by statistics from the Ministry of Health (MOH) reporting that “in late 2017, approximately 14,000 seniors have benefitted from subsidised home and community care services, compared to approximately 10,000 seniors who took up subsidised nursing home beds”.⁵ The Ministry added that an increased usage of community and home care services relative to nursing homes has been the trend for the past three years, pointing to a shift away from nursing homes. As the number of elderly swells, Singapore can expect a corresponding rise in demand for a wide range of community and home care facilities, with services and support tailored to their needs and the needs of their families. The Government has done much since the 1980s to alert Singaporeans to the changing demographics and the impact a rapidly ageing population will have on individuals, families and society. With barely 12 years to go before one in four Singaporeans will be aged 65 and above, more needs to be done, and quickly.

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VIEWES THAT MATTER: UNDERSTANDING SINGAPORE'S ELDERCARE LANDSCAPE

This report was commissioned to understand Singapore's eldercare issues on the ground, and identify solutions to improve community and home care. It examines the current state of healthcare and eldercare policies and programmes, and assesses the extent to which community care providers and home caregivers are equipped to meet the needs of ageing adults. It seeks to identify strengths and weaknesses in Singapore's caregiving system, and suggests appropriate actions to strengthen capabilities in sustainable ways. This report also acknowledges and highlights innovative aspects of Singapore's provisions for the elderly.

To better understand eldercare needs in community and home care, we sought the views of organisations delivering care services in Singapore. These care providers comprise non-profit VWOs that seek to meet needs in society, as well as private companies for whom eldercare is a business. At the time of our research, we estimated that there were approximately 105 non-profit providers and 63 private providers of eldercare in Singapore; there are no official numbers publicly available. We interviewed about one-third of the total, including the majority of the largest non-profit providers. Through focus group discussions and interviews, we obtained the views of 29 non-profit and 21 private care providers.⁶

To obtain a holistic understanding of the eldercare landscape in Singapore, we conducted supplementary interviews with 10 family caregivers of older Singaporeans, as well as 15 representatives of government ministries and affiliated agencies, non-government organisations, care sector leaders and other stakeholders in the industry. We also had a meeting with MOH officials

in April 2018 to discuss the research, and continued to correspond with MOH from May to July 2018 for clarifications.

The field research was carried out from July 2017 to May 2018. A total of 103 individuals participated in this study. We also made six site visits to selected eldercare facilities run by both non-profit and private providers. The focus group and interview transcripts were then coded and analysed using a qualitative analysis software. Following our analysis, our findings were discussed with a group of more than 20 care providers and other stakeholders in the eldercare industry at a Validation Workshop in May 2018. Further insights gained were included in the report.

Our focus group discussions with care providers were conducted from July 2017 to February 2018, before the Government announced in its 2018 Budget that eldercare services would be transferred from the Ministry of Social and Family Development (MSF) to the Ministry of Health (MOH). As such, our research captures the views of care providers who engaged with both ministries in carrying out their eldercare programmes. This report, appearing at the cusp of the policy shift, allows us to reflect on the benefits of consolidating eldercare under MOH, while noting the concerns of care providers towards the changes.

In this report, we use the term “older adults” to refer to resident users of eldercare services which may include Singapore citizens, Singapore permanent residents and, to a lesser extent, resident foreigners who are neither citizens nor permanent residents but either qualify for services provided by VWOs or pay to use the services of private providers. In Singapore, an older adult usually refers to someone aged 65 years and above. Our study recognises that

biological age may not be the sole determinant of physiological changes or the changing psycho-social needs of ageing individuals.

The terminology surrounding community and home care varies across and within different countries. While community care refers to both residential facilities and non-residential services, in this study we focus on non-residential services which include centre-based and home-based care delivered by non-profit and private providers, and transitional care provided by hospitals. “Centre-based care” is provided in a communal setting by a team of care workers overseeing social day care, dementia care, day rehabilitation and more. Where we use “home-based care”, we refer to services such as home nursing, home therapy and home personal care delivered to the elderly care recipient’s home by non-profit and private providers. Home care can also refer to care provided by live-in caregivers and foreign domestic workers who live with their employers. Also growing in popularity are integrated models of care that bridge the distinction between centre-based and home-based care. While non-profits have a long history in eldercare services, more private providers have spotted market gaps and entered the industry to meet the needs of middle- and higher-income families who prefer greater choice over the type and level of eldercare services for their elderly. Figure 1.1 shows the landscape of long-term care services in Singapore for Singaporeans who require medical or personal care should they fall prey to disability or disease. The majority of those who use these services are seniors, so for the purposes of this report, the terms “eldercare” and “long-term care” have been used interchangeably.

Figure 1.1 Landscape of Long-term Care Services in Singapore



- Nursing Homes provide residential care for seniors who have limited family support, and/or are unable to be cared for at home or in the community. These seniors would also require significant assistance with their daily activities and/or skilled nursing care on a daily basis.
- Palliative Care Services (e.g. Inpatient Palliative Care, Home Palliative Care and Day Hospice Services) for seniors who require terminal or end-of-life care.
- Centre-based Care Services (e.g. Day Care, Community Rehabilitation, Centre-based Nursing) for seniors with some family support, but require care in the day in the vicinity of their home.
- Home Care Services (e.g. Home Medical, Home Nursing, Home Therapy, Home Personal Care) for seniors who need to be cared for at home.
- Informal Care by family members and foreign domestic workers, who are often the main caregivers.

Source: ElderShield Review Committee Report, p.18. Retrieved from https://www.moh.gov.sg/content/dam/moh_web/careshieldlife/files/ElderShield%20Review%20Committee%20Report.pdf

GOOD MOVE: HEALTH MINISTRY TAKES OVER ELDERCARE SERVICES

Looking at Singapore's eldercare services today, it is clear that a number of new help facilities, schemes and programmes have appeared in recent decades. This reflects work done by the Government to raise awareness of the changing demographics in Singapore and signal the need to meet new demands in a rapidly ageing society. To situate our study within the broader context of government efforts, this chapter briefly considers past policy reviews that inform Singapore's current eldercare approach. The community has responded as well, with various efforts by VWOs and the private sector to meet the needs of the elderly as well as their families. This chapter also reviews the range of eldercare services offered by non-profit and private providers that are central to community and home care.

The healthcare system in Singapore comprises services provided across a care continuum and managed by MOH, including⁷:

- Primary healthcare, provided by 20 public funded polyclinics and about 1,700 private medical clinics run by general practitioners across Singapore.
- Hospital services, currently at nine public acute hospitals, one psychiatric hospital, eight community hospitals and five national speciality centres (including for dental services). The hospitals are organised as Regional Health Systems — the Central region comprises the National Healthcare Group and Alexandra Health

System; the Eastern region comprises Singapore Health Services and the Eastern Health Alliance; and the Western region comprises the National University Health System and Jurong Health Services.

- Intermediate and long-term care (ILTC) services include residential care, and non-residential centre-based and home-based care that is provided to patients during the day. Community hospitals are considered a type of intermediate care too. Although ILTC services are not exclusively for seniors, eldercare is a major component.

Previously, centre-based services that provided social care, such as Senior Activity Centres, cluster support and sheltered homes, were funded and managed by MSF (Appendix 1). The consolidation of eldercare services under MOH also expanded the role of the Agency for Integrated Care (AIC), which has been overseeing community and home care services for the elderly since 2009. In April 2018, AIC became the central implementation agency with a wide range of responsibilities for all eldercare services. The Pioneer Generation Office, established in 2014 to reach out to Singapore's oldest seniors and explain the financial schemes meant for them, has been renamed the Silver Generation Office and merged with AIC to extend outreach efforts through the Community Network for Seniors. MOH's Ageing Planning Office oversees the planning and implementation of strategies for Singapore's ageing population.

Our study found that AIC has on the whole succeeded as the key liaison point for non-profit and private care providers, and both groups consider the following to be the agency's key roles:

- Being a one-stop point for caregivers to obtain advice.
- Referring clients to non-profit and private providers that receive MOH subventions.
- Assessing client eligibility for government subventions.
- Assessing performance and upholding quality standards of non-profit and private providers.
- Supporting MOH in designing and managing grants and new programmes.

Several care providers noted that AIC has played a crucial coordinating and "enabler" role, helping organisations navigate the complex eldercare industry. Established non-profit providers, which have developed a larger range of operational capabilities over time, have found it especially helpful that AIC allocates a staff member as the point of contact for particular programmes and schemes, and who deals with related queries. This has made for a deeper working relationship with AIC. As one participant put it,

Several care providers noted that the Ministry of Health's Agency for Integrated Care has played a crucial coordinating and "enabler" role, helping organisations navigate the complex eldercare industry.

care providers now feel it is easier to discuss issues with AIC and they feel the agency will do its best to help when they raise concerns. Participants noted that AIC has simplified some administrative procedures, and one non-profit participant identified AIC's template of Standard Operating Procedures for new care models as an initiative that saves the care providers time from having to draw up their own checklists. Several non-profit participants welcomed AIC's initiative in sending its staff for regular visits and short-term attachments to understand how the organisations work and what they and their clients need.

Other ministries and statutory boards have functions relating to eldercare too. The Ministry of Manpower (MOM) oversees the employment of foreign domestic workers and their training, and provides grants and concessions related to their employment for eldercare. The Housing & Development Board (HDB) oversees a scheme which subsidises home modifications, such as the addition of grab bars and slip-resistant tiles, to enable older people to continue living at home safely. It also provides financial incentives to encourage adult children to live near or with their parents. Social service organisations that provide eldercare services come under the purview of the National Council of Social Service, which governs the conduct of member organisations and provides funding. Another relevant organisation is SG Enable, an MSF agency that focuses on people with disabilities, including the elderly.

Government funding for eldercare extends across three ministries — MOH, MSF and MOM — and the HDB. Two key funding areas are social assistance and subventions for care recipients and their families, and social service agencies. Private care providers can apply to MOH to be considered

for portable subsidies, and serve subsidised patients by bidding for Request for Proposals for Build-Own-Lease eldercare services.⁸ Details of the wide range of funding schemes available for each of these groups are found in Appendices 2–5.

ELDER BOOM: WE'VE SEEN THIS COMING SINCE THE 1980s

Singapore's approach towards ageing has been shaped by several policy reviews over the decades. In 1984, the Committee on the Problems of the Aged urged community organisations and voluntary bodies to provide services to help Singaporeans care for their ailing elderly family members at home. In 1988, the Advisory Council on the Aged recommended fostering intergenerational activities and paying greater attention to geriatric, befriending, respite, home-based care and day care services. It also urged the Government to work closely with VWOs providing such services, including on a cost-sharing basis. The report signalled staffing constraints in home-based care as an issue requiring attention, and suggested the possibility of allowing Central Provident Fund (CPF) members to use their Medisave funds for medical and rehabilitative community day care.⁹

In 1999, the Inter-Ministerial Committee on Healthcare for the Elderly argued for more integrated services, urged the Government to consider long-term care insurance (currently ElderShield; to be revised and enhanced as CareShield Life from 2020), and recommended capping community donations to 20 per cent of VWOs' operating expenditure for long-term care “to allow

them to concentrate on providing and improving care instead of raising funds”.¹⁰ It encouraged private-sector involvement to provide a wider range of eldercare services to those who could afford to pay.

Subsequent reports in 2006 and 2009 identified “ageing-in-place” and “active ageing” as key recommendations.¹¹ In 2012, MOH released the Healthcare Masterplan 2020, which signalled the Government’s intention to build the capability of the ILTC sector in attracting and retaining staff; encourage skills training to deepen ILTC-specific expertise and in areas such as dementia and palliative care; and improve productivity.¹² In 2015, MOH announced that the Government would commit \$3 billion to implement an Action Plan for Successful Ageing, which detailed more than 70 initiatives “to empower Singaporeans to age confidently and actively with strong bonds with family and community” over the next 10–15 years.¹³ The Government has moved from focusing on *healthcare*, including medical treatment and hospitalisation, towards encouraging overall *good health* in terms of primary care and, to an extent, in long-term care and preventive care.

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THE SINGAPORE WAY: FAMILY HELPS FIRST

Undergirding the Government’s position is the belief that families are the primary caregivers of the elderly, with community organisations playing a secondary role under Singapore’s “Many Helping Hands” approach to providing assistance. The Medisave policy illustrates this approach. Medisave was conceived in 1984 for CPF members to set aside part of their compulsory savings to help pay healthcare costs for themselves or close family members. The scheme allows immediate family members such as parents, spouses and children to draw from one another’s accounts to co-pay for specific healthcare expenses. The HDB schemes that encourage children to live near their parents or purchase multi-generational flats also emphasise the Government’s position that families ought to take the lead in caring for their elderly. Over the years, the Government’s annual Budget initiatives have regularly included various funding schemes and programmes pertaining to eldercare (Appendix 6). The 2018 Budget announced plans to encourage extended family members to live together, through enhancements to the HDB’s Proximity Housing Grant.¹⁴ In this way, too, families remain the nuclei for eldercare.

The Government’s approach fits broadly with the assumption that many Singapore families remain close-knit. The National Survey on Senior Citizens conducted in 2011 found that around 44 per cent of older people live with their spouses and/or other family members, and about 12 per cent live with their spouses.¹⁵ A 2010 academic study reported similar findings, including when a family member had dementia.¹⁶ A recent news report further noted that the

number of households made up of seniors only has almost doubled since 2012 and is likely to increase dramatically again by 2030.¹⁷ Many Singapore families rely on foreign domestic workers for help in caring for the elderly. Almost half the families polled in a survey commissioned by MSF in 2012, involving 1,190 pairs of elderly persons and their caregivers, said they used foreign domestic workers to care for frail elderly relatives.¹⁸ That survey also found that nearly half the helpers lacked experience or training to perform eldercare duties. Another aspect that deserves attention is the rising number of over-65s living alone. Their number more than doubled from 23,400 in 2006 to 47,400 in 2016.¹⁹ Improvements in eldercare must therefore anticipate further growth in the number of older Singaporeans living alone.

Many families also turn to community and home care services to meet their eldercare needs, especially for older Singaporeans aged 70 and above (Table 1.1). The number of centre-based facilities that received MOH referrals and subventions increased from 68 centres in 2014 to 88 centres in 2016, while home-based care providers that received government subventions or referrals rose from 14 in 2014 to 21 in 2016 (Table 1.2).²⁰ In comparison, the number of home palliative care providers increased only slightly from five in

The number of over-65s living alone more than doubled from 23,400 in 2006 to 47,400 in 2016. Improvements in eldercare must therefore anticipate further growth in the number of older Singaporeans living alone.

2014 to seven in 2016, reflecting an ongoing shortage even as demand for palliative care is poised to increase.²¹ In 2016, MOH announced that it intends to increase home and community care places (i.e. the number of seniors who can be supported at any point in time) by 50 per cent and 100 per cent respectively between 2015 and 2020; the latter includes 40 day care centres for seniors. About a quarter of the latter will be large Active Ageing Hubs in housing developments, providing active ageing and assisted living services to seniors.²²

Table 1.1 Demographics of Clients Using Home-based and Centre-based Services as at end-2016^a

	Community Rehab	Day Care	Dementia Day Care	Home Health	Home Personal Care
Unique patient count	9,400	2,800	2,100	6,500	2,000
Male	43.0%	36.8%	31.1%	44.2%	44.5%
Female	57.0%	63.2%	68.9%	55.8%	55.5%
Age					
• Under 60	14%	4%	1%	9%	9%
• 60 to 69	22%	14%	7%	14%	19%
• 70 to 79	30%	31%	33%	25%	31%
• 80 and above	34%	50%	59%	52%	42%

Source: MOH, direct communication, 2018.

^a Percentages may not add up to 100% due to rounding up or down.

Table 1.2 Long-term Care Facilities Receiving Government Referrals and Subventions

	2014	2015	2016
Centre-based Care Facilities	68	81	88
Home-based Care Providers	14	17	21
Home Palliative Care Providers	5	7	7

Source: Ministry of Health (2018) "Health facilities". Retrieved from https://www.moh.gov.sg/content/moh_web/home/statistics/Health_Facts_Singapore/Health_Facilities.html

Centre-based care facilities under MOH include social day care/maintenance day care as well as senior care centres. The latter are integrated facilities that provide a range of services such as maintenance day care, community rehabilitation services and dementia day care. MSF services transferred to MOH since April 2018 include befriending, "gero-counselling", a senior's helpline and Senior Activity Centres.²³ The previous division of services between MOH and MSF was an issue raised by several care providers in our study (Appendix 7). They ran eldercare services that received funding from both ministries, and were therefore accountable to both for key performance indicators and funding processes. Consolidating eldercare services in MOH is a positive step, say care providers who previously had considerable administrative work producing different documentation and programmes for two ministries. In a recent update, MOH said it has "more than doubled centre-based capacity from 2,100 day places in 2011 to 5,000 in

2017".²⁴ It should be noted, however, that AIC received 7,800 referrals for day care services in 2015, when there were only 3,500 day care places available.²⁵ Not only did the 5,000 places in 2017 still fall short of 2015 demand, but the demand has also likely increased since then. Although not all referrals result in the take-up of places and not all seniors attend day care on a daily basis, the numbers suggest there is a gap between the need expressed through referrals and the number of day care places available.

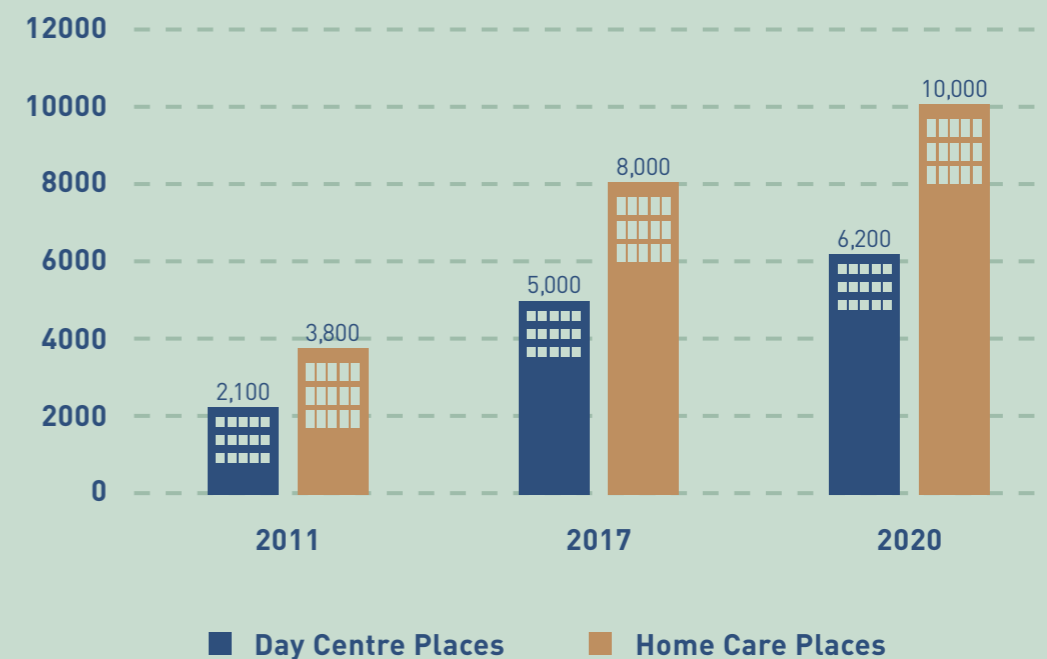
Home-based care is an important dimension of care as Singaporeans age. This includes home medical and nursing care, rehabilitation, palliative care, meal delivery services, escort services and personal care services (Appendix 8). Home nursing generally includes health assessment, such as monitoring blood sugar and blood pressure levels, administering injections and medication, managing tube feeding, catheterisation, stoma care and the like, as well as changing wound dressings, and providing patient- and caregiver-training. Eldercare at home is often the responsibility of family members and, for those who can afford it, their foreign domestic workers. For many families, however, employing a helper is not an option because of the cost. Even those with helpers may seek additional care services to meet specialised needs of elderly family members. This might be during the period after the elderly person is discharged from hospital, or over a longer term when they use the services of non-profit or private providers. Private providers usually operate independently from government funding although some qualify for AIC referrals and receive portable subsidies. Recognising that demand for home-based care has been growing, MOH and care providers

in both the non-profit and private sectors have ramped up such services. MOH reported that in 2017, there were 8,000 home care places, which is double the capacity of 3,800 places in 2011.²⁶

There are no publicly available national figures on what proportion of Singapore's severely disabled are currently using formal long-term care facilities. Many are undoubtedly looked after by family members or foreign domestic workers. There are now around 13,000 home and community care places for seniors who need long-term care; in addition there are 14,900 nursing home beds. However, some of these places (e.g. social day care) are taken up by elderly who are not severely disabled. While MOH has noted that "it is on track to achieve 10,000 home care places and 6,200 day centre places by 2020" (Figure 1.2),²⁷ a more immediate question is whether there will be sufficient places to meet the demand over the next decade or so. With the number of elderly expected to increase rapidly, and with many expected to be in an unhealthy state in the last 10 years of their lives, the supply of long-term care places could potentially be below future demand (even if we include the additional 2,100 nursing home places that will come on board by 2020, and take into consideration that some day care places can serve more than one senior as not all seniors use the services on a daily basis).²⁸

With the number of elderly expected to increase rapidly, and with many expected to be in an unhealthy state in the last 10 years of their lives, the supply of long-term care places could potentially be below future demand.

Figure 1.2 Number of Day Centre and Home Care Places in Singapore*



Source: MOH, direct communication, 2018.

*Figures exclude the capacity of private home and day care providers who serve self-funded clients, which is not tracked.

While it is important to increase eldercare capacity, supply represents only part of the picture. Not everyone who is referred to eldercare services makes use of the service. One study found that only about half of the 418 people referred for centre-based services over 2011 to 2012 used the services. The take-up rate was similar for 322 people referred for home-based services. Follow-up interviews done six months later showed that half of those who took up the services had dropped out. Perceived affordability was a strong consideration for those deciding whether to use the long-term care services they were referred to. Another study of 55 caregivers and 16 patients done from 2011 to 2013 found that the relatively low take-up rates were due in part to patients fearing a loss of independence or dignity, and family caregivers' doubts about formal providers and their capacity to care.²⁹ These studies remind us that increasing capacity must be accompanied by efforts to address the concerns of patients and their families when they decide whether to make use of eldercare services.

Integrated care models encompass centre-based and home-based services, as well as clinical and social care. They provide a continuity of care across different episodes in an older person's life. It means that people who normally use centre-based care but sometimes find themselves unable to leave home can have care delivered to their homes temporarily. Conversely, those who receive home-based care are encouraged to switch to centre-based services when they become more mobile. MOH piloted the Integrated Home and Day Care (IHDC) model in 2016 and there were 358 admissions between January 2016 and December 2017.³⁰ There are now eight IHDC providers³¹ offering care coordination and management to bridge day care (such as social

activities and rehabilitation) and home care services (including home medical and nursing, personal care and meal delivery), dementia care, and caregiving training and support. The VWOs offering integrated care services include AWWA, the Salvation Army's Peacehaven Nursing Home, Jamiyah, SASCO and the Tsao Foundation.

Other care models developed earlier are also being used. The AIC's Singapore Programme for Integrated Care for the Elderly (SPICE) provides comprehensive, integrated centre-based and home-based services for frail elderly people. It involves a team of medical, nursing, as well as allied health and ancillary professionals who provide a suite of services, ranging from primary and preventive care, to nursing care, rehabilitation services, personal care, and social and leisure activities that allow the frail elderly to recover and age within the community. The Tsao Foundation's Elder-centred Programme for Integrated and Comprehensive Care (EPICC) allows the elderly to attend a day club programme and receive a package of services customised to their individual needs. In 2012, the Tsao Foundation developed its Community for Successful Ageing (ComSA) programme, and launched it in Whampoa, a housing estate with a relatively high proportion of older residents. (See story next page)

Also offering integrated eldercare services are the purpose-built Active Ageing Hubs that have begun appearing in new HDB estates. MOH works with the HDB to create these one-stop day centres providing seniors a range of services, from day care and rehabilitation to grocery deliveries. At least 10 future HDB estates will have these hubs by 2020.³² (See story next page)

TSAO FOUNDATION PROGRAMME LETS ELDERLY AGE AT HOME, IN DIGNITY

Most people prefer to grow old at home and in the familiar surroundings of the neighbourhoods where they have lived for many years. Recognising this desire to “age in place” as well as the fact that growing old involves physiological as well as psycho-emotional wellness, the Tsao Foundation launched its Community for Successful Ageing (ComSA) in 2012 at Whampoa, a precinct with a higher than average proportion of older persons and with most residents living in public housing. The ComSA model has three interlocking domains: comprehensive health over the life-course; lifelong learning, elder empowerment and participation; and environment and infrastructure.

In 2017, ComSA’s multiple services and programmes were brought together at the Whampoa Community Club to create an integrated, community-focused system of care. These include the Hua Mei Clinic, a primary care clinic especially for managing chronic conditions; Hua Mei Care Management for elders with complex health and social care needs; Hua Mei EPICC, a day health programme for nursing home-eligible elders; the Learning Room, a platform for lifelong learning; and ComSA Kawan, a programme where seniors can share their skills and eventually

direct and run its activities. Having these functions in close proximity reflects ComSA’s commitment to offering person-centred and integrated health and social care within the neighbourhood.

ComSA’s innovative approach includes the surveys it conducts among seniors in the neighbourhood to assess their needs and vulnerabilities, before drawing up services to meet those needs. After a poll revealed that seniors had small social networks and sometimes felt lonely, the ComSA team developed elder empowerment and community development programmes seeking to address, in particular, the social isolation of older persons in Whampoa. In one innovative project titled “Curating Whampoa”, older persons acquired the skills to create a living museum of their personal artefacts and history, and acted as docents in the roving exhibition.

Underlying ComSA is a collaboration among residents, grassroots, service providers, researchers and policymakers. The ComSA team works closely with more than 20 government, healthcare and community agencies in Whampoa to ensure the successful provision of these programmes and services, and come up with new ideas to deal with ageing in the community.

ACTIVE AGEING HUBS AT NEW HDB ESTATES

Singapore’s first Active Ageing Hub is at the Kwong Wai Shiu Community Care Centre (KWSCCC @ McNair), which opened at McNair Road in November 2017. The centre integrates a nursing home with a community hub offering several long-term care services under one roof. It provides day care, day rehabilitation, home care and personal care, as well as assisted living services. Unlike other eldercare facilities which were added to existing housing estates, the Active Ageing Hubs are designed as part of new HDB developments. At McNair Road, new Build-to-Order HDB studio apartments were designed with the eldercare hub in mind. The studio apartments have an alarm system linked to KWSCCC @ McNair, where staff can be alerted to emergencies. In the months after the centre opened, there were two cases of older persons who fell and injured themselves at home.

In keeping with the concept of active ageing, KWSCCC @ McNair has a pool of volunteers aged 65 to 70 who conduct art or cooking classes at the centre. In this way it engages and serves both active and frail seniors in the community. The centre runs

talks on fall prevention, mental health wellness, traditional Chinese medicine and other topics, aimed at keeping seniors informed and healthy. To encourage community bonding across different age groups, it partners a nearby primary school for the school’s intergenerational programme.

There are, however, challenges in the hub model. Two main groups of elderly use the facilities — active seniors and those who need custodial care, such as dementia patients. It is not easy to foster interactions between the two groups, and the elderly with dementia need more attention. Also, while the intergenerational programme is an admirable effort, there is a language barrier between the schoolchildren who speak English and their mother tongue language, and the seniors who speak mostly Chinese dialects.

The Kwong Wai Shiu Hospital will have a second community care centre and Active Ageing Hub at St. George’s Lane, due to open in 2019. The organisation plans to build up a regional community health system for the central part of Singapore in Kallang, Whampoa, MacPherson and Potong Pasir.

Hospital transitional care services are for patients well enough to be discharged but who would benefit from follow-up treatment (Appendix 9). Transitional care bridges the gap between hospital and home by dispatching medical teams to visit patients at home and, where necessary, referring them to VWOs for follow-up rehabilitation and home care services. Transitional care may also involve training for caregivers. A study by the Singapore General Hospital in 2012 found that transitional care reduced hospital readmission rates by about half over a period of three to six months.³³ In April 2017, the Government launched the Hospital to Home (H2H) programme operated by the Regional Health Systems, and more than 14,000 patients have enrolled since.³⁴

In early 2018, Health Minister Gan Kim Yong reported that Singapore's national health expenditure increased from \$10.9 billion to \$18.9 billion between 2010 and 2015.³⁵ This amount includes both government and private spending on long-term care. He added that government expenditure on healthcare grew by about 120 per cent over the same period. The government expenditure on health was reportedly about 2.5 per cent of the Gross Domestic Product (GDP) in Financial Year 2015.³⁶ The increased investment in the sector is a positive step towards meeting the evolving needs of an ageing population. However, a recent study estimated that the cost of healthcare for the elderly could rise to more than \$66 billion by 2030. Eldercare experts point out that this estimated increase is a conservative figure, perhaps an under-estimation even, as it does not include "indirect costs such as transport, and opportunity costs from caregivers' time [and] assumes that we have the same ready access to cheap foreign labour, which may not be the case in the future".³⁷ The projected increase would also mean a rise in long-term care costs. With

an ageing population and rising costs, Singapore needs to be more proactive in preparing to age well at home and in the community.

This chapter has shown where community and home services for eldercare fit within the wider landscape of healthcare in Singapore. The evolution of eldercare services reflects the commitment of the Government to improve the quality and quantity of services, as well as to introduce new programmes. These include expanding the range of centre-based care services, enhancing home-based care, introducing integrated models of care, and extending hospital transitional care. The result is a variety of care models and a growing focus on integrated care. Nonetheless, key policy reviews done since 1982 highlighted several worthwhile recommendations which have not been completely followed through to date. These include addressing the burden that VWOs face raising charity dollars to meet the full costs of providing care, and despite the recent Government announcement that severely disabled persons can withdraw their Medisave to offset out-of-pocket payments for long-term care from 2020 onwards, more can be done to finance long-term care needs. Such issues resonate with contemporary concerns raised by the care providers and caregivers in our study.³⁸

The evolution of eldercare services reflects the commitment of the Government to improve the quality and quantity of services, as well as to introduce new programmes. Nonetheless, key policy reviews done since 1982 highlighted several worthwhile recommendations which have not been completely followed through to date.

ENDNOTES

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AFTER THEIR MOTHER died in 2004, Albert Jia became the sole caregiver to his intellectually disabled sister, Alice. He is 75, she is 76 and they live in the family flat. Alice suffered a broken leg in an accident some years ago and, although she can walk, she shuffles along slowly. Albert struggles with health issues of his own. Diagnosed with kidney failure in 2012, he needs dialysis three times a week. He is finding it physically and emotionally challenging to care for himself and his sister.

They have financial problems too. Alice receives \$500 in public assistance each month. Albert gets about \$300 from his Central Provident Fund payouts. Another \$100 in cash and a \$50 grocery voucher come each month from the church he attends. A charitable group covers the \$360 per month for Alice to receive five meals a week from a meal delivery programme. The siblings have two brothers, who neither visit nor contribute towards Alice's care.

Alice attends a voluntary welfare organisation's senior day care centre five days a week, taking the centre's transport between home and centre. Albert is anxious about having to pay \$220 each month for her day care services, and says he does not know how much the services she uses cost. He does not know how things work, where he might get help, and what will happen if there is an emergency. "I don't know," he says again and again, when asked about help schemes available to the siblings.

He is anxious about going to the wrong agency and becoming upset if he gets things wrong. "I don't know who to contact and what I can get. You don't just go to everyone and ask," he says. This helps to explain why, although he

qualifies for public assistance himself, he never checked why his payments lapsed or what to do to start receiving them again.

Albert Jia needs help navigating the system of eldercare services in Singapore, to learn not only about the range of help available to him and his sister, but also the assistance they might be entitled to receive. In recent years, a slew of community “ambassadors” have been roped in to explain various government help schemes to seniors. There are also “care navigators”, care or case managers, and others to help seniors navigate the care system. Yet, if there is a downside to the burst of new services, facilities, programmes and schemes for the elderly in recent years, it is that many among the elderly themselves still do not understand how things work and are not sufficiently aware of what is available to them. Our study found that even seasoned care providers sometimes find the administrative frameworks of the care industry a challenge as they try to work out appropriate arrangements for clients while bearing costs in mind.

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If there is a downside to the burst of new services, facilities, programmes and schemes for the elderly in recent years, it is that many among the elderly themselves still do not understand how things work and are not sufficiently aware of what is available to them.

This chapter focuses on care providers' views about the state of Singapore's eldercare industry and the environment in which both non-profit and private providers deliver eldercare services. On the positive side, we found that care providers have been proactive in meeting a range of eldercare needs — on their own initiative as well as in response to evolving government policies. They develop new programmes and forge partnerships with other care providers to expand services. Participants in our study acknowledged that the Government, and particularly the Agency for Integrated Care (AIC), which coordinates eldercare policies, have played a crucial coordinating and enabling role. However, they also signalled areas for improvement in the organisation of the eldercare industry and associated administrative procedures. The proliferation of programmes, funding schemes and management systems can be perplexing for care providers and caregivers alike. The themes discussed in this chapter highlight issues raised by both non-profit and private providers of centre-based, home-based and integrated care.

RESPONDING TO GAPS, EXPANDING ELDERCARE SERVICES

The significant growth in the number of eldercare facilities and providers between 2014 and 2016 reflects the willingness of both the Government and care providers to develop models of care that continuously adapt as the needs of seniors are identified. In recent years, Singapore has developed more holistic care and continuity of care for the elderly from hospitals to

care centres and the home. Non-profit providers in our study said they have expanded services and rolled out new ones proactively, to meet needs they have observed on the ground. For example, one non-profit provider which received funding from the Ministry of Social and Family Development (MSF) for social care of the elderly decided to address the clinical needs of clients as well by going into home care. It now receives referrals and funding from AIC in this area. Its representative said the non-profit had been successful in taking care of seniors' social needs, including preventing isolation of the elderly, but by expanding into home care it now provides more holistic services to its clients.

Private providers told us that they entered the eldercare market after observing gaps in the market for centre-based and home-based care, and several have come up with innovative ways to address those gaps. They consider themselves stakeholders in eldercare, playing a distinct role: some deliver eldercare to wealthier clients seeking premium care, while others cater to a middle-income market. Private providers may also partner non-profit providers to serve lower-income clients who qualify for portable subsidies. The following are two examples of private providers with innovative offerings for centre-based and home-based care respectively (See stories on the next two pages).



SHALL WE DANCE OR PRACTISE GOLF? A DOSE OF FINNISH FLEXIBILITY

Hovi Care (Singapore) is the local partner of Finnish aged-care provider Hovi Group, and it aims to embody the Finnish ethos of flexibility and non-regimentation. The private care provider operates HoviClub, an activity centre for seniors. For a 20-session package, it charges \$180 for each eight-hour day session; half-day session packages are also available.

The Hovi-model integrates values of individuality and openness, elements of nature as well as technology. The Finnish approach of "Green Care" is expressed through the inclusion of nature and animals in the care programme. Clients can engage in aquatherapy, physiotherapy, pet therapy and equine therapy. Its weekly programmes allow clients to choose from a menu that includes dance,

handicraft-making and golf practice, under the care of a registered nurse or qualified personal trainer.

Finnish technology applications by HoviClub include a physio-acoustic chair that transmits low-frequency sound vibrations to treat common ailments among the elderly, such as insomnia. Memoera, a device offering quizzes and memory games, is designed to stimulate memory rehabilitation for people with dementia. Professional exercise equipment designed for seniors is also available for mobility strengthening.

Hovi Care (Singapore) was a finalist under the Best Day Centre Operator and Best Dementia Care Programme categories in the 6th Asia Pacific Eldercare Innovation Awards 2018.

JUST LIKE UBER: ON-DEMAND CARE, 24/7

Jaga-Me Home Care was set up in 2015 by a team of youthful tech-savvy founders with a vision to “Uber-ise” home-based care. Their online platform delivers on-demand home care to users in their homes, 24/7. The founders noticed patients at home who would benefit from a home visit instead of going to the hospital, and found a way to tap an available pool of trained healthcare workers willing to work on flexible hours. The services Jaga-Me provides include caregiving, medical and nursing care, and medical escort services. Seniors account for about four in five of its clients. Jaga-Me considers itself a social enterprise, being a private provider with a social cause that includes helping financially needy patients. Its charges range from \$20 per hour to \$80 per visit.

Jaga-Me relies on freelance licensed nurses and trained caregivers to serve its clients. It uses qualified nurses who have stopped working to pursue their studies or to care for their young children, among other reasons. These nurses are unable to commit to

the shift hours expected in hospitals, but are willing to work part-time in the community. According to the Ministry of Health, 5,708 nurses were not in active practice in 2017.¹

Jaga-Me can deploy a nurse to a user’s home within as little as two hours. It also provides ad hoc home-based respite care and one-off services like help with performing clinical procedures. The service has reached more than 1,000 people since 2016, and Jaga-Me estimates that it has successfully pre-empted over 1,000 episodes of emergency department readmissions by using its technology platform to rapidly dispatch nurses to homes.

Jaga-Me has also demonstrated a public-private partnership model for patient care, together with established public health institutions and VWOs. In 2017, Jaga-Me won the President’s Challenge Social Enterprise Startup Award, and the technology challenge at AIC’s Global Conference for Integrated Care 2018.

PARTNERSHIPS THAT BENEFIT EVERYONE

The benefits of forging partnerships emerged as a key theme in our study. Partnerships between care providers, as well as between providers and hospitals and other agencies, make for an efficient means of achieving economies of scale and specialisation while ensuring the goals of providing holistic care and continuity of care are met. The representative of a non-profit provider of centre-based and home-based care described how helpful it is to have a hospital nurse visit its centre once a week for half a morning. Its clients, who live near the centre, get to see the nurse there instead of making a trip all the way to hospital and waiting for treatment. Another participant said it is useful when care providers are included at the multi-disciplinary meetings held by hospitals in the Regional Health Systems (RHS) to discuss the needs of patients about to be discharged. As each case is raised, the hospital staff ask who among the care providers present can take on patients who require transitional care, home medical or nursing care or even personal care. This demonstrates the effectiveness of close partnerships between hospital transitional care teams and care providers in the community. A representative of one of the hospitals involved told us it works with four non-profit providers it identified through networking events organised by the RHS. The hospital’s 20-strong care team serves nearly 2,000 patients, half of whom are elderly. The low staff-to-patient ratio suggests that there is room for hospitals to develop partnerships with a greater range of external care providers, including private providers.

Successful collaboration among eldercare service providers has come about thanks to networking opportunities, as well as discussions during events organised by AIC or the RHS. Initiatives to bring like-minded partners together have enabled the expansion of care services to meet multi-dimensional eldercare needs. Strategic partnerships allow care providers to leverage one another's strengths and capacities to meet evolving needs. Such organic partnerships and networking activities are aspects of what is working well in Singapore's eldercare landscape and, if done right, create a beneficial situation for providers as well as the elderly who need care. (See story on facing page)

Initiatives to bring like-minded partners together have enabled the expansion of care services to meet multi-dimensional eldercare needs. Strategic partnerships allow care providers to leverage one another's strengths and capacities to meet evolving needs.



PEACEHAVEN DEVELOPS STRATEGIC PARTNERSHIPS TO HELP ELDERLY AT HOME

Peacehaven Nursing Home is part of the Salvation Army, a well-established player in Singapore's voluntary welfare organisation scene and one which has constantly innovated to meet needs in the community. Peacehaven's efforts to reinvent and expand its services led the non-profit care provider to establish a strategic partnership with an up-and-coming private care provider.

Peacehaven operates a nursing home, but it recognises that it is better for people to age in place, in their own homes and in the familiarity of their neighbourhoods. With this in mind, it piloted its Integrated Care in Place (ICP) Programme in 2008, providing dementia day care and integrated rehabilitation day care. Around 2010, it developed more non-residential care options by offering the Singapore Programme for Integrated Care for the Elderly (SPICE), which combines centre-based and home-based services. It added Integrated Home and Day Care (IHDC) services after the Ministry of Health introduced this care model in 2016.

As the IHDC model includes home-based services, Peacehaven went into a partnership with

a private care start-up, Homage, a finalist under the Best Home Care Operator category in the 6th Asia Pacific Eldercare Innovation Awards 2018. Homage had developed an online application in 2016 to match users with healthcare services. It employs a team of full-time nurses who assess the care needs and develop care plans for clients who use the app. Mainly, however, it provides a pool of freelance caregiving and related services. In its partnership with Peacehaven, Homage steps in to deliver personal care services on demand, including showering, housekeeping, grocery shopping and cooking. Peacehaven views this as a complementary partnership that is helping to fill gaps in services to the elderly.

To help seniors age in place, Peacehaven partnered a nearby hospital to create a transitional convalescent facility at its home in 2012. Elderly patients discharged from hospital move there for three to six months of rehabilitation to help them regain their strength and mobility before they return home to live independently. More than 70 per cent of these patients returned home after a temporary stay at Peacehaven.

CARE PROVIDERS HAMPERED BY A LACK OF GOOD DATA

Eldercare in Singapore is changing rapidly, with many more eldercare options today than just a few years ago. While there are welcome signs of those in the industry coming together to work better for the elderly, services have sometimes expanded in a piecemeal fashion rather than in an integrated, planned manner. This perhaps reflects the nature of a care ecosystem made up of old and new players, non-profit and private providers, as well as hospitals and other healthcare agencies. Some care providers were concerned that it could appear that providers were working in silos, rather than working together in a more coordinated way.

On deeper reflection, they say this apparent lack of coordination partially arises from providers' lack of access to data related to the demand for services as well as supply measures the Government plans to encourage. A private provider planning to establish centre-based care services argued for more access to data to help providers as well as those seeking care. In terms of demand, for example, he was not sure if there is currently an undersupply of services, or an under-served segment among the elderly, because detailed statistics are hard to come by. Fuller knowledge of the eldercare demand and supply landscape would enable providers to contribute in a more informed and coordinated way towards achieving the Government's vision for eldercare.

Fuller knowledge of the eldercare demand and supply landscape would enable providers to contribute in a more informed and coordinated way towards achieving the Government's vision for eldercare.

Although the Ministry of Health (MOH) shares its plans during regular industry briefings, care providers feel it would be more useful if they received finely distilled demographic data on the geographical distribution of services at the local level, perhaps by constituency or housing estate. They would welcome detailed demographic data on age cohorts, income, family caregiving and frailty profiles, especially for the geographical areas their organisations serve. Some demographic data is available on the website of the Department of Statistics, but care providers said they do not have the resources to trawl through the statistics. If the Government could pull together and highlight complex demographic data in accessible formats, lay users would be able to grasp the information more easily.

On the supply side, care providers wanted information on MOH's longer-term plans. The representative of a non-profit provider of centre-based care observed that industry players often find out about new plans from advertised government tenders. That is when they realise a new service is coming up, sometimes in the very area that they are already operating in and consider their geographic base. "You want to serve more, but you do not know what is coming next," one non-profit participant observed. While MOH has organised an annual industry briefing for care providers on upcoming tenders since 2017, care providers would like MOH to provide longer-term forecasts and an overview of these plans by geographical zones. This would let a care provider know whether to act on an advertised tender or wait for another that would be more suitable to its location or capabilities. Relatedly, developing and making public an eldercare masterplan that identifies

concrete working plans by a series of time frames (short-, medium- and long-term) would enable providers to negotiate anticipated changes and challenges to the sector better.²

The lack of detailed data affects care providers in other ways too. The representative of a non-profit provider in home-based care told us that MOH's decision to allow centre-based providers to extend their services to home nursing through the Integrated Home and Day Care (IHDC) model, although well-intended, could result in increasing competition for existing home-based care providers. At the same time, restructured hospitals are also improving their transitional care programmes. Concerned that these moves may shrink their pool of potential clients, affected care providers are then left wondering whether it makes sense to bid for tendered projects. Without knowing how the Government intends to organise care services at specific locations in the longer term, care providers may expose themselves to unnecessary market risks by submitting a tender without being able to assess sufficiently if the supply of services might outstrip demand.

The data that care providers would find useful is currently not readily available. They point out that it is not impossible for the Government to gather and make available such data. For example, the Ministry of Education and MSF jointly provide data on the number of childcare and infant care providers in specific housing estates as well as the names of childcare centres that have opened or closed.³ Data on upcoming centres is also available.⁴ Such information enables childcare providers to make informed decisions on whether a particular housing estate is saturated with operators or under-served. A similar set of data on eldercare provision, indicating the availability

and distribution of eldercare service providers, the age density of housing estates and the residential patterns of older people across Singapore, would prove helpful to care providers. Such a database could also include search functions that will enable care providers to organise the data thematically according to their needs.

PROLIFERATION OF FUNDING SCHEMES, PROGRAMMES AND SYSTEMS

With the expansion of services has come a proliferation of funding schemes, programmes and systems for eldercare. Appendix 2 lists 13 funding schemes administered across four ministries with functions related to eldercare. Seniors are sometimes overwhelmed by the array of subsidy cards meant for them. These include the blue and orange Community Health Assist Scheme (CHAS) cards⁵, which provide portable primary care subsidies to lower- and lower-middle income families; the Pioneer Generation card, which extends subsidies to those born before 1950 and who became a Singapore citizen by 1987; and the Passion Silver Card and Senior Citizen Monthly Concession Pass.

At a focus group discussion with non-profit providers of home-based care, participants said the multiple funding schemes left older Singaporeans confused because "our elderly now hold a lot of cards!" One participant suggested having a single card to cover all subsidies a senior is entitled to. Others agreed, pointing out that

Consolidation across different government agencies managing the various schemes can simplify processes for clients and care providers.

technology is already available to create a smart card that can consolidate the various schemes and is easy to use. Consolidation across different government agencies managing the various schemes can simplify processes for clients and care providers. The discussion also pointed out the importance of helping care recipients to understand the numerous schemes and programmes that are available or not available to them so that they can make informed decisions.

Care providers themselves have difficulty understanding the multiple programmes and systems in the eldercare industry. At the time of this research, MOH and MSF were managing different programmes, and that created confusion or additional work for providers when liaising for funding or submitting data related to their key performance indicators (KPIs).⁶ The latter could include, but were not limited to, the percentage of accepted government referrals, occupancy or utilisation rate of facilities and services, clinical outcomes, and customer satisfaction.⁷ With MOH in charge of eldercare services since April 2018, providers hope some of the duplicate work they used to do will become a thing of the past.

A fundamental ongoing issue has to do with collecting data to report on their KPIs. Staff-strapped providers say they have to decide between allocating resources to collect the various data and information required and staying focused on providing quality care. A senior manager of a large non-profit provider told us: “We need to strike a balance between collecting enough data to figure out whether the programme is successful and the resources required to collect that data, because honestly we’re not funded to collect data. They fund us enough to run the programme, but they don’t give

us funding for the research work.” There also exist practical barriers related to the way that IT software packages may require data to be input, and for some, integrating information from multiple systems can be an overwhelming task. One care provider wished for a software package that would give VWOs a painless way to maintain client data, generate the data required for reporting to ministries and funders, and track the quality of care. Care providers hoped this is a matter AIC will look into.

Care providers also highlighted that existing data management systems do not integrate information about a client’s clinical and social care. A hospital transitional care representative explained that healthcare institutions can obtain patients’ healthcare records from the National Electronic Health Record (NEHR) system, but if a patient has medical and social needs taken care of by community care providers, records of the patient’s interactions with medical social workers may not be shared. The care providers would have to ask the hospital for the information. One private provider described an occasion when she faced extreme difficulty finding out a home-based care client’s contact precaution status, to prevent the spread of infection, because the hospital refused to release the information. Yet this was information the provider felt its staff needed to know. Care providers told us that having an information access platform that integrates data on clinical and social care would make for better continuity of care and more efficient service delivery. More crucially, it is not easy for one provider to access data maintained by others even though this would provide a fuller picture of the various services a client is using. An elderly person could be served by two or three different care providers for different services, yet none of the providers would be able

see on the AIC system the whole range of services a client is receiving, and from whom.

There should be greater integration of clinical and social records, as well as across the range of providers involved in care delivery for a client. Constraints on information sharing are attributed to the Personal Data and Protection Act (PDPA) as well as concerns over client confidentiality. However, patients can be offered an opt-out option of sharing their records among care providers and healthcare institutions, as a way around this.

CAREGIVER'S LAMENT: HELP ME UNDERSTAND THE COMPLEX SYSTEM

This chapter began with caregiver Albert Jia who seemed clueless about the assistance he and his elder sister might be entitled to or how he could find out. "I don't know," was what he kept saying. Given the numerous players in the eldercare industry and the large number of programmes and systems, care providers told us that clients and even caregivers themselves sometimes find it hard to figure out their eligibility for services. The procedures and paperwork alone can prove mind-boggling. A hospital medical social worker told us of patients who said they felt overwhelmed when they enquired about care services and were told to take a form, go to a family service centre and get a social worker to provide a report, before returning to apply for the service they enquired about. A non-profit representative cited the example of a potential client who was told to take a form to a polyclinic to get his health assessed thoroughly, possibly seeing multiple medical staff, before he could apply for the eldercare services he asked about.

Older people, already anxious in an unfamiliar environment when they make enquiries about eldercare services, are often put off by the "standard answers" they receive from healthcare staff, as noted by one care provider. Hence, the whole process can seem daunting and frustrating. The difficulty of navigating a complex eldercare system is made worse when information fails to be exchanged seamlessly between the potential client, AIC, the medical social worker and frontline staff. The hospital medical social worker above told us communication breakdowns may occur when lower-income patients discharged from hospital are supposed to move to centre-based care, and need to find out more information. This is a summary of what she said:

The hospital's medical social worker who refers the patient to AIC to assess his subsidy entitlement may have the case returned because the patient says he cannot afford the care centre's service fees. Even though the medical social worker indicated that the patient needed to see a social worker, the case sometimes does not move past the administrative officer who tells the patient he will have to pay, say, \$220 a month at the care centre. The patient's immediate reaction is: "Oh no, I don't have the money, I don't want to go to the care centre, I'll just stay at home." As the referral source, the hospital medical social worker must then ensure the patient sees the care centre's social worker who would be able to discuss his financial issues and work out a way for him to receive the care he needs.

This account offers a glimpse of the reasons why lower-income clients and service providers alike sometimes find the eldercare system perplexing. Being directed from person to person, or told to go from one place to another, can be frustrating to the point that the elderly who enquire about services give up trying. Family members of elderly people who need care are usually in a state of distress when they seek information. Being directed from person to person or place to place heightens their emotional stress and can deter them from seeking professional care services. Worthwhile services and dedicated care teams may be available to provide the help needed, but sometimes the cases just get stuck when the administrative officer tells them: "First, you have to take this form and go there, and then do this, and that, and the other thing."

Private providers who interact with middle-income clients echoed similar concerns, saying it can be difficult for these families too, when they try to identify appropriate care services. A private provider of home-based care said middle-income clients also find themselves directed to different people and different places when they ask about care options. However, middle-income families are more likely to source for care services independently, either because they do not qualify for government subsidies and therefore do not liaise with voluntary welfare organisations, or they think they can do it themselves. Furthermore, families with the financial resources to take care of their loved ones prefer to rely on themselves and foreign domestic workers if they can afford one.⁸ It is only when an emergency arises or their elderly family member has a pressing need for care services that they realise how daunting it can be to sieve through the numerous options and different services available. (See story on facing page)



UNINFORMED, STRESSED AND DETERRED BY DISTANCE


Mr Ang is a professional in his late 40s. For two years, he was a caregiver to his grandmother and mother. His grandmother had cancer of the womb as well as dementia and was in her 80s when she died; his mother had Parkinson's Disease and died at the age of 62. The family had a foreign domestic worker who helped with caregiving, but Mr Ang experienced bouts of caregiving stress when his grandmother and mother became bedridden at the same time.

He found out about home nursing services only when he telephoned the hospital where his mother had been warded previously and asked for help to reattach her urinary catheter. The hospital directed him to a home nursing provider, and he used the service whenever his mother and grandmother needed their urinary catheter reinserted. Other than that referral, Mr Ang was unaware of other services and did not know

he could approach AIC for information on care options.

He told us that in his mother's case, the hospital only gave him a card with details of care services for people with Parkinson's Disease. He checked a care provider's website but was dismayed by the lack of useful information, including costs. When he telephoned, the person who answered asked him to just bring his mother to the centre. That put him off, because the centre was quite a distance away and did not provide a transport service. His mother would have had to go there by taxi, accompanied by their helper. It proved too inconvenient and in the end, he did not take his mother to the centre even once.

He found the entire process of finding suitable care "very difficult". What would have helped a stressed caregiver like himself, he said, was to have a point-of-contact, someone who would have advised him clearly and comprehensively about the options available.

Our study found that caregivers were likelier to be advised on community care options when their family members are admitted to hospital and “in the system”. A recent study of dementia care use found that caregivers’ decision not to use available services had to do with their concerns over transportation to centres, the no-frills functionality of the physical environment in centres, the suitability of activities at day care, and their concerns about whether their elderly family member would be comfortable there.⁹ Families that had a foreign domestic worker or sufficient support at home were also less likely to use the services at centres. These views were corroborated by the care providers and caregivers we interviewed. Overall, the complexities faced by caregivers and the resources and time needed to make sense of an array of care services can deter them from seeking help from the Government and care providers. 

ENDNOTES

- 1 Ministry of Health (2018) “Health manpower”. Retrieved from https://www.moh.gov.sg/content/moh_web/home/statistics/Health_Facts_Singapore/Health_Manpower.html
- 2 An example of this is Australia’s Aged Care Road Map published in 2017. It was developed by a committee of experts comprising government representatives, care providers, care workers, non-governmental groups, and led by an independent chair of the committee. Retrieved from <https://agedcare.health.gov.au/aged-care-reform/aged-care-roadmap>
- 3 Child Care Link (2018) “Quarterly report statistics on child care services”. Retrieved from <https://www.ecda.gov.sg/Operators/Pages/Statistics-n-Reports.aspx>
- 4 Ministry of Social and Family Development (2018) “Upcoming centres”. Retrieved from https://www.childcarelink.gov.sg/ccls/home/CCLS_HomeUpcomingCentreDetail.jsp
- 5 The Community Health Assist Scheme (CHAS) cards are officially known as Health Assist Cards.
- 6 The care providers mentioned using the Social Service Net (SSNet) for reporting to MSF; National Electronic Health Record (NEHR) for MOH; E-Case Management System (ECMS) and Enhanced Programme Evaluation System (EPES) for NCCS. Such systems collect data to monitor outcomes and they are distinct from one another. The care providers highlighted that keying in data separately can be time-consuming.
- 7 MOH, direct communication, 2018.
- 8 Kang, S., Tan, E. & Yap, M. (2013) *National Survey of Senior Citizens 2011*. Institute of Policy Studies. Retrieved from <https://www.msf.gov.sg/publications/Pages/National-Survey-of-Senior-Citizens-2011.aspx>; Chan, A., Ostbye, T., Malhotra, R. & Hu, A.J. (2012) *The Survey on Informal Caregiving*. Retrieved from <https://www.msf.gov.sg/publications/Documents/The%20Informal%20Care%20Survey%20Report%20Part%201.pdf>; Huang, S., Griva, K., Bryant, C.A. & Yap, P. (2017) “Non-use of day care services for dementia in Singapore — a dilemma for caregivers”. *International Psychogeriatrics* 29, 455–466.
- 9 Huang, S., Griva, K., Bryant, C.A. & Yap, P. (2017) “Non-use of day care services for dementia in Singapore — a dilemma for caregivers”. *International Psychogeriatrics* 29, 455–466.



3 WHO WILL HELP ME PAY FOR ELDERCARE?

More financial help available, but gaps persist

THE ELDERCARE SECTOR is receiving more funding than before, and Singapore has seen a significant increase in care services and programmes for the elderly. As this report was being finalised, the Government took several steps to strengthen the financing system for those most in need of long-term care. ElderShield, Singapore’s severe disability insurance, is being extended to provide lifetime coverage under the new CareShield Life scheme, which will offer increased payouts as well. The severely disabled will also be able to draw cash from the medical savings scheme, Medisave, for the first time, and a financial safety net for the needy, ElderFund, will serve the same group of Singaporeans who need additional help to meet care costs. According to the Government’s criteria, severely disabled persons are those who are unable to perform three or more “activities of daily living” (ADL) from a list of six — feeding themselves; bathing; dressing; transferring themselves in and out of bed; using the toilet; and walking or moving about. These new schemes will begin in 2020.

Given that some care services for the severely disabled can cost as much as \$3,100 per month¹, including transport and consumables, these changes are immensely welcome. But financing issues still remain. For one, only 6.6 per cent — or around 34,000 of the current cohort of seniors — is severely disabled² and would benefit only from the anticipated changes to CareShield Life, ElderFund and Medisave withdrawals. For most Singaporeans, the current financing structures could continue to direct many elderly towards hospitalisation, rather than community and home care, even if they do not need hospital treatment. Further, since ElderShield was optional, as of 2017,

around a third (34 per cent) of the resident population aged between 40 and 84 are not insured by it. CareShield Life will remain optional for older cohorts and how many will join the scheme remains to be seen.

Care providers, both non-profit and private, continue to grapple with money issues too. Non-profit organisations say they need to raise funds to help clients who are unable to afford care, as well as to cover operational costs that are not eligible for government subventions. Private providers wonder about the sustainability of their business operations given the pressure to keep quality care affordable despite receiving less government support than non-profits. As for care recipients, the lower-income elderly who qualify for a variety of subsidies and help schemes may not find these adequate in reality, while the middle-income elderly and caregivers in the “sandwiched” generation who qualify for fewer subsidies may struggle with financing their care responsibilities. The concerns raised during our study bring up crucial questions about the social compact of care in Singapore.

Family has long been the first line of support for Singaporeans who need care, and government spending on long-term care is still relatively modest compared to other advanced ageing nations. In FY2016, the latest year for which figures are available, preliminary government estimates are that \$800 million was spent on long-term care services — including nursing homes, palliative care, centre-based services and home care. This includes both the capital/development costs of building new facilities, as well as recurrent costs such as means-tested subsidies for users. While this is a jump from the \$600 million spent in FY2015, it still accounted for only 0.19 per cent of

Singapore’s Gross Domestic Product (GDP) for the year FY2016. By comparison, advanced nations in the Organisation for Economic Cooperation and Development (OECD) spent an average of 1.4 per cent of GDP in FY2014, the latest year for which figures are available.³

The overall government expenditure on health has soared from \$4 billion in FY2011⁴ to \$10.7 billion in FY2017⁵ as the country underwent a veritable building boom of new hospitals, nursing homes and other aged care facilities to prepare for rapid ageing. While institutional care will require large investments, many studies have shown that the majority of Singaporeans would like to age in the comfort of their own homes. However, a relatively small proportion of the government budget is being spent on enabling seniors to “age in place”. The expenditure on home and community care in FY2016, the latest year for which figures are available, was only \$240 million, up from \$200 million in FY2015. This means that only around 2.5 per cent of the health budget was spent on home and community care in 2016, up from 2.2 per cent the previous year.⁶

Notably, it may not be feasible to expect Singapore to increase long-term care funding to OECD levels at a time when many advanced ageing countries such as Japan and Australia are cutting long-term care expenditure after spending too much. The rather strict eligibility conditions of ElderShield/

Many studies have shown that the majority of Singaporeans would like to age in the comfort of their own homes. However, a relatively small proportion of the government budget is being spent on enabling seniors to “age in place”.

CareShield Life and relatively high costs of community and home care have led to questions on the need to increase long-term care protection in Singapore. But higher spending in Singapore, too, may eventually mean higher taxes. Indeed, the unprecedented pace of ageing and shrinking family sizes in Singapore mean there is an urgent need for more informed collective conversations among Singaporeans about what kind of care system we want for our grandparents, parents — and eventually ourselves — and how much we are willing to pay for it.

LONG-TERM CARE FINANCING

Healthcare financing (see Appendix 10) is supported by MediShield Life, which is a basic universal health insurance plan administered by the Central Provident Fund (CPF) Board to pay for large hospital bills and selected costly outpatient treatments. All Singaporeans, including those with pre-existing conditions, are covered for life. Co-payment by patients can be made in cash or through the Medisave portion of CPF savings. In addition, Singapore Citizens and Permanent Residents receive subsidies for inpatient (up to 80 per cent), specialist outpatient clinic (up to 70 per cent) and polyclinic services in public healthcare institutions.⁷ Further healthcare subsidies are

The unprecedented pace of ageing and shrinking family sizes in Singapore mean there is an urgent need for more informed collective conversations among Singaporeans about what kind of care system we want for our grandparents, parents — and eventually ourselves — and how much we are willing to pay for it.

available through the Community Health Assist Scheme (CHAS) cardholders for selected services provided by CHAS general practitioners, while Flexi-Medisave for the Elderly provides patients aged 60 and above with up to \$200 per year for outpatient medical treatment at qualifying specialist outpatient clinics and participating CHAS general practitioners.

Medifund is administered by the Government for Singaporeans who cannot pay their healthcare bills even after factoring in subsidies and drawing on financing schemes. In 2007, Medifund Silver was set up as a separate scheme to provide targeted assistance for over-65s who cannot afford basic healthcare despite available subsidies, Medisave and MediShield. The number of applications approved for Medifund and Medifund Silver assistance grew by almost 4 per cent to reach 1,136,000 in FY2016 from the year before.⁸ According to the Ministry of Health (MOH), \$25.1 million was provided through Medifund and Medifund Silver to needy patients in intermediate and long-term care (ILTC) facilities during FY2016.⁹

As Medisave and Medishield Life are mainly used to pay for hospital bills rather than community or home care, more older Singaporeans choose such care over community or home care whenever possible. Currently Medisave can be used for only palliative care, day rehabilitation and some home therapy. A 2015 study of day care centres found that clients preferred to attend accredited rehabilitation centres because they could use Medisave or Medifund to pay. The researchers suggested allowing the same approach for other day care services to reduce out-of-pocket costs, as this would lead more seniors to use eldercare facilities that help maintain their well-being.¹⁰ A 2014 report by

the Institute of Policy Studies had noted that “the financing system for ILTC services is less well developed than it is for healthcare, in particular lacking an explicit mandatory savings component; there is no Medisave equivalent for ILTC services although ElderShield premiums may be paid out of Medisave”.¹¹ This is set to change with enhancements to the new CareShield Life scheme (see below), but it is worth noting that the changes would benefit only those considered “severely disabled”.

ElderShield is an insurance scheme for those who need long-term care because of severe disability, defined as the inability to perform three or more activities of daily living (ADLs). Those eligible receive payouts of \$300 to \$400 per month for up to six years. By 2030 the number of residents aged 65 and above requiring assistance with at least three ADLs (at a single point in time) is expected to reach 69,000,¹² about double the current numbers.

In planning to meet this increased need, a committee was tasked with reviewing ElderShield. In May 2018, it recommended *inter alia*: (1) increasing payout rates to \$600 per month for claims made in 2020 (with future increases to be reviewed regularly)¹³; (2) lifting the six-year cap on the duration of payouts; (3) enhancements to the scheme that will increase premiums from \$175 for men and \$218 for women to \$206 and \$253 respectively¹⁴; and (4) having premiums paid over a longer duration from age 30 (currently 40 years old) to at least 67 years (currently 65 years). The enhanced scheme, to be called CareShield Life, will be compulsory for all Singapore Citizens and Permanent Residents aged 40 and below in 2020. Premiums for older cohorts will increase to \$1,000 or more per year before subsidies and incentives. This

is because premiums for CareShield Life, like ElderShield, are “prefunded” during one’s working years so older cohorts have fewer working years left to spread out their premiums payable.¹⁵ The Government will also provide subsidies and incentives to encourage older cohorts to enrol in CareShield Life, and has given assurance of financial help for those who have trouble paying the premiums.¹⁶

The Government announced in June 2018 that two other enhancements will be made to long-term care financing, to take effect alongside CareShield Life in 2020. First, recognising that care needs vary significantly across individuals, severely disabled Singaporeans will be able to use up to \$200 per month of their own or their spouse’s Medisave account to pay for long-term care, subject to maintaining a minimum Medisave balance of \$5,000 (Table 3.1). Second, a newly established ElderFund will enable lower-income Singaporeans (aged 30 years old and above) who are severely disabled to apply for and receive lifetime payouts of up to \$250 per month. The latter scheme is targeted at those who are ineligible to join CareShield Life, or have low Medisave balances and insufficient savings for their long-term care needs.¹⁷ Notably, only those requiring assistance with at least three ADLs can avail themselves of these schemes.

Table 3.1 Medisave Withdrawals Allowed for Long-Term Care w.e.f. 2020

Medisave Balance	Medisave Withdrawal Quantum
\$20,000 and above	\$200
\$15,000 and above	\$150
\$10,000 and above	\$100
\$5,000 and above	\$50
Below \$5,000	Nil

Source: Lai, L. (4 July 2018) "Cash from Medisave helps meet diverse care needs: Gan". *The Straits Times*. <https://www.straitstimes.com/singapore/health/cash-from-medisave-helps-meet-diverse-care-needs-gan>

The Government has noted that "[t]o help our seniors age-in-place with peace of mind, there are multiple layers of support for their healthcare needs. No one will be denied appropriate healthcare because of the inability to pay".¹⁸ Despite the various government schemes available, however, there is still some way to go in the area of long-term care financing. In our interviews with care providers and caregivers, they identified concerns to do with restrictions tied to government funding schemes and means-tested subsidies. These impact the ability of older Singaporeans to access care. Before we go on to discuss the concerns raised, it is important to understand the type of government subsidies available to older Singaporeans.

GOVERNMENT SUBSIDIES FOR ELDERCARE

In recent years the Government has moved from focusing on lower-income beneficiaries and non-profit voluntary welfare organisations (VWOs) to a wider range of care recipients and stakeholders in eldercare. This includes funding support to middle-income families, and to eligible private care providers to encourage them to recruit Singaporeans and do more to train their staff and raise productivity.

Generally, government subsidies are available only to Singapore Citizens and Permanent Residents, those who meet the admission criteria of the ILTC services required, are receiving care from MOH-funded service providers, and fulfil the households means-testing criteria. The per capita monthly household income is calculated by adding up the incomes of the care recipient, his/her spouse and all working family members living in the same household, and then dividing that sum by the total number of family members living in the same household. For households with no income, the annual value of their home is considered. Those from lower-income households receive higher subsidies under the means-testing framework. The staggered tiers of subsidy level by per capita monthly household income are listed in Table 3.2. To assess whether the subsidies cover the cost of care, the estimated costs of centre-based and integrated services are provided in Tables 3.3 and 3.4 (data for Tables 3.3 and 3.4 from the Agency for Integrated Care's (AIC) Singapore Silver Pages unless otherwise indicated).

Table 3.2 Subsidy Level by Per Capita Monthly Household Income¹⁹

Income Category ^a	Per Capita Monthly Household Income	Subsidy Rate	
		Singapore Citizens	Permanent Residents
Lower income	\$700 and below	80%	55%
	\$701 to \$1,100	75%	50%
Lower-middle income	\$1,101 to \$1,600	60%	40%
	\$1,601 to \$1,800	50%	30%
Upper-middle income	\$1,801 to \$2,600	30%	15%
Higher income	\$2,601 and above	0%	0%

^aAdapted from the Ministry of Health (2014) *MediShield Life Review Committee Report*, Singapore, p.8.

Table 3.3 Fees for Centre-Based Care²⁰

Service Type	Service Fees Before Subsidy
Social/Maintenance Day Care	\$900–1,500 per month
Dementia Day Care	\$1,100–1,700 per month
Singapore Programme for Integrated Care for the Elderly (SPICE) and Integrated Home and Day Care (IHDC)	\$1,600–2,200 per month
Community Rehabilitation Centre	\$60–90 per session

Table 3.4 Fees for Home-Based Care²¹

Service Type	Service Fees Before Subsidy
Home Medical	Starts from \$150 per visit
Home Nursing	Starts from \$70 per visit
Home Therapy	Starts from \$100 per visit
Home Personal Care	Average price is about \$23 per hour

Despite means-tested subsidies, care recipients still have to pay a proportion of the costs in co-payment. A 2017 study estimated that 40 per cent of long-term care financing was borne out-of-pocket by individuals or families; the study included estimated expenditures for home-based and community-based care, nursing home care and care by foreign domestic workers.²² The aggregate figures, however, do not sufficiently contextualise the co-payment burden on individual families. In the following tables we distil the co-payment portion that families fork out for two types of community care, depending on their income status and eligibility for ElderShield payouts. ElderShield provides some financial relief for those who have enrolled in the scheme. It is worth noting that, as of 2017, about one-third (34 per cent) of the Singapore population aged 40 to 84 years old has not purchased the basic ElderShield scheme.²³ Although CareShield life will be universal for future

cohorts born in 1980 and later, co-payment for long-term care can constitute a sizeable expense for families who receive less government subsidies, especially if there is more than one elderly person in the family who require long-term care. It is important for such families to prepare early for their future long-term care needs.

Table 3.5 shows that the poorest households with a per capita monthly household income of \$700 and below have to co-pay 20 per cent of at least \$900 (the lower fee threshold) for using social day care services. This would mean \$180 in monthly out-of-pocket expenses for social day care users who are unlikely to meet the criterion of being unable to fulfil three or more ADLs to qualify for ElderShield/CareShield Life payouts. Care recipients that use Integrated Home and Day Care (IHDC) services would co-pay 20 per cent of \$1,617 (the cost of the most commonly used Package 2) or incur approximately \$323 in out-of-pocket expenses. This is equivalent to 46 per cent of the per capita monthly household income without ElderShield/CareShield Life as compared to at most 3 per cent if either of those insurance options applied.

Table 3.5 Average co-payment for a lower-income family earning \$700 per capita monthly household income

Type of long-term care	Full cost	Per capita monthly household income	Subsidy %	Co-payment %	Out-of-pocket (no ElderShield or CareShield Life)	% of per capita monthly household income	Out-of-pocket (with ElderShield \$300–400 or CareShield Life \$600 ^a)	% of per capita monthly household income
Social Day Care ^b	\$900	\$700	80%	20%	\$180	26%	Unlikely to fulfil payout criteria for ElderShield/CareShield Life	
IHDC Pkg 2 ^c	\$1,617	\$700	80%	20%	\$323	46%	\$0–23	0–3%

^a To be eligible for ElderShield/CareShield Life payouts, the applicant must be unable to perform at least three of the six ADLs. We use \$300–400 in our calculations since it is the range for ElderShield payouts depending on the year of enrolment. In September 2007, ElderShield 300 was enhanced to ElderShield 400. Existing ElderShield 300 policyholders were offered a one-time opportunity to switch to ElderShield 400 (Source: https://www.moh.gov.sg/content/moh_web/eldershield/eldershield-300.html). For the enhanced CareShield Life scheme, we assume a fixed payout of \$600 per month for claims made in 2020.

^b We use Social Day Care (also known as Maintenance Day Care) instead of Senior Care Centre because the latter costs \$1600–\$2000, which is close to the cost of IHDC services. However, seniors who use Social Day Care do not usually qualify for ElderShield/CareShield Life payouts since they would not yet fulfil the severe disability criteria.

^c There are three types of IHDC packages and the cost increases with the intensity of care needed. Care providers advised that Package 2 was the most commonly used by clients.

Table 3.6 considers the case of lower-middle income families. This group can be divided into two bands under MOH's income band stratification: \$1,101–\$1,600 and \$1,601–\$1,800. They qualify for 60 per cent and 50 per cent means-tested subsidies respectively. Table 3.6 indicates that even with ElderShield/CareShield Life payouts, their co-payment for using IHDC services could be as much as 32 per cent of the household's per capita monthly income. Without those insurance options, their monthly out-of-pocket expenses range from \$360–\$450 for social day care, or up to 33 per cent of the family's per capita monthly household income, depending on income band. The families most hard hit by co-payment expenses would be those using IHDC services, which can amount to as much as 59 per cent of the family's per capita monthly household income,²⁴ a considerable expenditure for lower-middle income families.

Table 3.6 Average co-payment for a lower-middle^a income family earning \$1,101–\$1,800 per capita monthly household income

	Full cost	Per capita monthly household income	Subsidy % (for SCs)	Co-payment %	Out-of-pocket (no ElderShield or CareShield Life)	% of per capita monthly household income	Out-of-pocket (with ElderShield \$300–400 or CareShield Life \$600 ^b)	% of per capita monthly household income
Social Day Care ^c	\$900	\$1,101–1,800	50–60%	40–50%	\$360–450	23–33%	Unlikely to fulfil payout criteria for ElderShield/CareShield Life	
IHDC Pkg 2 ^d	\$1,617	\$1,101–1,800	50–60%	40–50%	\$647–809	40–59%	\$47–509	3–32%

^a The lower-middle income comprises two bands under MOH's income band stratification: \$1,101–\$1,600 and \$1,601–\$1,800 (see Table 3.2).

^b To be eligible for ElderShield/CareShield Life payouts, the applicant must be unable to perform at least three of the six ADLs. We use \$300–400 in our calculations since it is the range for ElderShield payouts depending on the year of enrolment. In September 2007, ElderShield 300 was enhanced to ElderShield 400. Existing ElderShield 300 policyholders were offered a one-time opportunity to switch to ElderShield 400 (Source: https://www.moh.gov.sg/content/moh_web/eldershield/eldershield-300.html). For the enhanced CareShield Life scheme, we assume a fixed payout of \$600 per month for claims made in 2020.

^c We use Social Day Care (also known as Maintenance Day Care) instead of Senior Care Centre because the latter costs \$1600–\$2000, which is close to the cost of IHDC services. However, seniors who use Social Day Care do not usually qualify for ElderShield/CareShield Life payouts since they would not yet fulfil the severe disability criteria.

^d There are three types of IHDC packages and the cost increases with the intensity of care needed. Care providers advised that Package 2 was the most commonly used by clients.

Table 3.7 illustrates the case of upper-middle income families (\$1,801–\$2,600) whose subsidy drops to 30 per cent compared to the 50 per cent subsidy level of those earning \$1,601–\$1,800 per capita monthly household income (the upper band of the lower-middle income group; see Table 3.2 for income classifications). Social day care would cost \$630 for such families or up to 35 per cent of the family's per capita monthly household income. Even with

ElderShield/CareShield Life, the family pays a rather substantive co-payment of as much as 46 per cent of its per capita monthly household income for IHDC services. Without those insurance options, the co-payment burden increases to as much as 63 per cent for using the IHDC. This illustration of a family at the lower end of the upper-middle income category highlights the difference that earning a dollar more (in this case, \$1,801 versus \$1,800) makes to the amount of subsidies one qualifies for and the impact on a family's out-of-pocket expenses.

Table 3.7 Average co-payment for an upper-middle income family earning \$1,801–\$2,600 per capita monthly household income

	Full cost	Per capita monthly household income	Subsidy % (for SCs)	Co-payment %	Out-of-pocket (no ElderShield or CareShield Life)	% of per capita monthly household income	Out-of-pocket (with ElderShield \$300–400 or CareShield Life \$600 ^a)	% of per capita monthly household income
Social Day Care ^b	\$900	\$1,801–2,600	30%	70%	\$630	24–35%	Unlikely to fulfil payout criteria for ElderShield/CareShield Life	
IHDC Pkg 2 ^c	\$1,617	\$1,801–2,600	30%	70%	\$1,132	44–63%	\$532–832	21–46%

^a To be eligible for ElderShield/CareShield Life payouts, the applicant must be unable to perform at least three of the six ADLs. We use \$300–400 in our calculations since it is the range for ElderShield payouts depending on the year of enrolment. In September 2007, ElderShield 300 was enhanced to ElderShield 400. Existing ElderShield 300 policyholders were offered a one-time opportunity to switch to ElderShield 400 (Source: https://www.moh.gov.sg/content/moh_web/eldershield/eldershield-300.html). For the enhanced CareShield Life scheme, we assume a fixed payout of \$600 per month for claims made in 2020.

^b We use Social Day Care (also known as Maintenance Day Care) instead of Senior Care Centre because the latter costs \$1600–\$2000, which is close to the cost of IHDC services. However, seniors who use Social Day Care do not usually qualify for ElderShield/CareShield Life payouts since they would not yet fulfil the severe disability criteria.

^c There are three types of IHDC packages and the cost increases with the intensity of care needed. Care providers advised that Package 2 was the most commonly used by clients.

These calculations of out-of-pocket expenses do not include opportunity costs for family members who may have stopped work to be full-time or part-time caregivers, or variable expenses such as transportation between home and the care centre, which costs \$24 to \$43 per visit, according to care providers. MOH has disbursed close to \$100 million in transport subsidies, and grants for assistive devices and consumables, to more than 49,000 beneficiaries since the Seniors' Mobility and Enabling Fund was launched in 2011.²⁵ Even if this amount was used for transportation only, this would work out to approximately \$2,041 per person on average over seven years, or only \$291.55 per person each year, which is equivalent to a dozen trips per year at the rate of \$24 per trip by van.

Despite the subsidies and growing list of services available, many people who are referred by the Government to eldercare services do not use them. Perceived cost is a reason, say researchers who have studied the low take-up rates. But they also observed that "perceived affordability may not necessarily positively correlate with household income".²⁶ Families that earn \$2,601 or more per capita household monthly income would not be eligible for any subsidies and have to pay the full cost of eldercare themselves. As an example, the full cost of using day care and transportation to day centres can amount to nearly \$2,500 per month. A family of three which has a household income of at least \$7,803 would spend nearly one-third of its income on eldercare.

Despite the subsidies and growing list of services available, many people who are referred by the Government to eldercare services do not use them. Perceived cost is a reason.

As our analyses above indicate, the out-of-pocket expenses for eldercare can be substantial for middle-income families that qualify for lower subsidy levels or no subsidies at all, leading them to forgo community and home care. Our research with care providers and caregivers support these arguments.

THE FINANCING STRUCTURE AFFECTS HOW SENIORS CHOOSE CARE

"I might as well stay in hospital until I'm very well." That is what many older people think, knowing they can use Medisave to pay the hospital bill without incurring out-of-pocket expenses. The senior manager with a non-profit care provider who shared that observation was explaining to us how Medisave usage influences the way people make decisions on healthcare services. Many find community care or home care less appealing than being in hospital because they cannot use their Medisave to pay for the former and have to fork out cash. A study of patients undergoing rehabilitation from 2008 to 2009 found that only 40 per cent intended to continue with the recommended treatment after leaving inpatient care. By the third month after discharge, only 20 per cent remained in rehabilitation and, after a year, fewer than 5 per cent continued. Two reasons why patients gave up on rehabilitation were the financial impact of prolonged treatment and their lack of interest in continuing.²⁷ A more recent, as yet unpublished, study found that the proportion who continued with rehabilitation at the end of three months may have risen from 20 per cent to 50 per cent.²⁸ We note that this improvement coincided with the decision to allow Medisave to be used for community rehabilitation.

It does not stop with seniors choosing to remain in hospital. Although hospitals have introduced transitional care services partly to relieve the demand for beds by patients who do not need to be warded, patients are reluctant to use transitional care which can cost \$40 to \$250 per visit depending on the type of treatment. A hospital transitional care representative told us that as many as 20 per cent of patients turn down transitional care because of cost considerations or they do not want the hospital to contact them. As transitional care is considered a home-based service, such care is not payable by Medisave; this deters discharged patients from using those services. The representative of a non-profit care provider also observed that there are clients who return to hospital to see a specialist and collect their medicines there, so that they can pay with Medisave. Subsidised medicines are available at the centre run by the non-profit, but the clients would have to pay cash.

If seniors prefer hospitalisation or hospital treatment because they can use Medisave, this is a significant issue. Singapore's hospitals have experienced recurring episodes of bed shortages. In 2014, Health Minister Gan Kim Yong said the ageing population was a contributing factor to the high occupancy rate at public hospitals. According to MOH, the proportion of patients aged 65 and above who were admitted to public hospitals edged up from 30.2 per cent in 2015 (of 499,889 patients) to 32 per cent in 2017 (of 568,117 patients).²⁹ This is disproportionately higher than the percentage of elderly in the population — only 13 per cent are aged 65 and above.³⁰ One solution to relieve the demand for hospital beds would be to allow patients to

tap into subsidies and Medisave to pay for community and home care.

Currently it is possible to use Medisave to pay for home palliative care and some home therapy. From 2020 under CareShield Life, severely disabled Singapore residents aged 30 and above can use their own or their spouse's Medisave (once their own account no longer has sufficient funds) to withdraw up to \$200 each month for long-term care expenses.

However, just as with ElderShield, the qualifying criteria is restrictive as the applicant has to be unable to fulfil three or more ADLs. The policy change, though welcome, is likely to benefit only a limited pool of Singapore families and may be too late in the life course for older Singaporeans to receive the type of long-term care that would stave off ill health and delay frailty. As of FY2016, there was \$82 billion in unused Medisave balances and the amount has risen sharply in recent years.³¹ Allowing more Singaporeans the latitude to use Medisave for eldercare can encourage more who need eldercare services to use them. Safeguards against the careless use of Medisave can include medical screening for eligibility, assessment of the applicant's family circumstances, and setting limits on usage. Such measures already exist to assess eligibility for other types of help schemes, including Medifund, and can be extended to Medisave use for eldercare.

The payment structure used by Singapore insurers poses another barrier to older people using community and home care. Insurance can come in the

Allowing more Singaporeans the latitude to use Medisave for eldercare can encourage more who need eldercare services to use them.

form of company insurance, private insurance (with or without the Integrated Shield Plan), or ElderShield. The Integrated Shield Plan, which allows Singaporeans to purchase additional private insurance for healthcare, is mainly for hospitalisation and selected outpatient treatments such as dialysis or chemotherapy; only a handful of private insurers offer riders for home care and the take-up rates are unknown.

As a severe disability scheme, ElderShield/CareShield Life provides basic coverage only when a policyholder is not capable of performing at least three ADLs, a criterion that care providers in our study considered prohibitive for clients who have less severe disabilities but require financial assistance nevertheless. For such clients, long-term care costs could work out to a substantial sum. For example, the pre-subsidy costs of home nursing can range from \$65 to \$102 per visit, while home medical care can cost from \$150 to \$290 per visit. If an older person requires weekly visits by a nurse for three weeks followed by a monthly visit by the doctor, the family would incur \$345 to \$596 in home care costs alone, not including medical consumable expenses. Even with the more generous CareShield Life payouts, some families would be financially stretched without supplementary insurance.

There exists a few private insurance options for long-term care such as ElderShield Supplements, Integrated Shield Plan riders for home care, and standalone schemes that help Singaporeans manage

The level of public awareness towards private insurance schemes for long-term care does not appear to be high.

the costs of such care as they age. The level of public awareness towards private insurance schemes for long-term care, however, does not appear to be high; none of the care providers or caregivers in the study mentioned them.

Currently, ElderShield policyholders can purchase supplementary coverage from private insurers to cover moderate disability, and use up to \$600 per year from their Medisave to pay for the premiums of these Supplements. For example, a comparison of several ElderShield supplementary plans offered by private insurers illustrated that annual premiums for a payout of \$1,000 per month could range from \$349.14 to \$615 for a man enrolled at age 40, and \$448.60 to \$779 for a woman enrolled at age 40.³² This works out to monthly premiums of \$51.25 at most for men and \$64.92 for women, which appears to be relatively affordable for middle-income Singaporeans. According to MOH, however, only one in three ElderShield policyholders purchase Supplements.³³

The low take-up rates for ElderShield Supplements seem at odds with research done by consultancy firm Nielsen for NTUC Income and the Lien Foundation in 2016. The study found that nearly one in two of those aged 30 to 59 rated long-term care insurance among the top three instruments to finance eldercare. Most were willing to pay around \$180 each month for long-term care insurance which promised a fixed monthly payout and comprehensive coverage.³⁴ The apparent discrepancy between the low take-up rates for ElderShield Supplements and the expressed willingness to pay for long-term care found in the Nielsen study needs to be better understood; for example, whether it is due to the restrictive conditions of fulfilling a stipulated number of ADLs to

claim for benefits, perceptions that the different types of policy coverage offered are inadequate for one's eldercare needs, and/or a general lack of awareness towards the importance of long-term care insurance protection.

Three broader issues bear consideration. First, risk-pooling through both national and private long-term care insurance schemes can add flexibility to meet a wider range of eldercare needs, and there needs to be greater public education on the benefits of long-term care insurance. Second, greater public and private financing for preventive care and rehabilitative treatment to delay or even reverse frailty would also better prepare Singapore for ageing. Third, insurance for acute care, primary care and long-term care should be approached as a continuum. As one care provider said, acute and long-term costs care can be reduced by encouraging preventive care through primary care insurance that offers rebates (earned from premiums) to general practitioners who guide their patients in developing healthy lifestyle behaviour, thereby reducing visits to the doctor which then results in lower payouts by the insurer. Bringing the different types of insurance together would bring us closer towards an integrated eco-system of healthcare for better healthcare protection and fiscal sustainability.

More immediately, neither ElderShield nor CareShield Life adequately addresses the financing concerns of the current cohort of seniors. Those who opted out of ElderShield can switch to CareShield Life — but only from 2021, and they must not be severely disabled. For this group, subsidies for long-term care services and other assistance schemes are crucial. Older Singaporeans would also benefit from financial help even before they meet the current threshold of not being able to fulfil three ADLs. Rather than increasing the

payout rate at a fixed amount across the board as suggested for CareShield Life, we recommend a graduated payout rate depending on the number of ADLs one has. This would mean a wider range of older Singaporeans who have some degree of disability would benefit; moreover, it pegs payout rates to the level of care needed. Supporting treatment earlier in the disability process would facilitate rehabilitation treatment that could slow down frailty for the individual, and save costs in the longer term.

FUNDING CONCERNS OF CARE PROVIDERS

The care providers in our study acknowledged that the Government has established many funding schemes to help needy families offset eldercare costs and raised funding to support VWOs. They appreciated that MOH has regularly adjusted the norm costs to reflect the rising cost of eldercare. The norm cost is the observed average cost of providing a service, arrived at by comparing care providers. MOH subsidies for various services are calculated as a percentage of the norm costs. Nonetheless, the care providers highlighted several funding issues they would like to see improved so as to optimise service delivery and keep their operations sustainable. The main ones are:

Rather than increasing the payout rate at a fixed amount across the board as suggested for CareShield Life, we recommend a graduated payout rate depending on the number of activities of daily living one has. This would mean a wider range of older Singaporeans who have some degree of disability would benefit.

(a) Improving the coverage of funding under norm costs

Non-profit providers were appreciative that the Government has adjusted the norm costs regularly to reflect the rising costs of manpower, transport and utilities. However, exactly what constitutes the norm cost and how it is calculated was not clear to the providers. A key issue for them was the persistent gap between the norm costs and real costs of caring for medical and non-medical needs. They feel norm costs ought to consider the specific resource needs of different medical conditions, particularly in terms of manpower.

Dementia, for example, is known to impose a high burden on caregivers. The Institute of Mental Health estimates that dementia affects 10 per cent of those aged 60 and above.³⁵ Based on a Duke-NUS study that projected Singapore's elderly population (aged 60 and above) to be 1.3–1.4 million in 2030, this would mean that Singapore could potentially have 130,000–140,000 people with dementia in a dozen years' time.³⁶ According to care providers, the current norm costs for day care range from \$45 per session for social/maintenance day care, and \$58 to \$68 per session for dementia care. Dementia care is more labour-intensive than social day care which usually comprises basic care and simple exercises for a frail elderly person. Yet, the difference in the norm costs for social day care and dementia care is slight (\$13–\$23) compared to the difference in manpower costs required. Since means-tested subsidies are tied to norm costs, the relatively low level of norm costs for dementia care can deter providers from offering such care. The representative of a non-profit

provider said MOH should review the resources given to run dementia care programmes. Her VWO was driven by its mission to serve and went into providing dementia care knowing from the start that it would be “a bleeding game” and it has to raise the funds needed to sustain the programme. “It is very laborious,” she said. “You need a lot of encouragement on the ground to keep it going.”

Although MOH provides higher funding for different types of services in recognition of the need for manpower resources, care providers pointed out that shortfalls in manpower funding remain. Such shortfalls would need to be met by charity dollars.

(b) Mitigating the burden on charity dollars

All the non-profit providers who participated in our study emphasised that as charities, they have to raise funds to cover the cost of their operations. The Community Silver Trust provides matching dollar-for-dollar funds for donations raised by charities; it received a \$300 million top up from the Government in 2018 to support the long-term care sector.³⁷ However, the onus for fundraising still falls on charities. As ageing needs increase, the sustainability of chasing charity dollars has to be reviewed carefully. A recent study on long-term care financing in Singapore estimated that up to 9 per cent of such financing is met by charitable contributions.³⁸ Our study, however,

The onus for fundraising still falls on charities. As ageing needs increase, the sustainability of chasing charity dollars has to be reviewed carefully.

found that for an individual organisation, charitable contributions needed to offset the actual operating costs can range from about 10 to 70 per cent of the full costs of a service, depending on the type of service and the VWO's client base.³⁹ Table 3.8 shows figures from an anonymised care provider for its home-based services. We use the case of a lower-income family that qualifies for 80 per cent subsidy after means-testing. The figures show that for this care provider, charity contributions offset 29 to 41 per cent of the full costs of the various home care services.

Table 3.8 How Charity Helps to Offset the Cost of Home-Based Care

Service	MOH norm cost	Full cost	Means-tested subsidy (80% of norm cost) ^a	Client's actual co-payment ^b	What charity covers (actual amount and % of full cost)
Home nursing (per visit)	\$109	\$139.43	\$87.20	\$12.00	\$40.23 (29%)
Home therapy (per visit)	\$129	\$205.09	\$103.20	\$18.00	\$83.89 (41%)
Home personal care (per hour)	\$22.67 (Tier 1) \$22.78/hr (Tier 2)	\$28.67/hr	\$18.14/hr	\$2.20/hr	\$8.33/hr (29%)

^a Maximum subsidy for families earning \$700 or less per capita monthly household income. The client co-payment portion may still be eligible for ElderShield, Medifund or other government assistance subject to eligibility assessment.

^b Amount paid by the client is less than 20 per cent of the remaining norm cost as some of it is absorbed by the charity.

Source: Anonymised care provider.

When there is a shortfall, charity and fundraising help make up the difference. A non-profit provider said: "We can say we want to increase the price, but can the consumer pay? That is the issue — somebody must pay." Another non-profit involved in centre-based and home-based care said it raises up to 20 per cent of the costs of service delivery through an annual flag day, charity dinner, and a variety of activities to attract sponsorships and donors. This reliance on charity dollars means non-profit providers have to divert manpower to fundraising activities. They have found that donors are prepared to help clients directly, but are less keen to help cover the cost of manpower needed to run the services.

If charity continues to be the back-up source of funding, the demand for donations will only keep growing as the population ages and services expand. As far back as 1999, the report by the Inter-Ministerial Committee on Healthcare for the Elderly pointed out that it would not be financially sustainable for VWOs to keep raising a significant portion of their operating expenditure and recommended limiting it to 20 per cent.⁴⁰ It is unclear how that recommended proportion was determined at that time. More discussion is needed today on what charities feel would be a manageable and sustainable level of fundraising. Whether eldercare should be part of funding channels such as Medisave, Medifund and MediShield Life would also be best addressed through a national dialogue. The problem is that many components of eldercare are not regarded as part of healthcare but as charity, a senior manager from a non-profit provider of palliative care told us. "Do we see eldercare, eldercare services, and everything that we do as mainstream or not? That's fundamental to the whole discussion," she said.

(c) More support for private providers

MOH provides funding support for manpower and training to eligible private providers in community care, and allows private providers to tender for portable subsidies for centre-based services, home care and IHDC tenders. However, private care providers feel they are up against non-profit providers that have an unfair advantage as beneficiaries of both government funding and charitable support. A private provider noted that the extra support gives VWOs a greater advantage in the competition for an already limited pool of labour. Participants in our study also hope to see funding extended to private providers of social care for the elderly. A private provider said MOH had previously rejected her request for funding because her centre provides half-day social activities rather than the type of medically oriented services at Social/Maintenance Day Care and Senior Care Centres. She felt that her clients were elderly people who needed care, and deserved subsidies too. With MOH taking over eldercare services previously overseen by MSF, participants in our study hoped that more funding options will become available for private providers in social care.

FUNDING CONCERNS OF CARE RECIPIENTS

When we examined the experiences of eldercare recipients, three issues to do with affordability emerged. There is a range of government funding schemes,

but they may come with conditions that get in the way of delivering care to the elderly who need it. Funding restrictions have an impact on the choices the elderly make and their access to services available.

(a) Funding caps: Put people's needs at the centre

A non-profit provider of rehabilitation care pointed out that different types of home therapy are lumped together as "rehabilitation" to qualify for subsidies. MOH subsidies come with limits on either the number of visits or the maximum period for receiving treatment. Physiotherapy, occupational therapy and speech therapy are all regarded as "rehabilitation" to be delivered over a maximum of 18 visits, or for up to six months, whichever comes first. However, post-stroke patients may need a combination of all three treatments. Depending on the client's condition, the care provider may recommend more sessions of physical and occupational therapy first, to be followed by speech therapy. But, given the MOH limits of 18 visits or six months, clients may choose not to proceed with speech therapy if they are no longer eligible for the subsidy and will have to pay the full price. The VWO representative said: "Most people, especially if they feel a little cash-strapped, would rather forgo speech therapy, even though it helps with swallowing and speech. It's just as important as physiotherapy and occupational therapy."

Participants in our study also identified some restrictions of the Seniors' Mobility and Enabling Fund (SMF) that deserve relooking. The

SMF supports ageing in place, allowing the elderly to get subsidies for a range of purchases such as wheelchairs, walking sticks and hearing aids to hospital beds, commodes and adult diapers, as well as specialised transportation to MOH-funded care services. Notably, the elderly person is allowed to buy only one wheelchair using the SMF, but may outlive it and need it replaced. The Assistive Technology Fund administered by SG Enable provides an alternative funding source for persons with disabilities to purchase assistive technology devices to enable independent daily living, but it does not offset other types of healthcare consumable costs. Although the SMF offers financial assistance to buy a range of healthcare items, care providers say the total cost of diapers and other medical consumables can easily exceed the funding limit. One care provider representative said the \$1,200 provided by the SMF is enough for just a year's supply of regular diapers, probably medium-sized. That financial support runs out faster if a client needs larger-sized diapers, or insists on changing diapers frequently. Greater flexibility in funding would be more consistent with putting patients' needs at the centre of eldercare.

(b) Make eldercare more affordable for lower-income families

Although there are different funding schemes available for eldercare, the mounting costs of care can become prohibitive over a prolonged period, especially for frail older people with multiple care needs.

Even after qualifying for subsidies, those who use eldercare services are expected to co-pay a portion of the costs. Centre-based care providers told us affordability remains an issue for lower-income elderly. They may qualify for 80 per cent of the cost to be covered by subsidies, but even that may not be enough for some. One centre representative said that if the total monthly bill is \$1,000 and the client qualifies for \$800 in subsidies, he or she must still pay \$200 a month out of pocket. "For any elderly person with no income, that is very hard," the centre representative said.

Participants at a focus group discussion recalled instances of discharged patients rejecting care services they would benefit from, because of the cost involved. One described how clients get alarmed when the hospital social worker mentions charges. "Even before receiving more information about the service, the client says: 'No, I don't want all this.'" Another participant said: "Most of our clients either live on life savings or handouts, so to them, every cent counts. They think, 'I have only this much of life savings. If I don't spend it wisely and I don't have enough, how?'"

At another focus group discussion on home-based care, a non-profit representative estimated that home therapy may cost as much

“Most of our clients either live on life savings or handouts, so to them, every cent counts. They think, ‘I have only this much of life savings. If I don’t spend it wisely and I don’t have enough, how?’”

as \$280 a month after the maximum 80 per cent subsidy for lower-income families, and that sum is prohibitive for someone with a per capita monthly household income of \$700 or below. A non-profit representative recalled the case of an elderly woman with Parkinson's Disease who was sometimes left at home alone when her husband, the sole caregiver, had to run errands. On one such occasion, she fell and broke her nose, and it bled profusely. The case was referred to the VWO's day care services centre because the couple looked like they needed support. As soon as the husband heard about having to co-pay, he turned down the offer of eldercare services.

The poorest families who cannot afford to co-pay even after subsidies can apply to Medifund⁴¹ (or Medifund Silver) if they use MOH-accredited ILTC facilities, including for some home-based services. However, care providers noted that Medifund cannot be used for social care and home personal care, and not all the lower-income elderly want to get means-tested for Medifund because some elderly are estranged from their children and the last thing they want is for their children to get involved.

Care providers were also concerned about lower-income families who cannot afford items not covered by Medishield and Medisave; these include transportation, medical escort services and medical consumables. A portion of these costs can be covered by the Seniors' Mobility and Enabling Fund, but expenses in excess are still the responsibility of an individual. The care providers mentioned that

such costs for a diabetic patient could add up to as much as \$1,000 a month if a client tests his or her sugar levels three times a day and uses a new needle each time. To ensure that families with co-payment difficulties do not end up forgoing necessary eldercare, it would be helpful to expand Medifund coverage to offset the costs of transportation, medical escort services and medical consumables beyond what is available through existing government schemes. Extending Medifund coverage to social care within the community and home personal care would also be consistent with a more holistic understanding of eldercare.

While the lowest income can qualify for Medifund to offset those costs, families who do not qualify for Medifund will have to pay for such costs themselves. The case of Madam Wong's family illustrates how families struggle with out-of-pocket expenses despite subsidies, and transportation costs that are not eligible for means-tested subsidies. (See story next page)

RESILIENT BUT STRUGGLING AND ANXIOUS

Madam Wong is 73 years old, and has been in poor health for eight years. She was diagnosed with kidney failure in 2010 and, a year later, was found to have ovarian cancer. Chemotherapy brought the cancer under control, but she still needs dialysis three times a week. Madam Wong also attends a maintenance day care centre run by a VWO for five days a week.

She has only one child, Chee How, who is married with two teenaged daughters and they all live together in a four-room Housing Board flat. Chee How is the main breadwinner, earning about \$4,000 a month. His wife, May, is Madam Wong's main caregiver though the elder daughter, who is 18 years old, helps occasionally. Money is tight, with both girls receiving financial assistance from their

schools. Although already stressed by her caregiving responsibilities, May is trying to take on occasional part-time work to supplement the family income.

Madam Wong receives a 75 per cent means-tested subsidy from the Government (as a percentage of the MOH norm cost) and an additional subsidy from the VWO for using the day care centre and for two-way transportation costs. Without subsidies, the total cost for day care and transportation would have put the family back by nearly \$2,500 per month. The VWO subsidy covers about 40 per cent of the actual full cost.

Thrice a week, Madam Wong also goes for dialysis which is paid for mainly through a combination of private insurance, subsidies, Medisave and cash. She takes a taxi home after dialysis since transport from

the dialysis centre is not provided and she is too frail to take a bus; such transportation expenses are not subsidised. The family also incurs additional out-of-pocket transport expenses when an ambulance has to be called for Madam Wong (for example, when she experiences respiratory distress), which can happen a few times a year.

Despite the considerable subsidies, there is still a co-payment portion required of the family for using eldercare services. Madam Wong does not qualify for ElderShield payouts. The family pays more than \$700 each month, after subsidies, for her day care, transportation, and hospitalisation insurance which helps offset the costs of dialysis. Whenever possible, they use Medisave to pay for the bills. Occasionally, Madam Wong receives government top-ups (e.g.

Pioneer Generation package) to her Medisave account. But over the years, both Madam Wong and Chee How's accounts have been depleted by the medical expenses for chemotherapy and dialysis. The day care and dialysis bills put an additional strain on the family's finances.

Although they struggle to pay the bills, May and Chee How firmly believe that they should cope with their caregiving responsibilities to the best of their ability. Nonetheless, they expressed anxiety about their ability to continue to finance Madam Wong's eldercare costs over the longer term, and what the future holds should Madam Wong's condition deteriorate further. If the latter happens, it could mean an even greater financial burden on the family.

(c) Middle-income families need help too

Singapore's middle-income population is heterogeneous and covers a wide income range. Income level or household type are used as indicators of a family's ability to afford eldercare services, but there are other factors such as the number of older members the family is responsible for beyond the immediate household, other dependants in the family including those with special needs, and the period of extended eldercare required. As discussed earlier, middle-income families who qualify for fewer and lower subsidies under means-testing have to bear heavier financial costs for eldercare. These families are also often "sandwiched" between caring for their children as well as older family members — in some cases, two sets of ageing grandparents. A senior manager of a non-profit provider noted that when such families enquire about care services, some do not take up the services when they realise the cost involved.

VWOs could try to help if families mention their financial difficulties, but few ever say they cannot afford to pay. Providers suspect that middle-income earners are embarrassed to "lose face" if they admit they are cash-poor. Another non-profit representative described older people who are "asset-rich, but cash-poor"; they own property, including private property, but do not have savings. Although they might be a household with no income, the annual value of their property disqualifies them from receiving government


subsidies for long-term care.⁴² An earlier study found that these people were reluctant to sell their homes and downgrade because of a sense of rootedness and familiarity.⁴³ The "sandwiched class" and families that are "asset-rich, cash-poor" are only two examples of middle-class Singapore families who face financial difficulty related to eldercare needs. Some receive financial assistance on a case-by-case basis, but the criteria to qualify for such assistance are unknown. More generally, providers say that when these families that do not qualify for assistance have to use care services, they take only the minimum because they cannot afford more.

The label "middle-income" does not capture the variety of personal circumstances that are also considered during government evaluations for subsidies. What we can infer, however, is that as this segment of the population ages, the increasing eldercare needs of the middle-income will be of growing concern. For middle-income families currently caught in a bind, the approach of assessing their needs on a case-by-case basis is a commendable transition measure. However, planning must start now to prevent more families from falling between the cracks in future. The ElderShield Review Committee Report, for example, encourages Singaporeans who wish to have additional benefits to consider private insurance as supplementary protection. However, as highlighted previously, the current schemes do not seem sufficiently appealing to Singaporeans

(e.g. in terms of value, coverage and threshold for benefits for claim). Public education to raise awareness of the importance of financial planning for eldercare is also necessary.

Integral to financial planning is also the need for improving both pricing transparency and the financial literacy of families when it comes to the costs and payments for eldercare services. Our interviews with caregivers suggest that most, even middle-income and well educated families, do not always fully understand how the costs of eldercare and subsidies are derived. Sample invoices that we obtained do not indicate the unsubsidised or actual cost of running an eldercare service, or the percentage level at which subsidies (either from the Government or through charities) are pegged. Not all invoices differentiate the amount of charity dollars that goes into subsidising a patient's care compared to subsidies from the Government. Such opaqueness makes it difficult for families to assess whether they are paying more, or less, for the same service compared to those by other providers. Providing such information on the invoices would enable patients and their families to better understand their co-payment expenses. Such information would facilitate families in their decision-making regarding selecting eldercare services as well as better equip Singaporeans to fully comprehend the costs of care as they plan for their families and their own future eldercare needs.

The issues raised by care providers and caregivers tell us we need a fuller conversation not only about eldercare but also the

health culture of this country. It cannot be only about the problems that arise in old age and the services we need to respond to them. It is not a conversation for and about the elderly only. Younger people have to join in too, because the greying of Singapore involves and affects them too. We have to talk about health insurance and long-term coverage, the value of regular health screenings, good nutritional diets, exercise and healthy lifestyle habits. We need to discuss relationships, within families and within families whose ties are broken. There are eldercare questions for healthcare providers and neighbourhood general practitioners (GPs) who can talk to elderly patients and remind them to take their medication or press on with physiotherapy and rehabilitation, or advise them about preventing falls and injury, as well as the availability of aids and devices that keep them safe and independent. The Government needs to engage with citizens in a national dialogue as it reviews the wider Healthcare Masterplan to meet the evolving needs of older Singaporeans. We need a clear understanding of what Singaporeans consider a desirable and sustainable eco-system of health and care across the life course. 

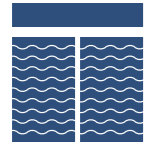
We need a fuller conversation not only about eldercare but also the health culture of this country. It cannot be only about the problems that arise in old age and the services we need to respond to them.

ENDNOTES

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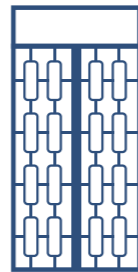
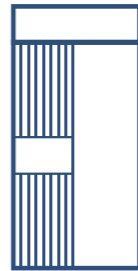
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4 WORKING IN ELDERCARE: IT'S SO HARD, WHY DO IT?

Developing human resource
capacity; valuing workers more



THE ELDERCARE SECTOR needs good workers, and more of them at all levels, as services expand and the number of seniors rise. Efforts to shift eldercare demand from hospitals and nursing homes to community care services at centres or in the home depend crucially on a sustainable supply of trained staff. They have to be a mix of doctors, nurses, physiotherapists, occupational therapists, speech therapists, administrators and managers, as well as an army of support staff who include personal caregivers to help the frail or disabled elderly with everything from bathing, getting dressed and feeding to going to the toilet and clipping their fingernails and toenails. Much of it is demanding work, physically exhausting and mentally and emotionally draining, and the hours can be irregular because emergencies will happen when an elderly person has a fall, or a sick senior takes a turn for the worse. Everyone in the eldercare sector agrees that it takes training, dedication and a lot of heart to work in this sector. Little wonder, then, that attracting and retaining workers is a major challenge, staff turnover is high and Singapore relies on large numbers of foreigners to make up for the shortage of Singaporeans especially at the lower end of the occupational ladder.

It takes training, dedication and a lot of heart to work in this sector. Little wonder, then, that attracting and retaining workers is a major challenge.

ENSURING A SUSTAINABLE SUPPLY OF HEALTHCARE WORKERS

The Government has long recognised the never-ending shortage of healthcare workers and other caregivers in the eldercare sector, and the need to grow a local supply. Nurses are acknowledged as being the backbone of efforts to build up the intermediate and long-term care (ILTC) sector and transform the healthcare system by delivering preventive and primary health services to seniors with multiple conditions. In 2012, a National Nursing Taskforce was set up to suggest ways to strengthen the profession, including how to attract and retain nurses.¹ In 2014 the Government accepted its recommendations in four areas, to:

- Increase pathways for nurses' career development;
- Expand nurses' autonomy and decision-making authority;
- Improve recognition through pay increments and awards; and
- Provide more educational opportunities, with an emphasis on community nursing and rotation through the ILTC sector.

In addition, the Ministry of Health (MOH) is developing a framework to assess skills, career development and remuneration for workers across the range of jobs in healthcare, including nurses, allied health professionals and support care staff.

Several schemes and policies under the Action Plan for Successful Ageing aim to increase the capacity and quality of eldercare workers and develop the healthcare workforce, especially in terms of growing the local pool. These

include training courses and capability-building programmes to improve the quality of centre-based and home-based care, and dialogues between government and industry players on manpower-related issues.² Among other things, MOH and the Agency for Integrated Care (AIC) have also done the following:³

- Embarked on sector branding and worked with community care providers and recruitment partners to facilitate employment of individuals through recruitment fairs and raise awareness of job opportunities in the community care sector.
- Worked with Workforce Singapore to establish professional conversion programmes for mid-career Singaporeans to be trained as registered and enrolled nurses, physiotherapists, occupational therapists and diagnostic radiographers, as well as administrative and executive positions in the healthcare sector; and increased funding for such training.
- Worked with tertiary educational institutions to introduce new programmes to train allied health professionals. Among others, the Singapore Institute of Technology started programmes in physiotherapy, occupational therapy, diagnostic radiography and radiation therapy in 2016; the Institute of Technical Education started a diploma course in rehabilitation care in 2018; and the National University of Singapore is starting a two-year Bachelor of Science (Nursing) programme in late 2018.

- Established a scheme for Singaporeans with managerial experience to make a mid-career switch to the aged care sector. The Senior Management Associate Scheme facilitates their recruitment and provides funding support to providers for their remuneration and benefits.⁴
- Improved financial incentives to encourage non-practising local nurses to return to the healthcare sector and work in aged care.
- Improved the Community Care Traineeship Programme for new support care staff to pick up core skills and encourage Singaporeans to work as healthcare and therapy assistants. Providers are eligible for On-the-Job Training support of \$10,000 per local support care staff recruited, to facilitate mentoring, supervision and development of new hires. New local support care staff will be eligible for a retention bonus of \$3,000 after their first year of service.
- Focused more on training community nurses. MOH has been working with the Regional Health Systems to deploy nurses to community care partners for exposure to different aspects of community nursing. It is also working with the nursing profession to develop community nursing as a career track, including offering a Community Nursing Scholarship to attract O- and A-level students, and in-service nurses, to become nurses in this area.

Community nursing is important in enabling preventive health through public education, providing direct care to patients in their homes, especially after they are discharged from hospital, and supporting dementia care and palliative care. It was reported in late 2017 that MOH would invest approximately \$12 million over the next four years on training programmes to upgrade the skills and career opportunities of community care staff.⁵ To support the work done by full-time eldercare workers, the Government initiated the Community Network of Seniors to work with voluntary welfare organisations (VWOs) and grassroots organisations and enlist volunteers to befriend and assist the elderly in their neighbourhood.⁶

The Government has also increased support for households to care for elderly family members. Since 2012 more than 18,000 lower and middle-income families have benefitted from the Foreign Domestic Worker (FDW) grant that offsets the cost of hiring foreign domestic workers to care for seniors or persons with disabilities. Additionally,

It was reported in late 2017 that MOH would invest approximately \$12 million over the next four years on training programmes to upgrade the skills and career opportunities of community care staff.

between 2013 and 2017, about 34,000 caregivers tapped on the Caregiver Training Grant. In 2017 alone, close to 8,000 caregivers used the grant to attend training, a 15 per cent increase from 2013. Between November 2016 and December 2017, close to 300 foreign domestic workers were trained under the ElderCarer FDW Scheme.⁷

According to MOH, Singapore may need another 10,000 workers in the eldercare sector between 2015 and 2020,⁸ as the number of Singapore residents above the age of 65 is projected to reach 610,000 in 2020, up from 460,000 in 2015.⁹

As of March 2017, there were 8,300 direct care staff in the long-term care sector working in nursing homes, day care centres for seniors and in providing professional home care services.¹⁰ This number is expected to grow to 12,000 by 2020¹¹ — a jump of about 45 per cent in three years. This seems like a tall order, given that the sector is still plagued by relatively high turnover rates. A recently released study on long-term care manpower by the Lien Foundation found that the biggest demand is for direct care workers such as nurses, therapists, doctors, healthcare assistants and nursing aides, who are estimated to make up 75 per cent of the long-term care workforce. The remaining 25 per cent comprises workers in finance, human resources, administrative and ancillary roles.¹²

Singapore's eldercare sector is more reliant on foreign workers compared to other fast-ageing countries in the region. While official figures are not

available, the care providers in our study estimate that foreigners account for about three-quarters of direct care workers, including doctors, nurses, therapists and nursing or therapy aides, with many working in "support care" roles, assisting nurses or therapists. In a bid to reduce dependence on foreign workers, MOH has been working with AIC on initiatives to support community care providers in recruiting more locals and retain existing ones. Separately, MOH has also worked with providers to raise salaries of both local and foreign staff in the community care sector by around 30 per cent, in tandem with salary increases in the public acute care sector since 2012.¹³ It also extended some \$200 million to participating providers in the sector over the last six years to raise long-term care workers' salaries.¹⁴

These measures appear to have had some effect as attrition in the sector went down from 17 per cent to 14 per cent in recent years.¹⁵ However, salary levels for support staff, in particular, continue to be much lower than what is offered for similar jobs in Hong Kong, Japan, South Korea and Australia. To guide providers who have the flexibility to determine remuneration based on their pay philosophies, MOH shares aggregated sectoral salary information with providers through an annual salary survey. However, our study shows that more needs to be done, a view supported by the Lien Foundation survey on long-term care manpower. (See story next page)

FOREIGNERS HOLD UP ELDERCARE IN SINGAPORE, BUT SEEK BETTER PAY, PROSPECTS ELSEWHERE

Any discussion on eldercare manpower must recognise that the caregiving crunch is global. Many other advanced ageing nations — in the Asia-Pacific, Europe and North America — are facing a big shortage in workers to look after their growing ranks of seniors. In view of this, the Lien Foundation released a study in July 2018 which evaluates Singapore's long-term care manpower needs and the pay and prospects of its long-term care workers in comparison to four other ageing Asia-Pacific economies — Japan, South Korea, Hong Kong and Australia. Conducted by a leading international consultancy, the study is based on an in-depth literature review, interviews with around 35 care providers in the five countries as well as a face-to-face survey of 250 long-term care workers and 50 hospital workers in Singapore.¹⁶ Unlike official manpower surveys which poll only Singaporeans and permanent residents, the Lien Foundation survey included foreign workers, who form the bulk of the direct care workforce in Singapore.

The study revealed important findings. First, although Singapore has the second-highest national median wage among the five economies surveyed,

its long-term care workers are the lowest paid. The pay disparity is especially wide among support care workers, such as nursing aides and healthcare assistants who make up the majority of the care work force. Local support care workers, who assist nurses and perform personal care chores, for instance, are paid around S\$1,350 per month, whereas foreign workers doing the same work are paid around S\$850. By comparison, a support care worker is paid a post-tax salary of S\$3,300 in Australia, S\$3,000 in Japan, S\$1,830 in South Korea and \$3,750 in Hong Kong.

While no official figures are available, the Lien Foundation study estimated that foreigners make up around 70 per cent of the direct care workforce in Singapore, compared to around 30 per cent in Australia, 10 per cent in Japan and less than 5 per cent in Hong Kong and Korea. Significantly, foreign and local workers are paid the same in all four countries except Singapore.

Competition for these workers is heating up. Hong Kong, which has strict controls on foreign workers in the formal eldercare sector, is considering liberalising its foreign worker policies, given the

staff shortage. Australia has been actively hiring foreign workers for its aged care sector in recent years, with a 2016 government study estimating that among recently hired workers employed for a year or less, the percentage of foreign or foreign-born workers has climbed from 34 per cent in 2007 to nearly 40 per cent in 2016.

The Singapore Government has been trying to build up a local core of workers and wean the sector off its over-reliance on foreigners. This has proven tough, given not only the nature of the job, but also because the pay and working hours in the long-term care sector are simply not attractive to Singaporeans. In the Lien Foundation study, long-term care workers in Singapore worked the second-longest hours per week after those in Hong Kong. The study also showed that unlike those in Singapore, long-term care workers in the surveyed economies earn a relatively higher pay compared to many other low-income jobs. A receptionist, office clerk, department store clerk or bank teller in Singapore, for example, is paid more than a nursing aide, which is not the case in places like Hong Kong, Australia, Japan and Korea.

Dissatisfaction with pay was the biggest bugbear for local long-term care workers in Singapore, while for foreigners it was the lack of promotion opportunities.

It is no wonder then, that long-term care workers in Singapore do not stay long. The study found that nearly 55 per cent of foreign workers work in their companies for two years or less, with an average tenure of 2.8 years across nursing homes, home care and day care centres. More than 40 per cent of the foreign workers surveyed said they were likely or very likely to consider leaving Singapore. Canada and Australia were the top choices of where they would prefer to work. Including locals, Singapore's long-term care workers worked in their companies for an average of 3.4 years, compared to nearly eight years for hospital workers.

On the positive side, Singapore's long-term care workers receive more on-the-job training, amounting to 75 hours per worker per year, than workers in all the other economies surveyed. Close to eight in 10 workers also felt they were learning and growing in their roles, and making a positive impact on the lives of seniors.

COMPETITION AND POACHING IN THE LONG-TERM CARE SECTOR

Care providers in the long-term care sector compete for a limited pool of healthcare workers. Non-profit and private providers in our study said it was hard to retain trained and experienced staff because of strong competition and high turnover. Several lamented that younger workers, especially, accepted jobs in smaller organisations as a stepping stone to landing a position with a larger employer after gaining two or three years of experience and training. In particular, providers find it hardest to compete with restructured hospitals for clinical staff. Hospitals offer a more prestigious working environment and career advancement opportunities, besides paying well and affording the support of a team of colleagues.

Even when hiring newly qualified local healthcare workers, care providers find themselves in line behind hospitals. Many nursing diploma students, for example, have scholarships from the Regional Health Systems and are required to serve a bond when they graduate. A care provider who set up a recruitment booth at the careers fair of a polytechnic related how the graduating students kept saying they already had hospital jobs, thanks to the terms of their scholarships.¹⁷ Unless enrolment rises dramatically, the competition for newly minted healthcare workers is only likely to intensify given the new general and community hospitals that have opened in recent years or are due to open — Ng Teng Fong General Hospital in 2014; Jurong Community Hospital and Yishun Community Hospital in 2015; Sengkang General and Community Hospitals in 2018; Outram Community Hospital in 2020; and four more by 2030.¹⁸ These new healthcare institutions will contribute to an expanded demand for thousands more care workers. When

supply is tight, one care provider representative said, staff get poached.

Non-profit providers hoped that hospitals, with their greater human resource capacity, would do more to work with providers to improve eldercare in the community. If hospitals released more nurses and support care staff to do transitional care in the community, they would not only be supporting the work of community care providers, but also helping to reduce readmissions to hospitals. This would be a win-win situation for all, the care providers felt.

CHANGE DIAPERS? NO THANKS, SAY SINGAPOREANS

Care providers had no shortage of reasons to explain why it is hard to recruit and retain staff. A key issue is Singaporean workers' attitudes to performing the tasks involved in caring for the elderly, frail and ailing. This is work that requires dedication and the right attitude. Care providers have found that Singaporeans, especially the young, are generally averse to hands-on work associated with the bodily care of the elderly at care centres and in the seniors' homes. "Assisting with activities of daily living" is a tidy description that masks the reality of cleaning, wiping, bathing, drying, feeding, and maintaining the personal hygiene of the elderly person. Some new care staff imagine that eldercare is about befriending seniors, "elder-sitting" and escorting clients to and from appointments. They get a rude shock when they realise the job includes changing diapers, and some stop coming to work after just a few days. The representative of a large non-profit provider running an Integrated Home and Day Care (IHDC) said: "We provide showering at our centre, diaper changing. The young people don't want to do this work. It is difficult to get young blood in."

Home visits are physically demanding and a care worker may have to travel by public transportation to several homes in one day, and get down to work immediately, regardless of the state of the elderly person or the home. Some clients can be grumpy or unhappy. Others have family members who do not hesitate to tick off the care worker if they are unhappy with what the worker is doing. Some homes may be filthy or infested with bugs. A non-profit provider said many Singaporeans were unable or unwilling to endure the demanding and unpleasant aspects of the job. “You need to really hold the person up and shower them, or clean the house. Sometimes the homes of the elderly can be quite messy,” she said. The representative of another non-profit providing home care services said: “We really have to give credit to those doing home care because rain, shine, whatever, you still got to go. Then, regardless of what state the house is in, or the elderly person’s state, you have to serve. Sometimes you get scolded by family members for coming late.” When they cannot tolerate the job any longer, care workers quit, sometimes at such short notice that the organisations are left scrambling to find replacements.

Care providers stressed repeatedly that possessing the right attitude to work in eldercare is almost as important as having the skills, and it is not easy to find workers with both. Community nurses need the right attitude especially because they do home visits on their own. Good nurses may have

Care providers stressed repeatedly that possessing the right attitude to work in eldercare is almost as important as having the skills, and it is not easy to find workers with both.

the qualifications and skills, but not the heart to work with the elderly. A non-profit provider said those who prefer working 9-to-5 and dislike shift work can be put off by having to make home visits. For those who persevere and are willing to learn, the right attitude and commitment can be cultivated. A hospital transitional care representative noted that some nurses rotated through community nursing may start off feeling resentful, but change remarkably after a while. “I see the nurses going into the community, waving to the aunties, organising birthday parties on their own. They use their own pocket money to buy cakes, it’s so amazing,” he said.

Participants in our study pointed out another area that left staff feeling frustrated and strained efforts to retain workers: administrative chores, which include submitting reports and collating data about their operations and programmes to the Government, and fundraising. Many non-profit providers described staff who were overstretched by having to multitask because voluntary welfare organisations (VWOs) do not have funding to employ more administrative workers. Compiling statistics and preparing the paperwork to meet their key performance indicators or explain new programmes took up scarce resources which the care providers would prefer devoting to clients’ needs. When participants of a focus group discussion were asked if their organisations had raised the issue of funding for administrative staff with the relevant ministries, there was laughter all round. “MOH feels that the same person should do everything,” one representative said. “You’ve got to know how to counsel the elderly, run programmes, and do all the paperwork.” MOH clarified that administrative costs are factored into the subventions to VWOs, though they

are not stated as a separate line item, which may have led some VWOs to think their administrative staff are not funded. Nevertheless, care providers reported that their administrative load was a burden to bear, and cautioned that this will continue to discourage staff from remaining in the sector.

POOR PAY AND CAREER PROGRESSION IN THE SECTOR

Several factors contribute to the less-than-positive perceptions of long-term care sector jobs, of which remuneration and career progression are foremost. Non-profit providers acknowledge that pay is the main reason for the shortage of workers. Private providers felt the same way, noting that “our caregivers work very hard, so they ought to be paid well. And caregivers should not be subsidising care seekers, because they themselves have lives and families to feed”.

While the salary gap between the acute care sector and community and home care sector has narrowed over the years, one VWO representative estimated that VWOs generally offer only 70 or 80 per cent of what hospitals pay. Although nurses’ salaries were adjusted in 2014 and 2015 based on the nursing taskforce’s recommendations, the adjustments of 3 per cent to 10 per cent apply to public/restructured hospitals and intermediate and long-term care (ILTC) providers receiving MOH subventions.¹⁹ While this was good for the nursing profession overall, it reinforced nurses’ preference for working in hospitals. Other types of healthcare workers also earn more in hospitals. A 2016 news report noted that junior therapists earn about \$3,500 in hospitals, compared to S\$2,800 a month in nursing homes.²⁰ To attract more staff to

community care and retain them, more incentives are needed.

At the same time, however, non-profits emphasised that while remuneration plays a big part, working in the eldercare sector is not about money alone because “these are jobs done from the heart”, as one representative put it. To reduce the demand for workers, care providers were keen to see greater use of technology in home care. Available technology includes robotics such as mobile hoists and other forms of automation used in the homes of the elderly. They felt that using more technology might even attract younger Singaporean workers to the sector.

When it comes to the challenges of retaining staff, the non-profits are more concerned about the lack of career progression opportunities in the long-term care sector compared to hospitals. This was a recurring theme, and one non-profit provider explained that the VWO staff structure is relatively flat even in large organisations, with not many senior positions to aspire to. Paying more is the alternative form of reward, but VWOs face limitations on that front as well. Another non-profit provider said the situation is worse in small organisations which have just “one nurse and one senior nurse”. The manager of a Senior Activity Centre said non-clinical staff raise similar issues as well, and her programme staff questioned her regularly about their career prospects, asking: “How do we move up the career ladder? Does the centre have only one programme exec and one senior programme exec? If the person is there forever, then where’s my chance to move up?”

While some care providers felt that having clearer career paths might help them retain staff, others said that what the sector really needs are a more

professional image and greater recognition for non-clinical staff, including programme executives and home personal care attendants, as has been done for nurses and social workers. MOH's plan to develop ways to recognise skills and work out career progression pathways and remuneration frameworks for workers across the entire range of jobs in healthcare²¹ is clearly in line with sentiments on the ground. The representative of a non-profit provider of centre-based services and community outreach programmes said that unlike doctors, nurses and allied health staff who are considered professionals, jobs as healthcare attendants, personal care attendants and therapy aides are not well-regarded by the public. This critical group deserves recognition for their contributions, and suitable acknowledgement might help the sector retain these workers and possibly attract others. Something as simple as SG vouchers, like those given to national servicemen, could go a long way, the VWO representative argued.

To boost the image of those in the non-profit eldercare sector, another VWO representative said it might be better to consider renaming it. When VWOs are called the "non-profit sector", people are left thinking it attracts only those who are altruistic, cannot find other work, or are looking for a retirement job, the representative said. Going a step further, several private providers suggested doing away with the "non-profit" and "private" labels entirely, and treating the care sector as a single industry instead. Clients would then choose where to go according to the services offered and prices charged. This idea, however, needs careful consideration to ensure that the needs of the poor are not overlooked or left to the mercy of market forces.²²

SINGAPORE'S RELIANCE ON FOREIGNERS FOR CARE WORK

Persistent staffing problems have led care providers across the sector to employ foreigners for the more demanding and physical aspects of eldercare work. The representative of a large non-profit that provides both centre-based and home-based care said that most of its doctors, nurses and therapy staff are Singaporean, but the care assistants who look after clients' personal caregiving needs are foreigners. As noted earlier, providers estimate that the majority of workers in the sector are foreigners, doing mostly support jobs as care assistants or nursing aides. In particular, non-medical care work tends to be done by foreigners, as Singaporeans are reluctant to do these jobs. Some of these positions are filled by foreign-trained nurses²³ who are unable to meet the stringent registration requirements of the Singapore Nursing Board (SNB) to work as nurses in Singapore. According to the SNB website, foreign-trained nurses must (i) have an offer of employment with an eligible healthcare institution in Singapore before their application can be submitted by the potential employer on their behalf;²⁴ (ii) have nursing/midwifery registration from the country they trained in as well as a current licence to practise as a nurse; and (iii) show evidence that they have completed a nursing programme equivalent (as assessed by SNB) to an accredited pre-registration/pre-enrolment nursing programme in Singapore.²⁵ These criteria are especially difficult for recent nursing graduates from the region to fulfil; for example, many do not have sufficient clinical work experience in a large hospital setting.²⁶

Care providers say Singaporeans are not keen to perform personal care in the homes of elderly clients. Those who do join as personal care assistants

often have their own ideas of what the job entails. Currently there is neither an official definition of the roles of a nursing aide or healthcare assistant nor a clearly defined skills competency framework for such workers. A non-profit representative described Singaporeans who felt it was beneath them to accompany elderly clients to hospital appointments and wait with them. In comparison, foreign workers have the skills, the right attitude and are hungry to be employed. Many foreigners arrive with on-the-job experience in their own countries and hit the ground running when they start work. This is especially so for allied health therapy assistant positions. A hospital medical social worker said it hired Filipinos who were trained and working full-time as occupational therapists in the Philippines but could not convert their licences because of Singapore's stringent admission rules. Singaporeans might have better theoretical training, but they have less practical experience. Foreigners face some issues with language and communication, but care providers work around this by assigning them more task-oriented work or sending them to appropriate clients to minimise communication problems.

Care providers are mindful that the supply of foreign workers may dry up as a result of competition from other countries that pay considerably more. One non-profit representative already experiencing a slowdown in recruitment for the lower ranks of healthcare workers said: "Japan is paying them [more than twice as much], so why should they come to Singapore for \$850?" Unless there are some impactful policy changes to attract Singaporeans to eldercare, providers do not expect more of them taking up the jobs that need to be done. For now, foreigners are the answer. As one non-profit representative said: "Someone needs to give that senior a shower and change those diapers, so

foreign care workers are a great manpower source."

If Singaporeans continue to shun these jobs, Singapore must expect to pay more for foreigners as competition increases from other countries that are also short of care workers. The signs are clear that Singapore needs to work out ways to reduce its dependence on foreigners by providing more flexible working arrangements for Singaporeans to take on eldercare duties, or strategically developing a "touch economy" by revaluing currently unpaid forms of care carried out by family members, and improving the training, wages and work recognition of freelance and full-time home personal caregivers.

LITTLE RESPITE FOR CAREGIVERS WHO NEED A BREAK

An important issue linked to human resources is the lack of affordable alternatives for family caregivers to obtain respite care at short notice or for short periods or overnight. Caregivers could require respite care when they need extended medical treatment, a break from prolonged caregiving, or their foreign domestic worker is going on leave. Hiring private care providers to come to their homes, however, is generally an expensive option.


Respite care is provided at centres run by several VWOs at about a dozen locations across Singapore but families must submit an application at least five working days in advance and, even then, the service is provided for only a few hours during the day, usually until 7pm or 8pm, from Monday to Saturday (with very few centres open on Sundays).²⁷ At \$53 per day, it can prove a financial burden for families who are just above the cutoff for government subsidies and might need respite care for several days or longer; respite care is not payable

by Medisave too. According to the application form on AIC's Singapore Silver Pages, the VWOs' respite care programme excludes certain groups of elderly, such as those who are bed-bound and need more than one person's assistance, those on naso-gastric tube feeding, or individuals who may be disruptive in group settings. Families needing a temporary break from their care duties to recipients who have moderate to high nursing care can apply to the Nursing Home Respite Care programme. Applications must be submitted six to 12 weeks in advance if they intend to apply for means-tested subsidies, although it takes about a month to process referrals. Families can also apply to a limited number of nursing homes for Crisis Respite Care in an emergency and seek admission for the elderly care recipient within one to two days, but there is no guarantee of a place. The majority of the nursing homes that currently offer overnight respite care are privately run. Subsidised respite care is available only for Planned Respite Care and not Crisis Respite Care; without subsidies the daily fee in a private nursing home costs \$100–\$150 per day for a place in an open ward,²⁸ a sum which can be prohibitive for families.

Non-profit providers in our study sympathised with the needs of families who need respite care on Sundays, when their foreign domestic workers are off, or in an emergency, but they said the shortage of options was one more reality in a sector strapped for staff. "Getting service providers to come in on Sunday is a challenge because most operators don't function on Sundays," a VWO representative said. It is especially hard to find affordable help for families whose elderly have mental health issues, wake up frequently at night to call for assistance, or have a reverse day-and-night cycle.

Having to apply in advance for respite care does not make sense to caregivers

who may need the service in a hurry, and providers are aware that families cannot plan for emergencies. The result is that families who cannot make care arrangements end up taking the elderly person to hospital. This may well be an inappropriate use of hospital care, but families feel they have no choice and providers themselves do not expect the problem to go away anytime soon. If anything, it may get worse. A private provider's representative recalled her previous experience working in hospitals and studying the elderly patients at the Emergency department. "I realised that there were a lot of patients coming to A&E not because they were critically ill, or had been in an accident, but because their family just could not cope anymore," she said. "Seniors who are not critically ill are coming to hospital, taking up the space, taking up the resources, when those resources could be on standby for real emergency situations. This problem will definitely stay and become bigger with a greying population."

At different episodes of the eldercare journey, care recipients may move between centre-based, home-based and residential care. Caring for the elderly requires a multi-stakeholder approach, from trained healthcare professionals to administrative and support care and staff, foreign domestic workers, and family caregivers. Boosting the supply of local employees, ensuring staff retention, and improving productivity are top priorities in community and home care; ensuring that Singapore remains an attractive employment destination for foreign care workers is also necessary. We must enhance as well the training of foreign domestic workers and family caregivers in the home, and provide support for them so that their capacity to care for the elderly will be sustainable. 

ENDNOTES

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- 21 Ministry of Health (2018) "Speech by Senior Minister of State for Health, Dr Amy Khor, at the Ministry of Health Committee of Supply Debate 2018". Retrieved from https://www.moh.gov.sg/content/moh_web/home/pressRoom/speeches_d/2018/speech-by-dr-amy-khor--senior-minister-of-state-for-health--at-t1.html
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- 28 See "Nursing Home Respite Care". Retrieved from <https://www.silverpages.sg/care-services/Nursing%20Home%20Respite%20Care#apply>

Development (MSF) to the Ministry of Health (MOH). We are also concerned that eldercare providers which do not receive government subventions, particularly in the private sector, are not regulated by MOH. A holistic approach towards regulation would also establish mechanisms for fielding complaints from care recipients and caregivers, and dealing fairly with all stakeholders, including care providers.

The private home care sector is growing rapidly and we estimate that there are at least 55 such providers currently. Many of these private providers are relatively small enterprises attracted to the business opportunities in home care, a domain that is away from public scrutiny. It requires a much lower capital outlay to set up a home care business dispatching healthcare workers to clients' homes than to provide centre-based care which involves hefty costs to build or rent premises. It is likely that a large proportion of private providers escape the regulation and service requirements that eldercare providers which receive government subventions are subject to. Healthcare staff involved in eldercare, such as doctors, nurses and allied health professionals, are licensed by their respective professional legislation and ethical codes. However, disciplinary action for professional misconduct is taken only against the individual, rather than his or her errant employing agency. A private provider can simply replace one poor worker with another and carry on.

Gaps in the regulatory environment jeopardise the safety of vulnerable older adults, particularly those living at home. Poorly administered home care can harm the individual and add to the stress of family members. Among those we interviewed for this study was the following caregiver, whose experiences highlight some of the issues deserving attention. (See story on facing page)



HOME NURSES FALL SHORT OF EXPECTATIONS

Ms Peh is the main caregiver to her 85-year-old mother, who became semi-paralysed after a massive stroke in 2011. The elderly woman's condition worsened after she suffered a seizure in 2015; she is unable to support her neck, needs a special "tilt-in-space" chair, is fed by tube and must have an oxygen tank on standby. Ms Peh lives with her mother and has a foreign domestic worker to help in the caregiving. A home care doctor, who is on a non-profit care provider's panel of general practitioners, visits regularly.

In mid-2017, Ms Peh's mother had a high fever and the doctor advised her to engage a home nurse — via his contacts — to administer antibiotics through an intravenous (IV) drip. The company sent a man and woman who said they were both registered nurses. Neither asked about Ms Peh's mother's medical history or explained what they were about to do. Ms Peh said they spent two hours with her mother before telling her they could not insert the needle for the IV procedure because the veins on her mother's hands and arms had collapsed. In the end, they did the procedure on her mother's leg.

Two days later, when the fever did not subside, Ms Peh contacted the nurses to say her mother was not getting better and this was unusual because in the past, her mother usually improved within hours of receiving antibiotics. When she said she was considering taking her mother to a hospital, the nurses and the doctor dissuaded her, saying the nurses could come again and give her mother another dose. Uncomfortable with that prospect, Ms Peh took her mother to hospital. The doctor in the emergency department immediately asked why the IV procedure was done on her mother's leg, before taking less than a minute to do it on her hand.

Ms Peh was unhappy that the home nurses had claimed that her mother's veins had collapsed. She decided to check, and found that their company was only three months old and not listed as a provider of nursing services. She lodged complaints with the Singapore Nursing Board and the company, and filed a claim at the Small Claims Tribunals. The matter was eventually resolved through mediation. Ms Peh was refunded the full amount that she was charged by the company, but it is not known what action, if any, was taken against the company or the nurses.

SINGAPORE'S HEALTHCARE GOVERNANCE FRAMEWORK

From our discussions with care providers and caregivers, we believe Singapore needs to develop a more robust governance framework over training and accreditation, auditing on-the-job capabilities, and the quality of care delivered to clients. The Government announced in January 2018 that it intends to replace the Private Hospitals and Medical Clinics Act (PHMCA) with the Healthcare Services Act (HCSA).⁴ The PHMCA was enacted in 1980, last amended in 1999, and was long considered the capstone legislation for all healthcare services used by public and private patients. It regulates and governs the administration and management of all private hospitals, medical clinics, clinical laboratories and other healthcare establishments in Singapore. By 2016, the Government had recognised the limitations of the Act and the need to consider changes in healthcare delivery, including the growing use of mobile, online and co-located services. A review of the Act followed and the draft Healthcare Services Bill concluded its public consultation in early 2018.⁵

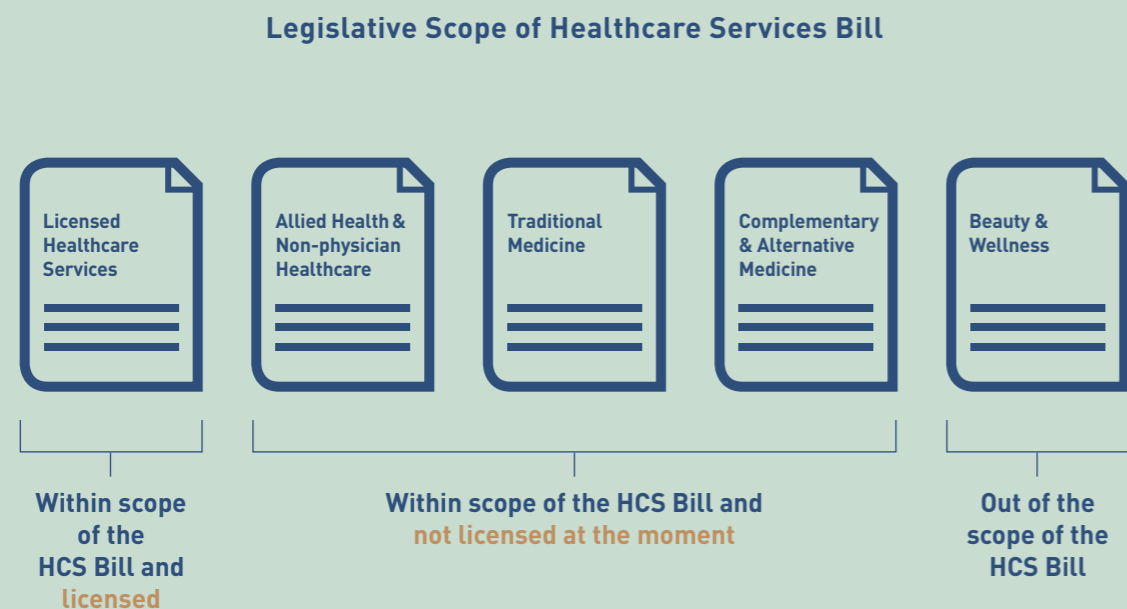
The proposed HCSA, which will gradually replace the PHMCA, seeks to enact governance over healthcare *services* rather than focus on the *premises* where healthcare services are provided. The change will allow the Government to prescribe regulatory standards for services delivered through mobile and virtual channels such as telemedicine and house call services, focusing on house call services delivered by doctors to patients.

Pending parliamentary approval, it is anticipated that the changes will be enacted in three phases from December 2019:

- 1st stage (December 2019 onwards): Will focus on medical and dental clinics under the existing PHMCA law
- 2nd stage (June 2020 onwards): Will cover nursing homes and hospitals licensed under the PHMCA
- 3rd stage (December 2020 onwards): Will cover services previously not regulated under the PHMCA

Allied health and non-physician nursing services are under the scope of the proposed HCSA, but MOH has clarified that the application of HCSA to home care and centre-based care needs to be studied more fully “to determine if, how and when the sector should be regulated under HCSA past 2020”. It explained that since home care and centre-based care are “nascent and evolving sectors”, “a decision to regulate should balance both the potential risk to patient safety and welfare, whilst not imposing excessive restrictions which may stifle growth”.⁶ Meanwhile, allied health professionals and nurses will still be governed under their respective professional Acts. It remains to be seen how HCSA will address the regulatory mechanisms for centre-based and home-based eldercare more specifically,⁷ including over private providers who deliver such services. Moreover, the proposed Act remains oriented towards governing clinical/medical care, leaving open the question of whether social care (i.e. services providing mental and emotional support or to prolong independent living) would be regulated adequately.

Figure 5.1 Scope of HSCA



Source: Adapted from Ministry of Health [2018] "Healthcare Services Act". Retrieved from https://www.moh.gov.sg/content/moh_web/hcsa/about-hcsa.html#WhatIsHCSA; reproduced with MOH's permission, 2018.

There are currently several laws that govern different aspects of long-term care (see Appendix 11). Non-profit providers registered as charities are governed by the Charities Act, while private providers are governed by the Companies Act. None of these laws is specific to the context of eldercare. Certain groups of care workers come under specific legislation such as the Allied Health Professions Act 2011 (MOH) and the Nurses and Midwives Act (Singapore Nursing Board). The Singapore Nursing Board (SNB) administers a set of Guidelines for Agency Nurses/Midwives and Agencies Engaging Them, which states that "the agencies engaging these nurses have the responsibility to ensure that the nurses they engage must meet SNB's criteria and deliver safe and competent care".⁸ The criteria for employing nurses pertain to registration and enrolment with the board, a minimum of two years' experience in providing direct inpatient nursing care (for registered and enrolled nurses preferably in a medical and surgical setting), and current certification in cardiopulmonary resuscitation and the use of automated external defibrillators.

In 2015, MOH introduced a set of guidelines for home care and centre-based care as part of ongoing efforts to improve the quality of the community care sector. The guidelines were developed in consultation with providers, policymakers and healthcare professionals, and "represent the *common aspirations* of the various stakeholders in defining the desired outcomes for centre-based and home care".⁹ MOH said the guidelines "*go beyond our service requirements and articulate the expected outcomes in four broad domains:* (a) provision of holistic care services; (b) safety and quality of care; (c) dignity

of care, informed and enabling care; and (d) organisational excellence and sustainable care”.¹⁰ Although the guidelines provide a reference point for care providers, they are not mandatory.

PRIVATE CARE PROVIDERS: A PRESSING NEED FOR REGULATION

In our discussions with non-profit providers and caregivers, we found that while some private caregivers are well-regarded, the private care market on the whole is viewed with some reservation and even distrust. These perceptions highlight the need for measures requiring greater accountability of private providers, who are likely to rise in number to meet demand from Singapore’s growing elderly population.

Some non-profits are wary of the profit motives of private providers. A voluntary welfare organisation (VWO) offering centre-based services was considering partnerships to expand its suite of services at the time of our study. Its representative said the VWO preferred partnering another non-profit because the charity sector is driven by a vision and mission for the common good, whereas private operators are market-driven. Non-profit providers also said they did not agree with some of the services and equipment recommended to families by private providers. A non-profit provider of home services said some clients turn to VWOs for help after running out of money for private care. “We have had clients who spent up to \$10,000 a month for about three months, paying private providers for specific treatments or buying all sorts of equipment. The cost was too high for them to continue,” that representative said. Private providers we engaged acknowledged that there

are poor practices in the sector. They too knew of providers who encouraged “unnecessary usage” of care services that could lead to excessive costs. One private provider told of a company dubbed “the Rolls Royce of care providers” because it is known to recommend costly services clients do not really need.

The extent of poor practices by private providers is unknown. We were told of cases where private providers dispatched care workers who lacked the necessary skills to provide the care clients needed.

The account of Ms Peh and her mother at the start of this chapter reflects the distress that results when ill-equipped staff show up. Caregivers usually turn to care providers during periods of emotional stress and expect they can rely on the expertise and advice of the care workers who come to their home. At such times, they may not have the foresight or emotional capacity to check the credentials of the companies that send care workers to their homes or question the advice given by the care workers. Ms Peh only realised that the home nurses sent by a private company had not done their job properly when her mother’s condition did not improve and they went to hospital. On further checking, she discovered that the company she called was not licensed to dispatch home nurses.

A core issue that extends across both non-profit and private providers is the lack of information for families to compare eldercare services and prices.

A core issue that extends across both non-profit and private providers is the lack of information for families to compare eldercare services and prices.

The eldercare sector needs the kind of transparency in price comparability available for hospitals since 2014, when MOH began publishing in-patient bills to show the variation in charges at different hospitals. This move sought to motivate hospitals with larger bills to examine ways to lower their prices.

Our discussions with the SNB and care providers suggest that the duty of care and ethical practice in privatised eldercare lies primarily with private providers and the workers they employ. SNB provides guidelines on the qualifications and experience required of agency nurses and imposes strict requirements on who can sit for the SNB exam to qualify to work as a nurse in Singapore,¹¹ but it has no enforcement power to penalise an agency that delivers poor quality care. SNB can initiate disciplinary action only against a nurse found to have flouted the professional code of conduct under the Nurses and Midwives Act. This presents a loophole in governance as the agency at fault may escape disciplinary action. SNB hoped that the implementation of the proposed HCSA would address this gap. We suggest further measures to ensure accountability to enhance the safety of vulnerable adults in need of care. However, this should not be done in isolation from the operations and multiple stakeholders involved in the eldercare sector, including medical and non-medical care personnel.

TRAINING AND ACCREDITATION FOR BETTER CARE QUALITY

Two key themes emerged in our interviews and focus group discussions with care providers on the quality of community and home care, particularly by

nurses. First, an exacting combination of qualities is required in the individuals who take on community nursing. Second, changes are needed in the training and accreditation of care workers, to ensure that patients are given reliable medical and non-medical care in their homes.

In our discussions with non-profit and private providers alike, we kept hearing this mantra: “Not any nurse can do home care.” This is work for the best of nurses, because of the challenging conditions. Unlike the nurse in a hospital or institutional setting, who is part of a medical team that will respond immediately in an emergency, the home nurse usually works alone. When a nurse visits clients in their homes, she must be able to make quick assessments independently and work confidently despite varying, and sometimes less than conducive, home environments. A nurse who works well in a hospital setting may not be as good working on her own in a patient’s home. A non-profit representative said: “You actually need the best nurses in home care because they have to function independently, and their calibre should be that of maybe emergency room nurses or Intensive Care Unit nurses.” An added challenge in community nursing is that the home nurse works under the scrutiny — and even interrogation — of the patient’s family members. A private care provider’s representative said that if the nurse calls a senior colleague to check on an issue, a family member might remark: “You are a nurse but you don’t know how to do *ah?*”

Senior nurses are often chosen for community nursing, and their experience counts when critical situations arise and they know a matter needs to be escalated. A private provider’s representative said the company

preferred engaging nurses with “at least six or seven years’ experience” for home nursing. Another private provider pointed out that seniority and years of service alone were insufficient because the community nurse needed current knowledge and recent experience. “You can say that you are a registered nurse, trained in a hospital, but if it has been 10 years since you last inserted a tube, I don’t think you can really say you can do it,” she said. Given the shortage of such nurses, however, she admitted that most private agencies end up hiring whoever is available, including nurses who may not have up-to-date training or competencies. The danger is that when such nurses are in the client’s home and have to perform a procedure they are not confident to do, they may still go ahead and try, because the private agency has to charge the family for sending a nurse.

Both non-profit and private care providers agreed it is important to establish clear supervisory procedures and escalation protocols, and introduce training programmes and certification specifically for community nursing as an industry-wide practice. This will raise standards and encourage nurses, therapists and others to join the sector. Without clear standard operating procedures and escalation guidelines, they said, care workers could feel vulnerable when things go wrong and they risk losing their licences. Establishing clear and thorough escalation protocols would

Both non-profit and private care providers agreed it is important to establish clear supervisory procedures and escalation protocols, and introduce training programmes and certification specifically for community nursing as an industry-wide practice.

mean that community and home nurses operating solo would know when to contact a more senior colleague for advice, or when to turn down a family’s request to perform a procedure. Several private providers said this is especially crucial for complex cases, for example, when an elderly patient falls, becomes unconscious or vomits. A private provider’s representative said its home nurses have been told what to do in emergencies: “We train all our nurses to call 995. We tell them, ‘You are not a doctor, you are not supposed to diagnose.’” However, as shown in the case of Ms Peh, not all private providers have stringent protocols to ensure patients’ welfare and safeguard the caregivers who engage them.

Training and accreditation of community nurses were issues highlighted by care providers as well. One private provider sends its nurses and other care staff to reputable agencies for healthcare training. Another said training and certification were important to help establish the company as one clients can trust, because during home care “the person gets touched in the most vulnerable of places in the most vulnerable of times”. Non-profit providers also recognised the importance of a formalised framework of training for community and home nurses in eldercare.¹² A hospital transitional care representative emphasised two important elements when considering formal training for community nursing. First, classroom training has its limitations because working in a client’s home is unlike practising nursing in other settings. The consensus among providers was that the most effective way to prepare workers for home nursing was through on-the-job training. Second, he questioned the quality of available training by people who may be certified

but were neither experts nor experienced in community nursing. “Just look at the curriculum, they cut and paste, mix and match, they come up with the curriculum and even give a certificate,” he said. Another non-profit provider lamented the ad hoc nature of training, which left individual service providers to decide how much they ought to train, monitor and supervise their staff.

On a positive note, several providers have developed their own in-house training programmes. Tsao Foundation, for example, provides a diverse range of training for its staff and others through its Hua Mei Training Academy.¹³ For community and home nursing, Tsao Foundation launched the Community Gerontological Nursing Certificate course in 2012 to train experienced, registered nurses to work with elders living in the community. Since 2016, the foundation has collaborated with Ngee Ann Polytechnic to jointly develop and offer a Specialist Diploma in Community Gerontology Nursing course for those already working with the elderly in their homes, or on their transitional care and planning, intending to work in this area. It trains registered nurses to make informed clinical decisions and understand the primary healthcare conditions seen by the community gerontology nurse. Tsao Foundation requires its nurses to have at least a specialist diploma of this nature. Those who do not have the specialist diploma are required to take the course on a part-time basis, sponsored by the foundation with no bond.

For non-medical care work, training and accreditation are just as important to ensure care quality. Tsao’s Hua Mei Training Academy offers courses for market entrants entering the eldercare sector to be trained as healthcare attendants and assistants, home care helpers, and managerial

and administrative personnel. Short courses are also offered by private agencies for those wishing to work as professional caregivers. For example, a private provider, Comfort Keepers, runs a five-day in-house training programme and hands out a certificate to those who complete it. In addition, a few of the more innovative private providers have begun using technology to ensure the quality of care delivery is maintained. One has an app to track their caregivers’ arrival and departure times at clients’ homes to check on punctuality and how long they stay. The app also allows the care recipient’s family to review and rate the service, ensuring accountability. The following example shows how one provider is using technology to improve coordination of its services and maintain the quality of care delivered by trained nurses. (See story in box)



INNOVATION HIGHLIGHT

AN APP TO TRACK CLIENTS, GUIDE FAMILIES

Tetsuyu Home Care is a private provider inspired by the Japanese care model of offering holistic services, including care assessment, care planning, care coordination and caregiver training. The company developed a home care management application known as the CARES app, which is at the heart of its operations, connecting nurses and an extended healthcare team to clients and their family members and caregivers at home.

Tetsuyu calls its nurses “care managers” and they use the app to update and coordinate all activities and all parties involved in caring for a client. They develop care plans in consultation with a medical team comprising a network of therapists as well as geriatric specialists. The company’s software system allows its care managers to coordinate the clinical workflow seamlessly, and record reports and updates from clients’ families and caregivers. The plans and schedules created by care managers guide and supervise family members at home. Caregivers receive real-time updates on the client’s progress, as well as reminders on medical appointments and scheduled treatments. The care managers are also available via a 24/7 hotline.

Overall, care providers agreed that it takes more than heart and ordinary nursing skills to make a good community or home nurse; they noted that it requires someone experienced and willing to work independently because they are often alone in the field. While quality control for existing services currently depends on the individual agency, responsible providers acknowledge that they have a “duty to care” and maintain standards. Training — in the classroom and on the job — as well as an accreditation scheme that sets minimum service standards will help to bring about changes the sector itself recognises as necessary.

ELDERCARE AT HOME: ‘MY MAID CAN DO IT’

There is another large group of workers delivering eldercare services, who receive even less attention in terms of training and monitoring. These are the foreign domestic workers and live-in caregivers¹⁴, as well as care workers dispatched by providers on a pay-per-visit basis. A key concern that emerged in our discussions with care providers was ensuring standards of home personal care provided by foreign domestic workers. Employers often expect these helpers to perform nursing functions such as managing medication, tube feeding, handling insulin injections, carrying out blood tests and the like. Care providers noted that this is a grey area that is difficult to monitor or regulate as the foreign domestic worker works behind closed doors and may be asked to perform specific tasks by the employer or family member. The foreign domestic worker may also have little say over what she feels

able or comfortable doing. Families watching costs often get the worker to perform tasks better left to trained nurses.

Several care providers cautioned that there could be unhappy results if foreign domestic workers were used as a substitute for, instead of as a supplement to, professional care especially if the patient is very ill. To stop incurring costs from frequent visits by the nurse, families are known to say: “My maid can do it.” A private provider’s representative described the case of an elderly woman who had dementia and was bed-bound. She lived alone with a foreign domestic worker employed by her family who did not want to pay for nursing services because of the cost. The family also rarely visited the old woman. Left largely on her own and unsupervised, the worker was not diligent about turning the woman over in bed, or cleaning a treatable wound early. By the time the family sought medical help, the wound was so badly infected that the woman had to spend six weeks in hospital.

A large proportion of Singapore families with frail elderly members employ foreign domestic workers, and as long as their supply continues, they will remain a popular eldercare option. However, the foreign domestic worker should, as far as possible, not be the sole or primary caregiver, and the family must remain responsible to support and be involved in the care of their own loved ones. When an elderly person is alone and cared for only by a

The foreign domestic worker works behind closed doors and may be asked to perform specific tasks by the employer or family member. Families watching costs often get the worker to perform tasks better left to trained nurses.

foreign domestic worker, regular visits and phone calls from extended family members and trusted friends or government and non-profit support organisations (e.g. befrienders) are important for ensuring the care recipient's well-being. The last group is particularly crucial to check on the elderly who live alone, without a flatmate or helper. It should be made mandatory for foreign domestic workers employed for eldercare to attend training courses approved by the Agency for Integrated Care (AIC) to understand their role and do their work better. The case of Madam Aw's family (see story in box) illustrates how the safety and well-being of vulnerable older Singaporeans can be compromised in the hands of a foreign carer if she is not adequately trained to perform eldercare duties.

Madam Aw might not have had a nasty experience with a helper who neglected her aged mother if that worker had been prepared adequately for her role. In a 2012 study of 1,190 caregivers, the researchers found that nearly half of those surveyed employed a foreign domestic worker specifically to care for a frail and older family member.¹⁵ An earlier study of 1,060 patients



CAREGIVER'S STORY

'HELPER NEGLECTED MY MUM'

Madam Aw is the main caregiver to her 91-year-old mother who had a serious heart attack about 10 years ago and has been hospitalised since then for several other medical conditions including urinary tract infection, hernia surgery, a second heart episode and malnutrition. Madam Aw, a part-time tutor, was the sole caregiver until her mother's needs intensified over time. She eventually took her husband's advice to hire a foreign domestic worker to help with looking after her mother.

The first helper did not work out. Madam Aw said that although the helper was told to focus on caregiving and did not have to do other household chores, she did not keep the older woman's bedroom clean and sometimes did not feed her. Madam Aw also claimed that the helper would wheel her mother to the void deck, leave her there then disappear for a long time. Neighbours who witnessed these incidents of neglect told Madam Aw. She claimed that the helper also took some of her mother's belongings. After four months, she had the helper replaced. Despite her bad experience, Madam Aw still relies on a foreign domestic worker to help her care for her mother.

admitted over a 10-year period (2000–2009) to Code4, a VWO providing home medical and nursing services to needy homebound elderly, found that 58.2 per cent were cared for primarily by foreign domestic workers. More importantly, over that 10-year period, the proportion of families employing foreign domestic workers as primary caregivers almost tripled from 31.4 per cent in 2000 to 80 per cent in 2009.¹⁶

While the dependence on untrained foreign domestic workers has risen steadily, care providers and training agencies in our study noted a general unwillingness among Singaporeans to pay more for live-in caregivers with nursing skills. The preference has to do with pay. Most live-in caregivers receive \$600 to \$1,000 per month, depending on their education and experience, whereas salaries for foreign domestic workers start from about \$450. Live-in caregivers are usually foreign-trained nurses whose qualifications are not recognised in Singapore and they have yet to complete a nursing programme equivalent to an accredited programme recognised by the SNB.¹⁷ They may work as live-in caregivers, but under the Ministry of Manpower policy, hold the same work permit as foreign domestic workers. Their main job is to provide dedicated care to the elderly and, unlike foreign domestic workers, they are not expected to perform household chores as well. Care providers said some Singapore families place unrealistic and unreasonable demands on both live-in caregivers and foreign domestic workers. Employers need to understand that an overworked caregiver performing multiple tasks is not likely to deliver quality care. Care providers felt that employers also need clear

Employers need to understand that an overworked caregiver performing multiple tasks is not likely to deliver quality care.

guidelines and ongoing education, in order to protect the workers as well as their elderly charges.

Currently, foreign domestic workers and family caregivers may enrol for eldercare training courses with several agencies in Singapore. The courses cover topics such as the care of older persons who cannot perform activities of daily living, and those with dementia, incontinence and other health issues. They can also learn how to communicate with the elderly, transfer an elderly person, manage diet and nutrition, and be alert to safety and fall prevention. Other courses deal with tube feeding, wound care and palliative care. Those who meet the eligibility criteria may tap on the Caregivers Training Grant and receive up to \$200 of subsidies per year to attend training; they co-pay only \$10 for most AIC-approved courses.¹⁸ Hospitals also provide training for foreign domestic workers and other caregivers to teach them how to take care of the elderly about to be discharged from hospital.

Most of the caregiving courses are either classroom-based or home-based and customised for the specific patient and caregiver. A hospital representative said classroom training covers only the basics whereas customised training prepares the caregiver for what will happen when they are at home. A foreign domestic worker may get through the classroom training, only to find it difficult to cope at home because the environment is completely different from the hospital. Singapore families who employ foreign domestic workers and live-in caregivers need to understand that there are limits to what helpers can do. For foreign domestic workers employed mainly for eldercare, training should be mandatory and combine both the classroom and home-based aspects of what they need to know.

A robust framework of governance is needed to ensure that care providers, their care workers, families and the care recipient are adequately protected despite the different expectations that various parties may have towards care.

AN INTERNATIONAL EXAMPLE OF GOVERNANCE

The United Kingdom (UK) provides a useful example to consider how to improve governance in the long-term care sector. No country has a perfect regulatory framework for long-term care but an Organisation for Economic Cooperation and Development (OECD) report in 2013 highlighted the UK's comprehensive legislation and quality assurance structure.¹⁹ There are two shared regulatory features that Singapore can learn from the UK: long-term care legislation and the institution of independent bodies for regulatory and complaint functions.

In the UK, the Care Act 2014 applies to England and governs adult social care. It places a legal obligation on local councils to provide or arrange services that would help prevent people from developing needs for care, or delay support for those who need ongoing care. In England, local councils (also known as local authorities or governments) function as social welfare providers besides their other municipal duties. The Act combined previously separate laws covering social care. Their consolidation under the Act is a turn away from reactive approaches to care, by focusing more on prevention through promoting community support. The provisions under the Act are meant to make it easier for the public to understand how decisions over care are made, to have greater choice in care services, and thus have more control over their

own lives. The Act (1) introduced universal rights to an assessment and legal support, including for self-funded care recipients; (2) placed enhanced duties on local councils to look after the well-being of the communities they serve, and to enable care recipients and caregivers to make informed choices; and (3) enforced greater regulation for care providers with tougher penalties for those who fail to meet a high enough standard of care provision. Additionally the Act places responsibility on local authorities and spells out procedures for safeguarding the well-being of adults at risk of abuse or neglect at home, in care homes or other settings.²⁰

The Act also introduced more concrete quality standards for regulated care, enforced by the Care Quality Commission — an independent regulator for health and care services in England that was established by the Health and Social Care Act 2008. Care providers are expected to meet a wide range of standards based on the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These quality standards include an assessment of financial sustainability of care providers, appointing suitable directors to manage their services and activities, and a duty to be transparent about safety incidents to users of their care services. Care providers, both non-profit and private (regardless of funding source) are required to register with the Commission, which also conducts performance monitoring and enforces sanctions. The Commission can fine, suspend or revoke the licence of, or prosecute, an errant care provider. The Commission's regulations also impose upon providers the duty to respond to complaints. Providers are also required to display conspicuously on their premises the inspection ratings given by the Commission.²¹

Both health and social care complaints can be submitted to the local

authority, which is governed by the regulations made under powers of the Health and Social Care (Community Health and Standards) Act 2003. A complainant who is dissatisfied with the outcome can escalate the complaint to the Local Government and Social Care Ombudsman (LGO), an independent body that oversees how local authorities carry out their legal duties and ensure accountability. The LGO also deals with complaints from self-funded care recipients who use private care services.²² Despite ongoing challenges that local authorities and providers face making good quality care accessible to all, especially given budget cuts, overall the regulatory framework in the UK provides a reasonable degree of checks and balances over care quality.


The UK example provides several learning points for Singapore's evolving eldercare sector. First, the consolidation of existing piecemeal legislation will enhance user understanding of the wider framework in which care takes place and allow for coordination across the different aspects of care provision. Singapore's proposed HCSA will be a positive step in this direction, but it remains to be seen whether HCSA's provisions will apply to centre-based and home-based care. Second, UK's Care Act and governing bodies explicitly include social care and private providers that do not receive government subventions. It is not yet known to what extent Singapore's proposed HCSA will address these aspects as well. Several providers who participated in our study expressed that social care, such as befriending services or home personal care for vulnerable older Singaporeans, is important to regulate. They also felt it was necessary for the Government to have greater oversight towards care delivery by private providers (both subvented and non-subvented ones). Third, the UK

has independent bodies that oversee regulation and complaints, separate from policy development and funding functions. Making regulation and complaints independent enhances transparency and confidence in these processes. Fourth, in the UK all home care providers are regulated regardless of whether they serve government-subsidised or self-funded clients. Regulating all home care providers would enhance care quality assurance in Singapore.

Fifth, decisions over how referrals are made is an area related to governance as well. The care providers in our study that received referrals from AIC noted that they did not know how the agency matches clients with care providers. Care recipients have a right to know how decisions affecting their care are made, and this is provided for in UK's Care Act 2014. Sixth, ratings given to care providers by the UK's accreditation agency are made public, enabling more informed consumer choice. Lastly, as part of the UK's legislative requirements, care recipients are given greater control over the type of care and financing they would use (e.g. through government-disbursed personal budgets).

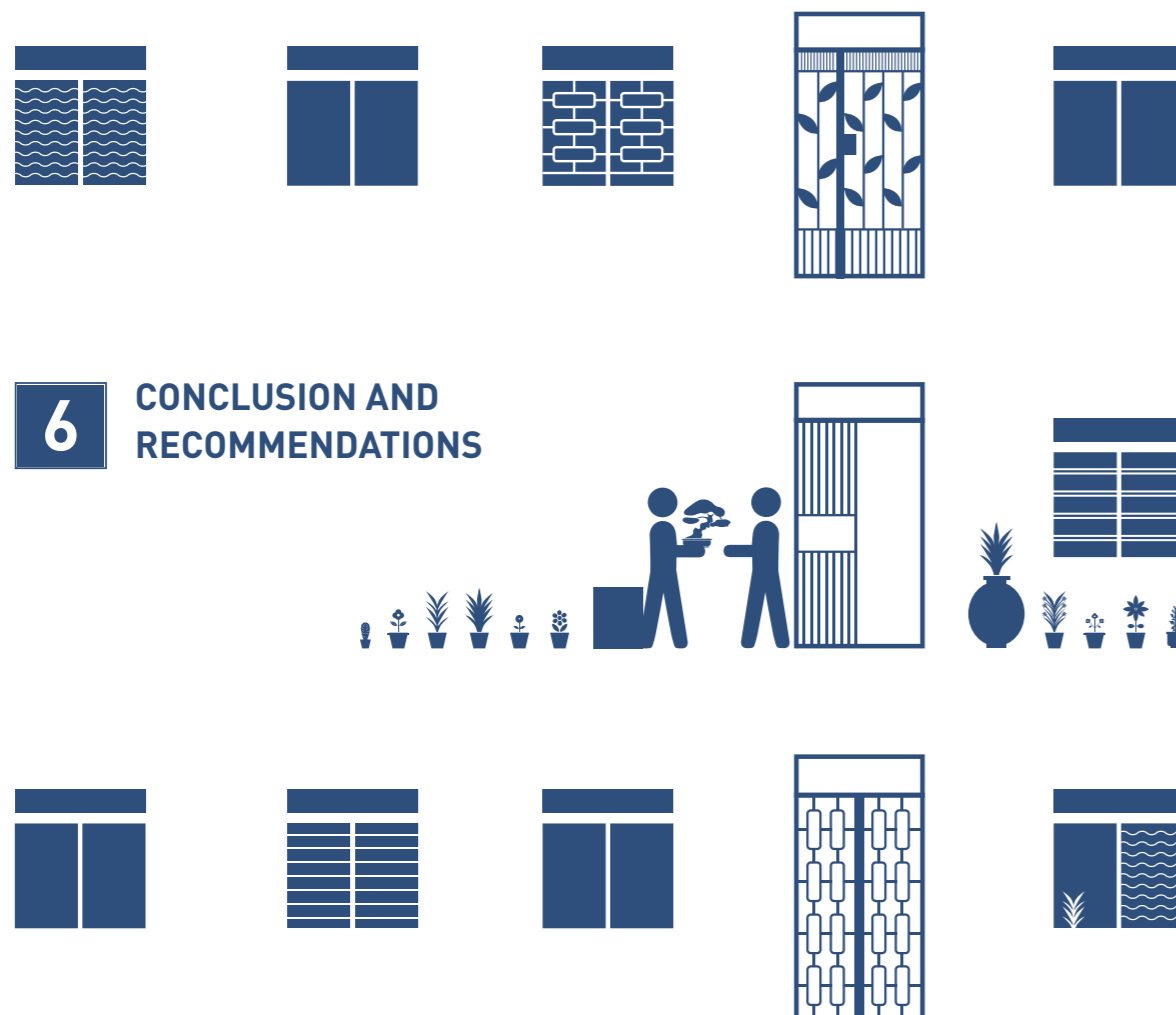
Singapore does not have similar independent bodies auditing and adjudicating eldercare. Currently, AIC oversees funding, care service coordination and implementation, while the professional bodies license and regulate medical, nursing and allied healthcare workers through their respective professional registration Acts. They may not have the capacity to field complaints or the will to enforce changes that will require an overhaul of existing regulations. An independent body made up of experts and practitioners in eldercare would fulfil such a role more effectively. With private providers set to play a more prominent role in care provision, particularly in home-based care, a separate and independent organisation that oversees care quality or accreditation, and fields user complaints would

ensure greater accountability over eldercare. Private providers are currently not governed by the Charities Act in the same way as non-profits, nor are they subject to government funding regulations if they take only self-funded clients. AIC might well assume such a role, but its core functions have expanded tremendously and the array of programmes, funding schemes and stakeholders that it manages already requires it to invest significant time and human resources. The regulatory and ombudsman role that we highlight here would best be undertaken separately, not only for efficiency but also to ensure independent judgment.

Singapore relies more heavily on foreign domestic workers and live-in caregivers than the UK and such workers are currently overseen by the MOM. Currently, foreign live-in caregivers who have nursing training but do not meet Singapore's criteria to be registered as nurses are given the same work permits as foreign domestic workers who come to work as maids. Care providers and training centres we engaged with recommended giving live-in caregivers a different work permit to distinguish them from foreign domestic workers. This will help to professionalise their image and clarify to employers the job scope of such workers. A greater effort must be made to encourage labour agencies and employers to send foreign domestic workers for eldercare training if their main role is to care for frail and ailing seniors. Foreign domestic workers must be made aware of their right to refuse to perform medical procedures that they are untrained to carry out, even if requested to do so by their employers. Public education for employers is also crucial. A multi-dimensional approach, bridging the different ministries involved, employers, maid agents and training centres, is required for the different aspects of eldercare to be addressed holistically. 

ENDNOTES

- 1 While the eldercare sector comprises centre-based and home-based care, this chapter focuses mainly on home-based care because several academic studies have already considered users' experiences and perceptions of centre-based care. The various studies focus on issues found in centre-based care. See Chen, A.W., Koh, Y.T., Leong, S.W., Ng, L.W., Lee, P.S. & Koh, G.C. (2014) "Post community hospital discharge rehabilitation attendance: Self-perceived barriers and participation over time". *Annals Academy of Medicine Singapore* 43, 136–44; Huang, S., Griva, K., Bryant, C.A. & Yap, P. (2017) "Non-use of day care services for dementia in Singapore — a dilemma for caregivers". *International Psychogeriatrics* 29, 455–466; Liu, G., Yap, P., Wong, G.H., Wei, H.X. & Hua, E.C. (2015) "Day Care Centers for Seniors in Singapore: Looking Back and Looking Ahead". *Journal of the American Medical Directors Association* 16(7), 630–e7; Wee, S.-L., Hu, A.J., Yong, J., Chong, W.F., Raman, P. & Chan, A. (2015) "Singaporeans' perceptions of and attitudes toward long-term care services". *Qualitative Health Research* 25, 218–227.
- 2 Currently, MOH conducts regular audits of care providers which receive government subventions for delivering home-based and centre-based care to ensure that they meet prevailing service requirements. This checklist spells out the mandatory contractual obligations of the provider towards clients, staff qualifications and care processes, standard operating procedures for managing incidents and emergencies, evaluating quality assurance, managing feedback and complaints, and the provider's reporting and auditing duties. See Ministry of Health (2018) "Home and centre-based care service requirements". Retrieved from https://www.moh.gov.sg/content/moh_web/home/Publications/guidelines/home-and-centre-based-care-service-requirements.html; MOH, direct communication, 2018.
- 3 MOH, direct communication, 2018; the portable subsidy scheme extends MOH-subsidised care to patients who meet the means test criteria and receive care from accredited private providers.
- 4 Ministry of Health (2018) "Healthcare Services Act". Retrieved from https://www.moh.gov.sg/content/moh_web/hcsa/about-hcsa.html#WhatIsHCSA
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- 6 MOH, direct communication, 2018.
- 7 MOH has indicated that some of the potential key areas of review include clinical care, governance framework, training requirements and appropriate qualifications. It recently launched the Licensing Experimentation and Adaptation Programme (LEAP), a regulatory sandbox where MOH works with providers to set clear operating parameters for their pilots, and to develop fit-for-purpose governance/regulations for the sector. MOH may consider extending this to home care and centre-based care providers; MOH, direct communication, 2018.
- 8 Singapore Nursing Board (SNB) (n.d.), "Guidelines for Agency Nurses/Midwives and Agencies Engaging Them". Retrieved from <http://www.healthprofessionals.gov.sg/content/dam/hprof/snb/docs/Guidelines/Guidelines%20for%20Agency%20Nurses.pdf>
- 9 Agency for Integrated Care (n.d.) "Factsheet: Implementation guides to the guidelines for centre-based care and home care". Retrieved from <https://www.aic.sg/sites/aicassets/AssetGallery/Factsheets/Factsheet%20-%20Implementation%20Guides%20to%20Guidelines%20for%20Centre-based%20%20Home%20Care.pdf>; emphasis ours. Links to the full guidelines can be found at https://www.moh.gov.sg/content/moh_web/home/Publications/guidelines/intermediate-and-long-term-care-guidelines.html
- 10 MOH, direct communication, 2018; emphasis ours.
- 11 See Chapter 4 (section on "Singapore's reliance on foreigners for care work") for details.
- 12 Examples of such training programmes in community nursing include a Specialist Diploma in Community Gerontology Nursing (offered by Ngee Ann Polytechnic) and an Advanced Diploma in Nursing (Community Health) (offered by Nanyang Polytechnic).
- 13 These courses include those for market entrants getting into the senior care sector (e.g. people doing a mid-career change) under the Workforce Skills Qualifications framework, as well as care professionals who wish to receive training specifically for community-based eldercare to address skills gaps (e.g. in community gerontological nursing or community gerontological counselling).
- 14 Foreign home nurses are often nurses who were trained overseas but whose certification is not recognised in Singapore and hence they are not able to practise locally. They are brought in by private providers as "live-in caregivers"; Wong, L. (27 December 2016) "Elderly sick turn to foreign, live-in caregivers". *The Straits Times*. Retrieved from <http://www.straitstimes.com/singapore/health/elderly-sick-turn-to-foreign-live-in-caregivers>
- 15 Chan, A., Ostbye, T., Malhotra, R. & Hu, A.J. (2012) *The Survey on Informal Caregiving: Summary Report*, May 2012. Singapore: Ministry of Community, Youth and Sports. Retrieved from <https://www.msf.gov.sg/publications/Pages/The-Survey-on-Informal-Caregiving.aspx>
- 16 The study also found that the other 41.8 per cent were cared for by their children, spouse or others; Mittal, R., Young, M., Tan, C., Chen, C., Tham, W. & Seong, L. (2016). "Trends of patients' characteristics admitted into a multi-professional home medical care service from 2000 to 2009 in Singapore". *Home Health Care Management & Practice*, 29(1), 35–45.
- 17 For criteria, see Singapore Nursing Board (2017) "Foreign trained nurses/midwives". Retrieved from http://www.healthprofessionals.gov.sg/content/hprof/snb/en/leftnav/registration_practising_certificate/registration_enrolment/internationally_qualified_nurses_midwives.html
- 18 For example, the Basic Eldercare Course is supported by the Caregivers Training Grant (CTG). See <https://www.silverpages.sg/caregiving/Basic%20Eldercare%20Course> and <https://www.silverpages.sg/CTG> respectively. According to MOH, about 34,000 caregivers tapped on the grant between 2013 and 2017; MOH, direct communication, 2018.
- 19 OECD (2013) "United Kingdom: Highlights". Retrieved from <https://www.oecd.org/els/health-systems/UnitedKingdom-OECD-EC-Good-Time-in-Old-Age.pdf>
- 20 Department of Health and Social Care (2016) "Guidance: Care Act factsheets". Retrieved from <https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets>
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- 22 Age UK (2018) "How to resolve problems and complain about social care". Retrieved from https://www.ageuk.org.uk/globalassets/age-uk/documents/factsheets/fs59_how_to_resolve_problems_and_complain_about_social_care_fcs.pdf



THIS REPORT HAS reviewed the state of eldercare in Singapore and highlighted key observations and concerns of critical players in the long-term care sector. Our study looked at four aspects of community and home care: the overall care landscape, including demand and supply; financing; human resource capabilities; and governance. There is broad acknowledgement that the healthcare and eldercare systems in place are the result of the Government's willingness in recent years to not only invest in the sector and strengthen financing models but also to alert Singaporeans to the multi-faceted opportunities and needs of the country's elder boom. Eldercare has also drawn sustained support from the charity sector, whose numerous voluntary welfare organisations (VWOs) have responded to needs among the elderly by rolling out services and programmes especially for the poorest seniors. In recent years, the private sector has spotted and stepped in to fill gaps in eldercare, especially for middle-class and wealthier Singaporeans who do not qualify for government subsidies or who desire higher quality care. Private care providers are expected to play a bigger role as Singapore moves towards having 960,000 residents aged 65 and above by 2030.¹

Singapore has a world-class acute care system and provides universal healthcare, but the long-term care system, despite recent efforts, remains relatively underdeveloped and underfunded. At 0.19 per cent of Gross Domestic Product in FY2016, Singapore's spending on long-term care, including nursing homes, is still much lower than the 1.4 per cent that countries in the Organisation for Economic Cooperation and Development spent on average in FY2014. The insights of care providers and caregivers in

our study tell us that while much is going right in Singapore, everyone with a stake in eldercare needs to do more, now. The number of elderly is going up every year. If services are available but the elderly do not use them, we have to ask why. If families decline or cut short home nursing visits because they worry about costs, we have to ask what do we do about that? If available financial schemes drive the elderly to hospitals instead of care services because Medisave allows them to pay hospital bills but not eldercare bills, we have reason to ponder. If Singapore is heavily reliant on foreign workers in hospitals, eldercare homes, centres and even at home, we have to ask if this is sustainable. And if community and home care will become increasingly integral to an ageing Singapore, we have to ask if this sector needs more holistic governance.

Meanwhile, the profile of the ageing population is changing. Among other things, future cohorts of elderly Singaporeans will be more educated and better off than the elderly today. We hope that they, as well as younger Singaporeans who will realise soon enough that time flies, will devote some attention to their eldercare options and rights as citizens and consumers of care services. Recent announcements by the Government to introduce the CareShield Life and ElderFund schemes, and to allow severely disabled Singaporeans to use Medisave to pay for long-term care, are positive indicators that the Government is responding to the changing demography and recognising Singaporeans' individual long-term care needs. In 2020, when the enhancements kick in, those with severe disability will have higher levels of and more options for financing their long-term care needs. The national

conversation must continue to include long-term care as we shift from delivering healthcare services mainly in hospitals to community healthcare that focuses on allowing seniors to grow old at home and in the familiarity of their neighbourhoods. Beyond considering long-term care financing, there is still much room for improvement with regard to using primary and preventive care to delay frailty as well as the need for institutional care.

Our recommendations address concerns that cut across centre-based, home-based, integrated care models and transitional care. We hope the insights and recommendations in this report will be taken into account as the Government's proposed Masterplan on Home and Community Care mentioned in the Action Plan for Successful Ageing takes shape, and the wider Healthcare Masterplan 2020 is reviewed.

TOP PRIORITIES

- 1 Boost public spending on community and home care to ease the cost burden on users and providers:** The Ministry of Health (MOH) spent around \$240 million on home and centre-based care in FY2016, accounting for about a third of the long-term care budget and 2.5 per cent of the overall health budget for that year. Formal care services in Singapore are not cheap. Attending a day care centre for seniors for five days a week, together with transport, can cost \$2,500 or more a month before subsidies, which is more than the median monthly fees for charity-run nursing homes. Up to two-thirds of all Singaporean households are eligible for

subsidies but families still have difficulties co-paying after subsidies, say providers. They may decline services, opting for foreign domestic workers, who are affordable but untrained, potentially leading to worsening health outcomes in the long run. Thus, it is worth increasing public spending to enable seniors to age and be cared for at home, rather than in hospitals or nursing homes. More subsidies can be targeted at seniors who are not severely disabled — and thus do not qualify for ElderShield or CareShield Life — but likely to benefit from professional rehabilitative care. Funding support to better meet manpower needs is also essential, with post-tax salaries for support care workers in other fast ageing countries such as Japan, South Korea, Hong Kong and Australia being at least twice of what they are in Singapore.²

- 2 **Catalyse informed collective conversations on care financing and the social compact:** Singaporeans need to have informed collective conversations on what kind of care system we want and how much we are willing to pay for it — whether through premiums or taxes. For decades, family has been the first line of support for those who need care. But the Republic has had below-replacement fertility rates for more than 40 years. The baby boomers were part of large families but went on to have very few children themselves. Given rapid ageing and shrinking family sizes, we

It is worth increasing public spending to enable seniors to age and be cared for at home, rather than in hospitals or nursing homes.

need to discuss whether we should change the social compact and have a long-term care safety net that is stronger and more inclusive than what exists today.

- 3 **Reconsider the eligibility criteria for long-term care insurance:** One of the most pressing gaps in Singapore's long-term care funding is in the area of insurance. Singapore must move away from the current custodial model where payouts kick in only when the person is severely disabled towards a model that supports rehabilitation (more immediately for the current cohort of elderly), prevention (for all in the longer term) and is more inclusive. This can happen on several levels:
- First, ElderShield or CareShield Life functions as a severe disability insurance — rather than a long-term care insurance — and the criteria to qualify for benefits exclude those who need financial help before they are unable to perform at least three activities of daily living (ADLs). A graduated payout rate depending on the number of ADLs would benefit a wider range of older Singaporeans with different degrees of disability and slow down frailty. Significantly, in countries like Germany, Japan and South Korea, long-term care insurance payments kick in well before a person loses the ability to perform three activities of daily living. All these countries have a tiered system of payouts, depending on level of care, and the burden of premiums is shared between individuals and employers

— and in some cases the government. In South Korea, for instance, 50 per cent of the long-term care insurance system is funded by taxes, while employees and employers both contribute to monthly premiums. The benefits for home care cover up to \$1,357 per month, depending on care needs, with a minimum co-payment of 15 per cent.³

- Second, Singapore’s approach towards health insurance needs to consider acute, primary and long-term care holistically. Increasing public and private investment in financing preventive care and rehabilitation with the goal of changing the “health culture” of Singapore would help delay frailty and minimise the mounting costs of eldercare in the long run. Singaporeans need a mindset shift that recognises the importance of risk-pooling through investing in both national and private insurance for meeting their future eldercare needs. It is particularly important that the middle-income invests in supplementary protection.
- Third, getting women — who traditionally earn less — to pay higher premiums goes against the inclusive ethos of social insurance. Despite premium subsidies offered by the Government, older women in particular may choose to opt out of CareShield. It is worth relooking premium parity, especially since women usually shoulder the bulk of unpaid caregiving work.

- 4 **Recalibrate norm costs to match the real costs of services:** In many cases, government norm costs⁴, at which MOH subventions are pegged, are lower than what providers say are the real costs of operating their services. The Government should reconsider the current costing levels for care services that require more intensive or expensive resources, especially manpower. More can also be done to promote outcome-based funding, including bonuses for providers who are able to re-enable clients or prevent institutionalisation. Public information on exactly how norm costs are calculated for different services will help providers pinpoint their own shortcomings, if any, and enable the public to know if fees charged by their care provider are aligned with observed average care costs of other providers.
- 5 **Cap the fundraising burden on non-profits:** VWOs that provide eldercare services have to raise funds to make up for the shortfall between government subventions and the real cost of operating their programmes. They also need donations to help clients unable to co-pay their share of costs even after receiving subsidies. Singapore’s current model of care delivery relies heavily on charities to raise funds independently to meet financing deficits in the costs of care service delivery. It may not be sustainable for VWOs to keep raising more and more donations as they expand services to meet the growing needs of

Singapore’s current model of care delivery relies heavily on charities to raise funds independently to meet financing deficits in the costs of care service delivery.

the rising elderly population. It is worth considering a cap on the fundraising burden — at a certain percentage of a programme’s total operating costs, for example — to allow VWOs to concentrate on providing and improving care instead. In 1999, the Inter-Ministerial Committee on Healthcare for the Elderly recommended a similar cap on the operating expenses of VWOs. Such a step, we feel, is overdue.

- 6 Strengthen the regulatory framework, especially towards private providers and in home care:** Currently, unlike nursing homes or even childcare centres, providers of centre-based and home care services are not licensed. The proposed Healthcare Services Act (HCSA) will extend governance to different types of health services, but it is not yet clear how it will apply to centre-based and home-based care, or the social aspects of eldercare. Currently only home and day care providers that receive government subventions are subject to certain mandatory service requirements, such as on care processes and staff training. As of July 2018, out of about 60 private providers, only two were receiving subsidies, and thus subject to these requirements. On the one hand, we recognise that there is a fine balance to be achieved between ensuring sufficient regulation to safeguard patient welfare, and not imposing excessive restrictions which may dampen growth in an evolving sector. On the other hand, as more private providers enter the community and home care market, the sector needs a regulatory framework which holds them accountable to a high standard of care. Such a regulatory framework should:

- include legislation as well as independent bodies to oversee care quality and handle complaints and feedback from both government-funded and self-funded care recipients (see “Establish independent bodies for quality assurance and complaints handling”)
- address both the social and clinical/medical aspects of care, a move that would be aligned with the Government’s emphasis on integrated care; and incorporate both centre-based and home-based care, and all care providers regardless of whether they receive government funding.

As the draft Healthcare Services bill is being refined, the regulatory issues relevant to centre-based, home-based and social aspects of eldercare deserve careful deliberation by all stakeholders. Singapore needs a holistic and robust governance framework for all aspects of eldercare, covering training and accreditation, auditing on-the-job capabilities and the quality of care, particularly of services delivered in the home (see “Step up training and support for home care”)

- 7 Make useful data available for care providers:** Access to more and better information for care providers will enable them to provide better care for Singaporeans. Such information should include:
- Data to facilitate planning for care provision: To enable care providers to plan in advance and know what services to supply when

and where, better access to data is necessary. The Government has data on potential demand, the number of frail elderly, where they live, their eligibility for available subsidies, and more. Care providers would benefit not only from access to finely distilled demographic data by location (e.g. by constituency or housing estate) but also to short- (1–2 years) and medium-term (3–5 years) plans for tenders by service type and geographical zones. All of this is useful to non-profit and private care providers who operate in different geographical areas of Singapore and need to strategise for cost-effectiveness, efficiency and sustainability of their operations. Relevant data from official statistics should be distilled and presented in an accessible form, preferably online, to providers as well as the public.

- Data sharing of patient/client information: Healthcare institutions and care providers need to improve the sharing of medical and psycho-social care information about those who need eldercare services. Care providers should be allowed a timely and reasonable level of access to establish a clearer picture of clients seeking services. Privacy and confidentiality considerations do matter and are covered by the Personal Data Protection Act, but the law should not block sharing of information that ensures the patient's ongoing care needs are assessed well and fully. Inadequate sharing of information hampers the seamless continuity of service to clients, and this needs attention. Offering clients the choice to opt out of

sharing their records between care providers and healthcare institutions could be a way around the constraints of respecting confidentiality. An information platform integrating data on clinical and social care would make for better continuity of care and more efficient service delivery, even if the elderly client is served by several care providers.

- 8 **Expand and improve respite care options:** One of the most pressing needs is respite care for family caregivers during emergencies or when they need a break from stressful, prolonged eldercare duties. Demand for respite care is likely to increase, not only as the number of seniors increases, but also because family caregivers are ageing themselves. Enlarging the capacity and offering higher quality respite care options will also benefit the well-being of care recipients. Currently caregivers seeking respite are not able to pay for such care support through Medisave, thus bearing hefty out-of-pocket expenses, and have to apply for the service days in advance. Other than expanded overnight respite care options, Singapore also needs “on demand” centre-based respite care services for those who require it at short notice. We recognise that care providers will

Demand for respite care is likely to increase, not only as the number of seniors increases, but also because family caregivers are ageing themselves. Enlarging the capacity and offering higher quality respite care options will also benefit the well-being of care recipients.

need more support in the areas of manpower and funding in order to make such changes. For families who cannot afford to pay for external services for respite care, a cash-for-care scheme could enable a family member to take time off from work and assume caregiving temporarily, to give the main caregiver a break.

BROADEN FINANCING OPTIONS

- 9 **Review use of Medisave for eldercare:** Many seniors choose hospital care over available community and home care services because they can use Medisave to pay for hospital care and treatment, but will incur out-of-pocket expenses if they use the services of non-profit or private care providers. Affordability is a key issue in the take-up of eldercare services. Worries about costs result in many dropping out of beneficial programmes, or not following through with recommended rehabilitation treatments after leaving hospital. The Government's recent announcement that up to \$200 per month can be withdrawn from Medisave to pay for long-term care is welcome, but the qualifying criteria remain restrictive as the applicant must be unable to perform three or more ADLs. Allowing more of the elderly to use Medisave

Affordability is a key issue in the take-up of eldercare services. Worries about costs result in many dropping out of beneficial programmes, or not following through with recommended rehabilitation treatments after leaving hospital.

for long-term care before they reach the stage of severe disability can encourage people to use eldercare services that help delay ill health and frailty. Safeguards such as an annual cap or having a recognised list of services can be put in place to prevent abuse.

- 10 **Extend Medifund and Medifund Silver to more eldercare needs:** Medifund helps the poorest families who have co-payment difficulties, but it cannot be used for social care and home personal care. Lower-income families that just fall short of qualifying for Medifund and government subsidies are particularly stretched when eldercare costs add up to a big proportion of their monthly income. While they can obtain help through the Community Health Assist Scheme (CHAS) and the Seniors' Mobility and Enabling Fund (SMF), among others, there are limits on how much funding they can get for transportation and medical escort services, and medical consumables. Extending Medifund to cover expenses beyond its current financing limits would help those most in need.

ENCOURAGE STRATEGIC PARTNERSHIPS

- 11 **Strengthen collaboration, interaction and engagement among providers:** Partnerships between care providers, with their different specialisations and skills, can improve continuity of care from hospitals to care centres and the home. There are economies of scale to be reaped when

partnerships are formed, including between non-profit and private players. The Agency for Integrated Care (AIC) could take the lead in creating networking platforms for collaboration, cross-sector learning and sharing of innovations. On their part, care providers could establish an association to foster interaction among themselves and engagement with government agencies to voice their views collectively and be consulted as a body on major initiatives, including the proposed Masterplan on Home and Community Care.

BOOST ELDERCARE CAREERS

12 Make eldercare a more attractive career option: Care providers compete with one another, and especially against hospitals, for a limited pool of care workers. Low pay, shift work that is physically demanding, and the lack of public recognition deter Singaporeans from joining the eldercare workforce. Currently, the sector is heavily dependent on foreigners, especially for lower-end personal care needs that Singaporean workers shun. Much has been done to boost nursing as a profession of choice for locals but more can be done to attract and retain those in community nursing

Much has been done to boost nursing as a profession of choice for locals but more can be done to attract and retain those in community nursing given the greater physical demands of the job and the special qualities that providers say are needed particularly for those doing home visits.

given the greater physical demands of the job and the special qualities that providers say are needed particularly for those doing home visits. It is timely and necessary to professionalise and raise the profile of non-medical workers in the sector too. Singapore needs to continue to explore ways of attracting under-tapped segments of the population, such as those interested in making a mid-career switch and retirees. To do so, it is critical to ensure competitive compensation and improve public recognition for both nursing and non-medical staff in community and home care.

- 13 Improve retention rates and productivity:** Successful recruitment of eldercare workers is only a first step. Limited pathways for training and career advancement, and the challenging nature of eldercare work, especially in the community and in clients' homes, discourage Singaporeans from staying long in the sector. Improving productivity through technology and job redesign to reduce manpower needs would make working in the sector more sustainable. Creating advancement opportunities through training and opening up better career pathways could decrease attrition rates too.
- 14 Increase salaries in the sector:** MOH has worked with providers to raise salaries of both local and foreign staff in the community care sector by around 30 per cent since 2012. However, a recent study by the Lien Foundation⁵ showed that salaries for local workers in the long-term care sector lag behind many other jobs in Singapore — such as a hospital

clinic attendant, sales attendant or childcare worker — that require similar qualifications. More importantly, the salaries of local support care workers here are less than half the post-tax salaries for the same jobs in other advanced, fast-ageing economies like Hong Kong, Australia or Japan. This gap needs to be narrowed in tandem with increased skills and competencies. The salaries of foreign care workers, who typically earn 30–40 per cent less than their Singaporean counterparts in support care roles, must also be shored up. A portion of the foreign worker levies could be used to fund higher salaries of foreign workers, especially since the shortage of caregivers is global and foreign workers in particular could easily leave Singapore to do the same job elsewhere — and earn two to four times more — after gaining some experience here.

SHARPEN CARE COMPETENCIES

15 Step up training and support for home care: As eldercare evolves from predominantly hospital-based care to community care, we cannot continue to leave home care providers to set and monitor their own standards, for example, in the areas of certification of workers and escalation protocol in home care. When demand rises for home nurses and personal care workers, care providers are likely to employ whoever is qualified and available in a tight labour market. However, the elderly and others needing

The elderly and others needing care at home are particularly vulnerable groups. Safeguards for home care should be put in place.

care at home are particularly vulnerable groups. Safeguards for home care to be put in place should include:

- establishing accreditation standards similar to those set up by AIC for nursing homes (the Enhanced Nursing Home Standards), but tailored to the working conditions and skills needed for home care. These standards should apply to all providers and across the whole spectrum of workers from trained professionals to personal care staff, whether for social, rehabilitation or medical care; and
- making it compulsory for home nurses to undergo training (both in the classroom and on the job) and obtain certification before being deployed into the community. Home nurses ought to be experienced, up-to-date with knowledge and skills, and confident enough to work alone in homes, under the scrutiny of family members. There should also be standardised supervisory procedures and clear protocols for home nurses to escalate medical problems or emergencies that arise while they are with clients.

16 Train and set limits for live-in helpers: A large and rising number of families depend on untrained foreign domestic workers to look after the elderly at home. First, it should be made mandatory for labour agencies and/or employers to send foreign domestic workers for accredited eldercare training if they are expected to care for the elderly, especially those with medical conditions. Second, these workers need to be educated

on their right to refuse their employers' requests to perform medical procedures best left to nurses. Third, Singapore employers, many of whom make unreasonable demands on live-in helpers, need ongoing education about the limits to the tasks foreign domestic workers can be expected to perform and the risks involved.

EMPOWER CARE RECIPIENTS AND CAREGIVERS

17 Help seniors navigate eldercare services: This is a complex sector that is challenging for care recipients and caregivers from lower-income as well as middle-income families. Despite the proliferation of services, many do not know what is available, the subsidies they qualify for, or where to seek help. Nobody who needs care should say: "I don't know where to go, or what help I can get." Simplifying the process is vital. The information on government websites needs to be comprehensive and up-to-date, distinguish clearly between services offered by private and non-profit providers, and describe what they charge. Rather than having a senior hold multiple cards, technology should be availed to enable all concessions and subsidies that an individual qualifies for to be contained within one card. An online calculator that lets families assess their eligibility for services

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and subsidies will help too. Raising awareness must be a priority, including through community events and at the workplace.

18 Establish independent bodies for quality assurance and complaints handling:

The eldercare arena is sprawling and growing, spanning government, VWOs and private players, big and small, well established and start-ups. Care is delivered in hospitals and in the privacy of homes, and some eldercare workers and organisations are more closely regulated and monitored than others. Singapore needs independent bodies to monitor the quality of eldercare, to handle complaints and decide in disputes. These independent bodies should:

- extend their mandate to include care providers as well as labour agencies that supply all types of care workers, including foreign domestic workers and live-in caregivers of the elderly;
- have powers to enforce sanctions independently or via relevant ministries. This will ensure greater accountability of care providers and quality of care for an ageing population and improve communication between the eldercare stakeholders; and
- make a rating system of each provider's quality of care services publicly available, and develop an online register of complaints submitted and handled to enable consumers to make more informed choices and incentivise providers to maintain high care quality

19 Clarify rights of care recipients, roles of care providers: The number of private players in the eldercare sector is expected to rise to meet the demand for higher quality care as more of Singapore's future seniors will be better educated and better off. As eldercare moves towards a consumer-directed model, we need to encourage more informed decision-making as the care menu presents a wider range of choices. For this to happen, consumers need a clear idea of prices, costs, subsidies and the difference in services provided by non-profit and private care providers. We need to improve price transparency so that people can compare services across care providers, with comprehensive information about available options. Patients and care clients also deserve more information to understand why they are referred to a specific care provider, and how their co-payment levels are calculated relative to the full costs of a service, and subsidies by charities and the Government (including the MOH norm cost at which subsidy levels are pegged).¹

As eldercare moves towards a consumer-directed model, we need to encourage more informed decision-making as the care menu presents a wider range of choices.

ENDNOTES

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- 4 Norm cost is the expected operating cost of an efficiently run service, and MOH means-tested subventions are pegged at a percentage of norm costs.
- 5 See *Long Term Care Manpower Study*, 2018.

Note: This factsheet was provided by the Ministry of Health (MOH) to the Lien Foundation and NUS Social Science Research Centre, 20 July 2018, in response to questions for their Study on Community and Home-based Care for Older Adults in Singapore.

MOH has been investing significantly in the primary and intermediate and long-term care (ILTC) sectors to anchor care for seniors in the community and make home and community care services more affordable. Over the last decade, total government spending in the primary and ILTC sectors increased by close to four times, from \$1.3 billion in FY2007–FY2011 to \$5.1 billion in FY2012–FY2016.

To help seniors age in place with peace of mind, there are multiple layers of support for their care needs. **No one will be denied appropriate healthcare because of the inability to pay.** These financing sources include:

I. GOVERNMENT SUBSIDIES, ASSISTANCE SCHEMES AND COMMUNITY SUPPORT

ILTC subsidies have been enhanced to cover up to two-thirds of Singaporean households since 2012. Other government schemes also help to defray the costs of care at home and in the community, which include the following:

(I) The Seniors' Mobility and Enabling Fund (SMF)¹ supports caregivers in caring for their loved ones at home and has benefitted over 49,000 seniors, with close to \$100 million disbursed since the launch of the scheme in 2011. The SMF will be

topped-up by \$100 million over the next five years to support the continued provision of means-tested subsidies to offset costs of assistive devices and home healthcare items. Subsidies have also been extended for consumables to clients on home palliative care services.

(II) The Foreign Domestic Worker (FDW) Grant provides a monthly grant of \$120 to help to alleviate the cost of care at home for families who hire FDWs to care for persons with moderate to severe disabilities. Thus far, over 18,000 families have benefitted from the FDW Grant.

(III) The Interim Disability Assistance Programme for the Elderly (IDAPE) is another programme introduced in 2002 to benefit severely disabled Singaporeans who were not eligible to join the ElderShield scheme then because they were above age 70 or were already severely disabled. From 2002 to end 2017, the Government has spent more than \$110 million under IDAPE to help severely disabled Singaporeans defray their costs of care.

Community donations to voluntary welfare organisations (VWOs) providing ILTC services are also used to provide financial support to needy Singaporeans utilising long-term care services. In addition, the Community Silver Trust (CST) was set up in 2011 to encourage donations into the ILTC sector by providing dollar-for-dollar matching for eligible donations raised. The CST has thus far matched around \$500 million in donations raised by more than 80 eligible organisations.

II. INSURANCE

From 2002 to 2017, \$133 million has been paid out in ElderShield claims to severely disabled ElderShield policyholders. Insurance will need to play a stronger role in financing our long-term care needs going forward. The ElderShield Review Committee (ESRC) was appointed by MOH to review the scheme and recommend enhancements to better address the needs of Singaporeans who become severely disabled, especially in their old age. In May 2018, the Government accepted the ESRC's recommendations to introduce the new CareShield Life scheme, which will be universal for all Singapore Residents born in 1980 or later, starting from 2020. CareShield Life will provide better protection and assurance for long-term care needs, through lifetime payouts that last as long as policyholders are severely disabled. Payouts will start at \$600 per month in 2020, and increase over time.

III. PERSONAL SAVINGS AND FAMILY SUPPORT

Seniors can rely on their own personal savings, retirement payouts and support from family members. From 2020, severely disabled Singapore Residents aged 30 and above will be able to tap on their own or their spouse's Medisave for their long-term care needs. After setting aside a minimum amount to ensure adequacy for other medical expenses, they can withdraw up to \$2,400 per year (i.e. \$200 per month) in cash to supplement their long-term care needs.

IV. SAFETY NETS

Medifund and Medifund Silver provide discretionary assistance to those who are unable to pay for the rest of their subsidised bills at Medifund-accredited ILTC facilities even after exhausting other means of support. ComCare also provides a safety net for needy seniors who require further financial assistance for their care needs. In FY2016, a total of \$25.1 million in Medifund and Medifund Silver was provided to needy patients in the ILTC facilities. The Government will introduce an ElderFund scheme in 2020 to assist Singapore Citizens aged 30 and above from lower-income households, who are severely disabled and need additional financial support for long-term care. Eligible Singapore Citizens can receive up to \$250 per month in cash, with no cap on payout duration.

MOH will continue to review the long-term care financing framework to keep care affordable and provide support to those who need it.

¹ For more information on the eligibility criteria for SMF, please refer to: [https://www.silverpages.sg/financial-assistance/Seniors%20Mobility%20And%20Enabling%20Fund%20\(SMF\)](https://www.silverpages.sg/financial-assistance/Seniors%20Mobility%20And%20Enabling%20Fund%20(SMF))

Note: This factsheet was provided by the Ministry of Health to the Lien Foundation and NUS Social Science Research Centre, 20 July 2018, in response to questions for their Study on Community and Home-based Care for Older Adults in Singapore.

Singapore needs to expand our community care workforce in tandem to support capacity expansions. There are three key challenges in developing the community care workforce for the future: (1) Our local workforce growth is slowing down with an ageing population. Manpower growth for healthcare has to be sustainable and we have to enable our workforce to work better with higher productivity; (2) Providers requiring skilled staff in small numbers to provide care may face difficulties in attracting and retaining such staff amidst competition for skilled

manpower; (3) We also need to equip our healthcare professionals with relevant skills to address the increasing and diverse needs of seniors.

To develop the community care workforce for the future, MOH has worked with the Agency for Integrated Care (AIC) on initiatives to:

- Improve sector reputation and localisation efforts
- Tap on foreign manpower to complement the local workforce
- Raise competitiveness of salaries
- Train staff to raise capabilities
- Improve career progression and opportunities for advancement
- Enhance productivity improvements

Workforce Policies/Levers	Existing Schemes and Initiatives
Improve sector reputation and localisation efforts	<p>Since 2012, AIC has embarked on efforts to improve public perception of the community care sector.</p> <ul style="list-style-type: none"> • Facilitating local employment. AIC has been working with community care providers and recruitment partners like Workforce Singapore (WSG) and e2i to facilitate employment of individuals and raise awareness of job opportunities in the community care sector. Our recruitment efforts have resulted in more than 1,000 locals successfully finding employment in the sector over the past year. Of these, 250 locals were hired into support care positions like healthcare assistants. • The Community Care Traineeship Programme (CCTP) was introduced in 2015 and it provides funding support to community care providers to send their newly hired local support staff for structured bite-sized training over a three-month period. Providers are also eligible for an On-the-Job training support of \$10,000 per local support staff recruited, to facilitate mentoring, supervision and development of new hires.

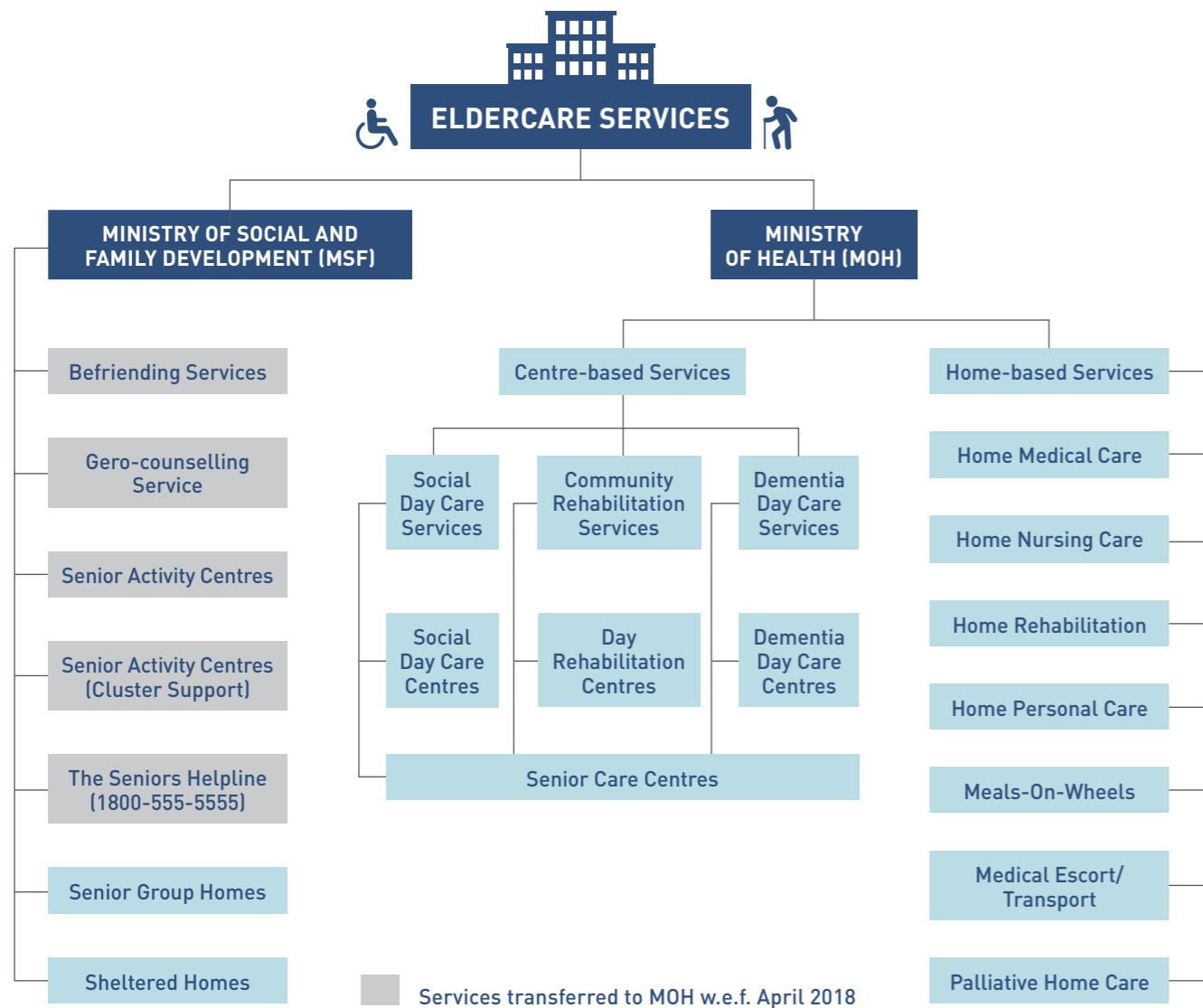
Workforce Policies/Levers	Existing Schemes and Initiatives
Improve sector reputation and localisation efforts	<ul style="list-style-type: none"> • The Return-to-Nursing (RTN) scheme was enhanced in 2016 to attract non-practising local nurses to return to the community care sector, by strengthening the refresher training in the area of geriatric care. The scheme has also adopted a Place-and-Train model under which returning nurses are first placed with their employers before commencing the refresher course. As a result, they will draw salaries for the duration of the course, instead of a training allowance. Nurses returning to the community care sector are eligible for a bonus of \$3,000 and \$5,000, for Enrolled Nurses and Registered Nurses respectively. Around 25 nurses had returned to nursing in the community care sector over the past two years. • The Senior Management Associate Scheme (SMAS)¹ was introduced in 2016 to facilitate the recruitment of mid-career professionals with supervisory or managerial experience into the community care sector as centre managers and operations directors. Uptake on the SMAS has been positive. More than 40 PMETs have successfully transited into the community care sector in 2017, working as centre managers and human resource managers. <p>Beyond these, there is also the Healthcare Professional Conversion Programmes (PCP), which help mid-career Singaporeans switch into the healthcare sector. Since 2003, over 1,000 mid-career professionals have participated in the healthcare PCPs, of whom around 800 were in nursing and 200 were in Allied Health Professions (AHPs). MOH and WSG recently introduced a new PCP for Registered Nurses at the degree level which is a two-year Bachelor of Science (Nursing) degree programme at the Alice Lee Centre for Nursing Studies in NUS. This is an addition to the existing diploma level nursing conversion programme at Nanyang Polytechnic (NYP). In 2017, we enhanced the PCPs for Enrolled and Registered Nurses by providing employers with more funding to support the training of mid-career nurses. In October 2017, we also introduced a second intake for PCP for Registered Nurses intake at NYP. In 2016, we expanded our PCPs to include the new degree programmes at the Singapore Institute of Technology (SIT) for Physiotherapy, Occupational Therapy and Diagnostic Radiography.</p>
Tap on foreign manpower to complement the local workforce	<ul style="list-style-type: none"> • While we have stepped up on efforts to recruit more locals, we will require foreign manpower to complement the local workforce so as to meet our overall manpower demand. Appropriate training programmes are in place to ensure they have the skills needed to provide safe and competent care. • All overseas-trained doctors and nurses need to meet stringent registration requirements by their respective professional boards before they can practise in Singapore. As communication is an important factor in healthcare, these foreign healthcare professionals have to meet minimum standards in English proficiency before they are allowed to practise locally. For example, a foreign nurse will also have to pass recruitment interviews and the Singapore Nursing Board's licensure examination which is conducted in English.

¹ Previously known as the Senior Management Trainee Development (SMTD) scheme, which started in 2013.

Workforce Policies/Levers	Existing Schemes and Initiatives
Tap on foreign manpower to complement the local workforce	<p>For foreign support care staff who are not registered professionals, there are training programmes under the AIC-Learning Institute (AIC-LI) to familiarise them with our local clinical practice, language and cultural context and help them adapt more quickly to the local working environment. Many providers, which are Approved Training Centres (ATCs) with the Institute of Technical Education (ITE), also train their foreign staff in-house to attain the ITE Skills Certificate (ISC) in Healthcare so that they can better support care for seniors.</p> <p>There are currently two ISC in Healthcare programmes, namely ISC in Healthcare (Home Care) and ISC in Healthcare (Dementia Care), which train candidates to assist patients with their activities of daily living (ADLs), basic nursing care and/or dementia care. Employers can apply to ITE to become ATCs to run the programme (classroom and on-the-job training) in-house for their employees. SkillsFuture Singapore (SSG) provides a training grant to providers who become ATCs to conduct training for their staff. As at November 2017, there were 39 community care institutions, comprising nursing homes and community hospitals, which were ATCs.</p>
Raise competitiveness of salaries	<p>To support the attraction and retention of manpower in the community care sector, we have worked with the community care providers since 2012 to raise salaries of their staff through the Intermediate and Long-Term Care Salary Adjustment Exercise (ILTC SAE), in tandem with salary increases in the public healthcare sector. We will continue to review the salaries of staff in the community care sector to ensure that they are recognised adequately for their expanding roles and contributions.</p>
Train staff to raise capabilities	<p>The AIC-Learning Institute (AIC-LI) facilitates the provision of modular training for the community care sector in a broad array of areas such as clinical, therapy, and administration, and the training programmes are subsidised. More than 40,000 training places have been facilitated by the AIC-LI. Courses attended by locals are subsidised at 90 per cent of the course fee while that of foreigners are subsidised at 45 per cent.</p> <p>The Community Care Training Grant (CCTG) supports institutions in sending their staff for training such as conferences beyond the courses offered under the AIC-LI. More than 600 training places for staff in 50 community care institutions have been funded under the CCTG since April 2017. Courses attended by locals are subsidised at 90 per cent of the course fee while that of foreigners are subsidised at 45 per cent.</p> <p>To further deepen skills, the Community Care Manpower Development Award (CCMDA)² introduced in 2017 provides sponsorships for local fresh entrants, mid-career switchers and current staff working in the community care sector to pursue advanced training in skills relevant to their work. It covers formal academic programmes and attachments to local or overseas healthcare and community care facilities. In the past year, about 60 individuals from 28 institutions have been awarded sponsorships to pursue advanced training. CCMDA also provides funding support for community care organisations to invite overseas experts who specialise in fields relevant to the sector, to impart their skills and share their knowledge with the community care audience.</p>

Workforce Policies/Levers	Existing Schemes and Initiatives
Train staff to raise capabilities	<p>Community nurses play a central role in the shift of care beyond hospital to the community to better meet the care needs of the population. We are also investing in strengthening leadership capabilities as we grow the community nursing workforce. The Community Nursing Scholarship, offered by MOH in partnership with the Regional Health Systems (RHS) and community care providers, aims to build a pipeline of nursing leaders to shape the future of community care. It is designed to attract new and existing nursing students, as well as in-service nurses who are keen to pursue a degree conversion programme, to work in the community after graduation.</p>
Improve career progression and opportunities for advancement	<p>As part of MOH's strategy to build a future-ready healthcare workforce, we are working with AIC to develop the Skills Standards Framework (SSF), which articulates various skills domain for support care roles, and is targeted to be completed by end of this year.</p> <p>Separately, SkillsFuture Singapore (SSG) is also developing the Skills Framework for Healthcare and Social Service, which articulates the competencies of each job role and helps employers recognise skills gaps and develop workplace-based skills training to meet changing industry needs. It will facilitate national recognition of skills in the healthcare industry and the development of career progression pathways and remuneration frameworks. The Skills Framework for Healthcare and for Social Service is targeted to be developed by the end of this year, and we will work closely with employers and the healthcare union on their adoption.</p>
Enhance productivity improvements	<p>MOH launched the Healthcare Productivity Roadmap in FY2012, supported by a budget of \$130 million for FY2012 to FY2017 under the Healthcare Productivity Fund (HPF). The roadmap focused on raising productivity by (i) encouraging ground-up initiatives by healthcare operators in the public acute and community care sectors to streamline processes and adopt mechanisation to save manpower, and (ii) promoting the use of IT, education and training to raise the productivity of the healthcare workforce.</p> <p>To sustain efforts in healthcare productivity, another \$80 million has been added to the HPF for the next three years (FY2018 to FY2020) to scale up proven initiatives and encourage innovations. For the community care sector, AIC will be supported under the HPF to collaborate with operators to develop process blueprints for operational excellence, adopt assistive equipment and technologies for care and further expand demand aggregation and bulk procurement of products and services to achieve economies of scale.</p>

² Introduced in 2017 after the consolidation and expansion of the following four community care scholarships: Balaji Sadasivan Study Award, Intermediate and Long-Term Care-Upgrading Programme (ILTC-UP), Social and Health Manpower Development Programme-ILTC (SHMDP-ILTC) and Community Care General Practitioner Partnership Training Award (CC-GPPTA).



Source: Compiled from various government websites.

Scheme	Year	Ministry/ Statutory Board	Description	Funding
Interim Disability Assistance Programme for the Elderly (IDAPE)	2002	Ministry of Health (MOH)/ Agency for Integrated Care (AIC)	Singapore Citizens (SC) who do not qualify for ElderShield due to pre-existing disabilities or because they were too old when it was launched in 2002. Applicants must be born on or before 30 September 1932; or born between 1 October 1932 and 30 September 1962 (both dates inclusive), with pre-existing disabilities as of 30 September 2002.	\$150-\$250 monthly cash payout for up to 72 months depending on household monthly income and means-testing.
ElderShield (CareShield Life from 2020)	2002	MOH/private insurers	An optional severe disability insurance plan that provides basic financial protection to those who need long-term care, especially in their old age. All Singapore Citizens (SC) and Singapore Permanent Residents (SPR) with Medisave accounts are enrolled in ElderShield at the age of 40, unless they opt out of the scheme. From 2020, ElderShield will be replaced by a compulsory scheme known as CareShield Life (for cohorts born in 1980 and later), with two additional enhancements — Medisave withdrawals and a new ElderFund for severely disabled Singaporeans to meet their long-term care needs.	For those who are unable to perform at least three of six Activities of Daily Living (ADL), ElderShield will pay a monthly cash benefit of \$300 per month for up to 60 months, or \$400 per month for up to 72 months. CareShield Life will offer payouts starting at \$600 per month (for claims made in 2020, with future increases to be reviewed regularly) for life. Severely disabled Singaporeans with at least \$5,000 in their Medisave accounts can withdraw \$50-\$200 in cash per month. ElderFund will provide needy severely disabled folk up to \$250 per month.

Scheme	Year	Ministry/ Statutory Board	Description	Funding
Caregivers Training Grant	2007	MOH/AIC	Training to equip caregivers with the capabilities to better care for the physical and socio-emotional needs of persons with disabilities and the elderly. The caregiver must be the person in charge of caring for the care recipient (this can include family members and foreign domestic workers).	\$200 per care recipient per financial year to attend approved courses; care recipient must be SC or SPR and above 65 years old; caregiver must complete the training to qualify for the grant.
Comcare Short-to-Medium Term Assistance	2005	Ministry of Social and Family Development (MSF)	Supports low-income SC or SPR who are looking for work or temporarily unable to work due to illness or full-time caregiving responsibilities for their dependants. The applicant must have a monthly household income of \$1,900 or below, or a monthly household income per person of \$650 or below, with little or no family support, savings or assets to rely on for daily necessities.	The individual and his/her household may receive help with rental, utilities and transport costs, monthly cash grants, medical assistance and job search and training.

Scheme	Year	Ministry/ Statutory Board	Description	Funding
Community Health Assist Scheme (CHAS)	2012	MOH/AIC	Previously the Primary Care Partnership Scheme (PCPS) which was introduced in 2000. There are two types of CHAS cards — blue or orange — which determine different levels of subsidies depending on the per capita monthly household income or the annual value of the home for households with no monthly income. There also exists a CHAS for Pioneer Generation card for those born before 1950 and who became an SC by 1987. Pioneers receive subsidies regardless of their income or annual value of their homes. In 2013, the threshold for the household monthly income per person was further raised from \$1,500 to \$1,800. In 2014, the age criterion (40 years and above) was removed, and the threshold for the annual value of residence was increased from \$13,000 to \$21,000.	Lower- and lower-middle income households are eligible to receive subsidies for medical and dental care at participating healthcare facilities.

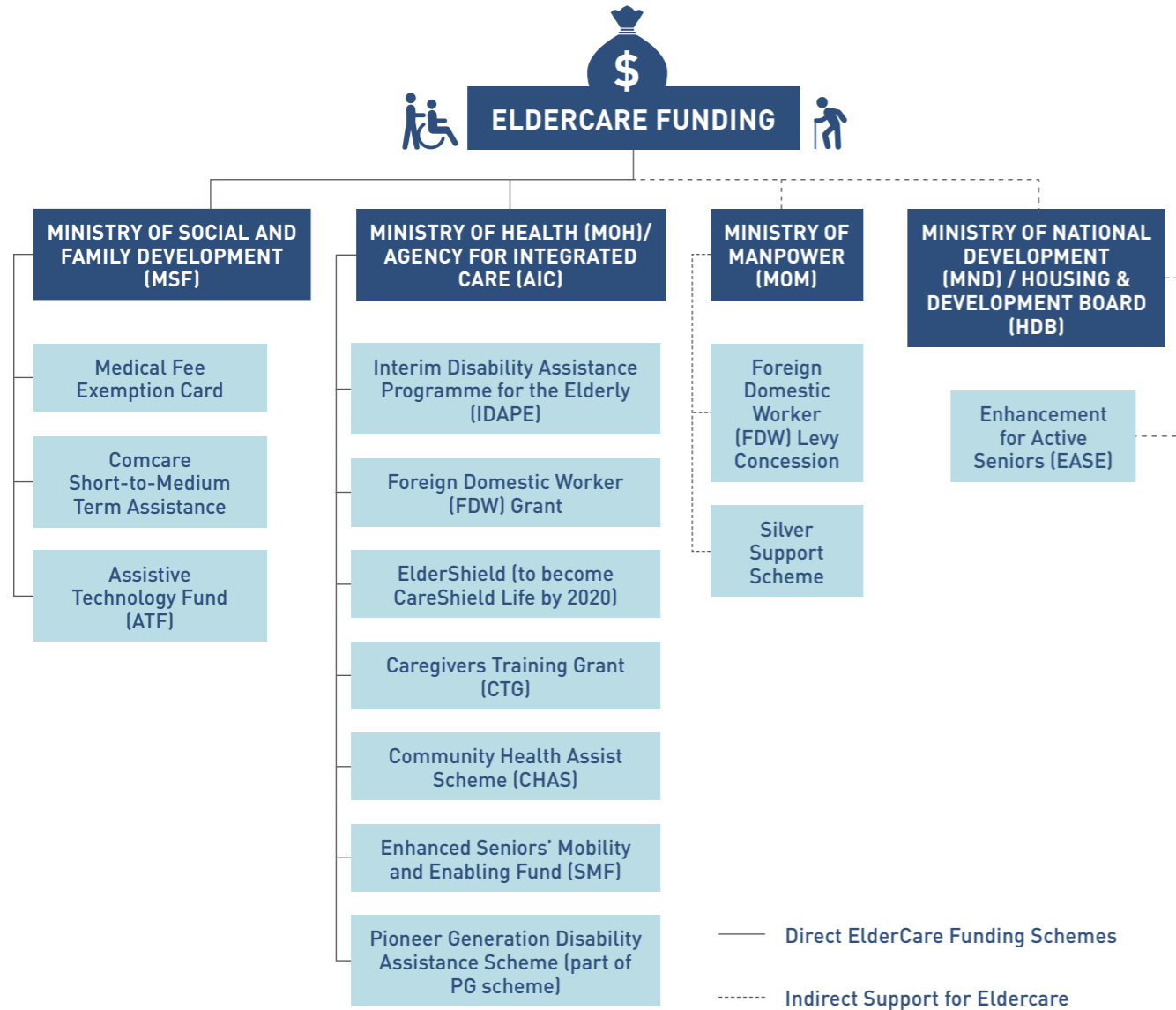
Scheme	Year	Ministry/ Statutory Board	Description	Funding
Foreign Domestic Worker (FDW) Grant	2012	MOH/AIC	To be eligible under this scheme, care recipients will need to be assessed by a qualified assessor as requiring permanent assistance with three or more ADLs. The applicant's household monthly income per person should not exceed \$2,600, or for those without household income, the annual value of their property should not exceed \$13,000. With effect from 1 April 2019, the levy for the first FDW will rise to \$300 a month and \$450 for a second FDW (compared to a flat rate of \$265 now).	\$120 monthly cash payment given to families who need to hire a FDW.
Enhancement for Active Seniors (EASE)	2012	Housing & Development Board (HDB)	Subsidies for home modifications such as grab bars and slip-resistant tiles in toilet. Required to submit a Functional Assessment Report.	1- to 3-room flats: 95% subsidy 4-room flats: 92.5% subsidy 5-room flats: 90% subsidy Executive flats: 87.5% subsidy

Scheme	Year	Ministry/ Statutory Board	Description	Funding
Enhanced Seniors' Mobility and Enabling Fund (SMF)	2012	MOH/AIC	The fund covers three aspects — subsidies for mobility devices, transport and consumables. It provides subsidies for basic and motorised wheelchairs, commodes, shower chairs, geriatric chairs, hospital beds, pressure relief mattresses, spectacles, hearing aids, milk, diapers etc. Singaporeans aged 60 and above with a household monthly income per person of \$1,800 or below are means-tested to determine their eligibility.	Eligible seniors can receive subsidies of up to 90 per cent of the cost of the devices needed; the maximum subsidy cap is dependent on the type of device. For transport and consumables, subsidy quantum depends on the means testing outcome for the senior.
Pioneer Generation Disability Assistance Scheme (Pioneer DAS)	2014	MOH/AIC	For pioneers born before 1950 and who became SCs by 1987, and unable to fulfil at least three out of the six listed ADLs.	Eligible applicants receive \$100 per month for expenses.

Scheme	Year	Ministry/ Statutory Board	Description	Funding
Silver Support Scheme	2015	Ministry of Manpower (MOM)	SCs aged 65 and above who are in the lowest financial bracket — the bottom 20 per cent — can qualify for this scheme. Recipients must have total Central Provident Fund (CPF) contributions of not more than \$70,000 by age 55; self-employed persons should also have an average annual net trade income of not more than \$22,800 between the age of 45 and 54. Recipients must also live in an HDB flat that is 5-room or smaller, and do not own or have a spouse who owns a 5-room or larger HDB flat or private property or multiple properties.	Eligible applicants will receive Silver Support payouts of between \$300 and \$750 every three months, according to the type of HDB flat that they live in.
Foreign Domestic Worker (FDW) levy concession	No data	MOM/AIC ¹	Care recipient below 16 years old or above 65 years old (w.e.f. 1 April 2019, the age will be raised to 67 years old). Each household gets concessions for up to two FDWs for two loved ones in one household at the same time. AIC administers a separate scheme for Persons With Disabilities.	Eligible applicants can qualify for the concessionary levy rate of \$60 per month instead of \$265 per month.

Scheme	Year	Ministry/ Statutory Board	Description	Funding
Medical Fee Exemption Card	No data	MSF	SC or SPR with \$6,000 savings or less, and less than \$700 in monthly per capita income; staying in an MOH-funded VWO nursing home, chronic sick hospital or inpatient hospice; or staying in a private nursing home under the portable subsidy scheme and means-tested.	Free treatment at restructured hospitals, polyclinics and approved intermediate and long-term care services
Assistive Technology Fund	No data	MSF/ SG Enable	SC or SPR with disabilities and needs to purchase assistive technology devices. The fund can be used to acquire, replace, upgrade or repair assistive technology devices. These devices include wheelchairs and hearing aids. The devices should aid in purposes of early intervention, education, training, employment, therapy, rehabilitation and/or independence in daily living. Applicants must undergo a qualified assessor's assessment to determine the need and type of device(s), and have a household gross monthly income per person of \$1,800 and below.	Eligible applicants can be subsidised up to 90 per cent of the cost of devices that aid in independent living, subject to a lifetime cap of \$40,000.

¹ AIC administers the functional assessment for the FDW levy concession for Persons with Disabilities. However, the levy concessions as a whole are administered by MOM.



Source: Compiled from various government websites.

Funder	Scheme	Funding Description
Ministry of Health (MOH)	Healthcare Productivity Fund (HPF)*	Since its launch in 2012, the \$130 million fund has helped to finance hundreds of projects and led to the implementation of more than 250 successful projects benefitting more than 70 public healthcare and community care organisations (as at end-2017). From 2018, an additional \$80 million will be injected into a fund to promote productivity in healthcare over the next three years.
MOH	Community Care Traineeship Programme (CCTP)*	The CCTP provides funding to support community care providers to send newly hired local support care staff to undergo training for their new roles as healthcare assistants and therapy assistants.
MOH	On-the-Job Training support*	Community care providers are eligible for monetary support of \$10,000 per local support care staff recruited, to facilitate mentoring, supervision and development of new hires. In addition, new local support care staff will be eligible for a retention bonus of \$3,000 after their first year of service.
MOH (administered by the Agency for Integrated Care [AIC])	Senior Management Associate Scheme (SMAS)*	This scheme provides funding support to providers for the remuneration and benefits given to mid-career professionals with managerial experience who are keen to switch to the community care sector as centre managers or operations directors. The uptake on the SMAS has been positive, with more than 40 professionals successfully transiting into the sector in 2017.
MOH (administered by AIC)	Community Care Manpower Development Award (CCMDA)*	The award provides fresh entrants, mid-career switchers and current staff working in the community care sector, as well as general practitioners with a passion and desire to serve the needs of seniors in community care organisations, with opportunities for training. It covers largely formal academic programmes and attachments to local or overseas healthcare and community care facilities. CCMDA also provides funding support for community care organisations to invite overseas experts who specialise in fields relevant to the sector to impart their skills to and share their knowledge with the community care audience.

Funder	Scheme	Funding Description
MOH (administered by AIC)	Community Care Training Grant (CCTG)*	This grant co-funds eligible organisations to send their staff for training beyond the courses offered under the AIC Learning Institute. It supports conferences, seminars, forums, etc. related to healthcare, community care and integrated care.
MOH (administered by AIC)	Community Silver Trust (CST)	CST is a dollar-for-dollar donation matching grant provided by the Government to enhance the services of voluntary welfare organisations (VWOs) in the intermediate and long-term care (ILTC) sector. Each VWO can receive a maximum of \$15 million in matching grant each year, and a maximum of \$100 million in matching grant in total.
Ministry of Social and Family Development (MSF)	MSF Recurrent and Capital Funds	Only VWOs appointed by MSF are eligible. Funding covers recurrent expenses such as operating costs to deliver the services, and capital expenditure for facilities, including construction, renovation, purchase of furniture and equipment and cyclical maintenance costs.
MSF (administered by National Council of Social Service)	VWOs-Charities Capability Fund (VCF)	VWOs, charities and Institutions of Public Character can tap on the VCF to improve their capabilities and services in the social service sector. The \$100 million fund aims to enhance the professional, organisational and services capabilities of VWOs providing social services in Singapore.
Tote Board (administered by AIC)	Tote Board Community Healthcare Fund (TBCHF)	TBCHF provides grants to not-for-profit organisations for programmes to improve preventive care, community care and/or build the capabilities of healthcare services.

Funder	Scheme	Funding Description
Tote Board and MSF (funded through Singapore Centre for Social Enterprise [raiSE])	VentureForGood*	VentureForGood awards up to \$300,000 for seed grants, targeted at new or existing social enterprises addressing a social gap or need. It is open to all new and existing locally based (registered) social enterprises.
Tote Board (administered by NCSS)	Tote Board Social Service Fund (TBSSF)	Set up in 2006, it provides grants for critical and strategic social service programmes and innovations and capital funding for the social service sector. It also provides funding support to organisations such as VWOS, so that they can better focus on service delivery, service standards, and achieving impactful outcomes for their beneficiaries. In 2016, Tote Board injected a new tranche of \$350 million into the TBSSF for the next three years, to enable the implementation of more programmes that benefit families, children, seniors and persons with disabilities.

Source: Compiled from various government websites.

*These schemes are also open to private providers (see Appendix 5).

APPENDIX 5 Funding Schemes Open to Private Providers

Funder	Scheme	Funding Description
Economic Development Board (EDB)	Training Grant for Companies (TGC)	TGC is aimed at encouraging firm-level manpower capability development and the development of talent across all levels. This includes technical and leadership capabilities. An entity awarded the TGC grant is eligible for co-funding support of up to 30 per cent of qualifying costs such as trainee salaries and overseas trainee expenses.
EDB	Productivity Grant (PG)	PG encourages firm-level transformation efforts to enhance the environmental and operational sustainability of existing industrial operations in Singapore. An entity awarded the PG is eligible for co-funding support of up to 20 per cent of the qualifying costs for projects which could result in significant efficiency improvements in resource utilisation. Qualifying costs for the PG grant include manpower, training, consultancy, equipment, software and materials costs.
SPRING SEEDS Capital	Startup SG Founder/ Startup SG Tech/ Startup SG Equity/ Startup SG Accelerator/ Startup SG Loan	Startup SG represents the shared interests of the startup community and positions Singapore as a leading startup hub. It provides entrepreneurs with a launch pad and a platform to connect them to the global stage and access to local support initiatives.
Tote Board and MSF (funded through Singapore Centre for Social Enterprise [raiSE])	raiSE Impact Finance (RIF)	RIF is focused on providing capital to Singapore-based social enterprises with a clear social mission to address human-centred social gaps and needs within a sustainable business model, clear intent and motivation among founder(s) and management team to achieve the social mission. It provides investment capital with a preference in convertible loans.
Ministry of Health (MOH)	Portable Subsidy Scheme	Under this scheme, subsidies are provided to eligible patients in private nursing homes appointed via Requests for Proposals (RFPs) to care for subsidised patients. These homes would have beds available for patients who are eligible for MOH subsidies and referred by AIC. The portable subsidy scheme has been expanded to home- and centre-based care operators.

Funder	Scheme	Funding Description
MOH	Healthcare Productivity Fund (HPF)*	Since its launch in 2012, the \$130 million fund has helped to finance hundreds of projects and led to the implementation of more than 250 successful projects benefitting more than 70 public healthcare and community care organisations (as at end-2017). From 2018, an additional \$80 million will be injected into a fund to promote productivity in healthcare over the next three years.
MOH	Community Care Traineeship Programme (CCTP)*	The CCTP provides funding to support community care providers to send newly hired local support care staff to undergo training for their new roles as healthcare assistants and therapy assistants.
MOH	On-the-Job Training support*	Community care providers are eligible for monetary support of \$10,000 per local support care staff recruited, to facilitate mentoring, supervision and development of new hires. In addition, new local support care staff will be eligible for a retention bonus of \$3,000 after their first year of service.
MOH (administered by AIC)	Senior Management Associate Scheme (SMAS)*	This scheme provides funding support to providers for the remuneration and benefits given to mid-career professionals with managerial experience who are keen to switch to the community care sector as centre managers or operations directors. The uptake on the SMAS has been positive, with more than 40 professionals successfully transiting into the sector in 2017.
MOH (administered by AIC)	Community Care Manpower Development Award (CCMDA)*	The award provides fresh entrants, mid-career switchers and current staff working in the community care sector, as well as general practitioners with a passion and desire to serve the needs of seniors in community care organisations, with opportunities for training. It covers largely formal academic programmes and attachments to local or overseas healthcare and community care facilities. CCMDA also provides funding support for community care organisations to invite overseas experts who specialise in fields relevant to the sector to impart their skills to and share their knowledge with the community care audience.

Funder	Scheme	Funding Description
MOH (administered by AIC)	Community Care Training Grant (CCTG)*	This grant co-funds eligible organisations to send their staff for training beyond the courses offered under the AIC Learning Institute. It supports conferences, seminars, forums, etc. related to healthcare, community care and integrated care.
Tote Board and Ministry of Social and Family Development (MSF) (funded through Singapore Centre for Social Enterprise [raiSE])	VentureForGood*	VentureForGood awards up to \$300,000 for seed grants, targeted at new or existing social enterprises addressing a social gap or need. It is open to all new and existing locally based (registered) social enterprises.

Source: Compiled from various government websites.

*These schemes are also open to non-profit providers (see Appendix 4).

APPENDIX 6 Overview of Key Budget Initiatives on Community and Home Care

Main Area(s) of Expenditure	2013	2014	2015	2016	2017	2018
Top-Ups to Existing Funds	Seniors' Mobility Fund is expanded to Seniors' Mobility and Enabling Fund (SMF), with a top-up of \$40 million, to include purchase of (i) assistive devices and (ii) healthcare consumables. Medifund is topped up with \$1 billion. ComCare Endowment Fund is topped up with \$200 million.		Transport subsidies under the original SMF were expanded to cover all seniors who need mobility assistance.		Medifund is topped up with \$500 million. ComCare Endowment Fund is topped up with \$200 million. GST Voucher Fund is topped up with \$1.5 billion.	SMF is topped up with \$100 million. Community Silver Trust (CST) is topped up with \$300 million to match donations raised for active ageing programmes.
Policies on Medisave, MediShield Life and ElderShield		Medisave is extended to more types of outpatient treatment, for use of up to \$300. Shift from MediShield to MediShield Life for elderly to better cover for large bills.	Medisave expanded to include four new outpatient conditions. In total 19 chronic conditions are covered under the Community Health Assist Scheme (CHAS) and Medisave.	Medisave lifetime withdrawal limit is extended to home palliative care, including day hospice services.		Review of ElderShield announced.

Main Area(s) of Expenditure	2013	2014	2015	2016	2017	2018
Community and Home Care Initiatives		<p>Home Care:</p> <ul style="list-style-type: none"> Interim Caregiver Service is expanded to all major restructured and community hospitals. Subsidies provided for Home-based Rehabilitation Services and Home Environment Assessments. Home Care Guidelines launched for public and industry consultation. <p>Centre-based:</p> <ul style="list-style-type: none"> Centre-based Care Guidelines launched for consultation. Capacity of Senior Care Centres expanded. To conduct pilot for Weekend Respite Services. 	<p>Home Care:</p> <ul style="list-style-type: none"> Reduced foreign maid levy for families with children or frail elderly. <p>Centre-based:</p> <ul style="list-style-type: none"> Community Hospital Common System (CHCS) to be implemented for VWO community hospitals (transition of patient care between acute and intermediate and long-term care settings). 	<p>To conduct pilot Integrated Operator Scheme to integrate nursing homes, eldercare centres and home care services within same area.</p> <p>To conduct pilot for Community Networks for Seniors, with full-time officers studying health and social needs of seniors and drawing together local stakeholders.</p> <p>Home Care:</p> <ul style="list-style-type: none"> Pilot for Eldercarer training programme to train domestic helpers. <p>Centre-based:</p> <ul style="list-style-type: none"> Work with HDB to pre-build spaces within Build-to-Order HDB developments to serve as Active Ageing Hubs. 	<p>Five-year Community Mental Health (CMH) Masterplan is launched, with additional \$160 million for VWOs to set up community-based teams to support those in need and educate the public on mental health issues, including dementia.</p> <p>Dementia-Friendly Communities to be expanded.</p>	<p>Community Networks for Seniors to be expanded nationwide by 2020.</p> <p>Dementia-Friendly Communities expanded to 15.</p> <p>Centre-based: Care Close to Home (C2H) programme expanded to four new sites in 2018.</p>

Main Area(s) of Expenditure	2013	2014	2015	2016	2017	2018
Other healthcare and social initiatives		<p>Pioneer Generation Package:</p> <ul style="list-style-type: none"> Additional 50 per cent off subsidised services at Specialist Outpatient Clinics and Polyclinics. Special subsidies for pioneers through the Community Health Assist Scheme (CHAS), which is available in Blue and Orange tiers. Annual Medisave Top-up of \$100 to \$200. MediShield Life premium subsidies starting from 40 per cent at age 54, rising to 60 per cent at age 90. 		<p>National Silver Academy is set up for Singaporeans aged 50 and above to sign up for short and exam-free courses.</p> <p>Healthcare Skills Future Study Awards worth \$5,000 will be provided under SkillsFuture to support skills upgrading of healthcare workforce.</p>	<p>Advance Care Planning expanded to enhance Palliative Care.</p> <p>Manpower schemes such as Professional Conversion Programmes to be made available over the next three years for healthcare professionals, with \$24 million allocated for the programme.</p>	<p>Social- and health-related services for seniors transferred to MOH, with AIC as the central implementation agency. The Pioneer Generation Office will also be merged with AIC, and renamed as the Silver Generation Office.</p> <p>Proximity Housing Grant (PHG): Singles who buy a resale public housing flat to live near their parents will receive S\$10,000 under the enhanced PHG scheme. For families buying a resale flat to live with parents or children, the PHG grant is also raised from S\$20,000 to S\$30,000.</p>

APPENDIX 7 Centre-based Care Offered by Ministry of Health and Ministry of Social and Family Development (prior to April 2018)

- A) The Ministry of Health's (MOH) services aim to provide healthcare/medical support to the elderly who need it. The following care services come under the purview of MOH:
- **Social/Maintenance Day Care Services:** These day care centres provide care, activities and opportunities for socialising for older Singaporeans who require supervision or would like to have social company when their family members are at work. Such centres run programmes that include simple exercise, activities to promote social interactions and quality of life, and caregiver support. Senior Care Centres provide additional nursing services.
 - **Community Rehabilitation Services:** These are day centres (e.g. Day Rehabilitation Centres) that provide physiotherapy and occupational therapy services for people with impaired functional abilities. The key aim is to improve the client's functional status to the maximum level medically possible, hence allowing them to regain their ability to perform activities of daily living.
 - **Dementia Day Care Services:** These day centres provide maintenance day care and activities for older Singaporeans with dementia, and support caregivers who are unavailable during the day.
- B) The Ministry of Social and Family Development's (MSF) eldercare services are focused on social care. See Appendix 1 for the list of MSF services transferred to MOH with effect from April 2018:
- **Befriending Services:** These include home visits, telephone befriending calls, organising outings, running errands, distributing rations, and referrals of appropriate services for socially-isolated seniors with little social support.
 - **Counselling Services:** Professional counselling is provided to the elderly or their family members to manage their emotional health, and personal and family challenges.
 - **Senior Activity Centres:** These are drop-in centres for vulnerable older Singaporeans living in HDB rental flats and studio apartments. Such centres hold activities similar to MOH's Social Day Care Centres. They also manage the "emergency alert response call" systems of rental flat units and may provide services such as Traditional Chinese Medicine, medical consultation and physiotherapy.
 - **Senior Activity Centres (Cluster Support):** These centres provide social support through monitoring, case management and counselling services. They facilitate coordination of community-based care and support services.
 - **Senior Group Homes:** These bring vulnerable seniors with some physical impairment together in a cluster of rental units. They provide them with daily living assistance through coordination of social and care services, enabling them to continue living in the community through a mutually supportive environment.
 - **The Seniors Helpline:** Seniors aged 50 years and above, as well as their caregivers, can call the helpline during working hours for tele-counselling, and to find out more about available community resources.
 - **Sheltered Homes:** Older Singaporeans who lack family support and need permanent accommodation plans can stay at Sheltered Homes. These homes are licensed under the Home for the Aged Act.

Source: Ministry of Social and Family Development (2016) "Services & programmes for elderly". Retrieved from <https://www.msf.gov.sg/policies/Helping-the-Needy-and-Vulnerable/Supporting-Vulnerable-Elderly/Pages/Services-and-Programmes-for-Elderly.aspx>; Ministry of Health (2017) "Intermediate and long-term care (ILTC) services". Retrieved from https://www.moh.gov.sg/content/moh_web/home/our_healthcare_system/Healthcare_Services/Intermediate_And_Long-Term_Care_Services.html

APPENDIX 8 Home-based Care (Ministry of Health)

- **Home Medical Care:** Doctors visit clients at home to provide consultations, assessment and management of the patient's condition. The aim is to keep clients healthy and functionally independent at home and in the community for as long as possible, hence delaying institutional care (such as admission into a nursing home).
- **Home Nursing Care:** Nurses provide nursing care such as wound dressing, stoma care and insertion of nasogastric tubes in the client's home. They also play a key role in managing and reviewing the care plan of the patient, in consultation with doctors, as well as training caregivers in basic care.
- **Home Rehabilitation:** Physical, speech and occupational therapists pay home visits to provide physiotherapy and occupational therapy services for patients suffering from conditions that impair their functional abilities (e.g. strokes, fractures, lower limb amputation).
- **Home Personal Care:** These include a variety of services, such as personal hygiene, housekeeping, medication reminder service, mind-stimulating activities and other personal care tasks.
- **Meals-On-Wheels:** Daily meals are provided at the doorstep of seniors who are unable to buy or prepare meals for themselves.
- **Medical Escort/Transport Services:** These ferry seniors to medical appointments should they be unable to use public transport, or if the frail and/or working caregiver requires such assistance. A medical escort will accompany the older person, if required.
- **Palliative Home Care:** These provide medical and nursing care to terminally ill patients and support for their families. Carried out by a multi-disciplinary team of doctors and nurses, and at times, social workers as well, the home palliative care seeks to improve the quality of the patient's remaining days through pain control, symptom relief and counselling.

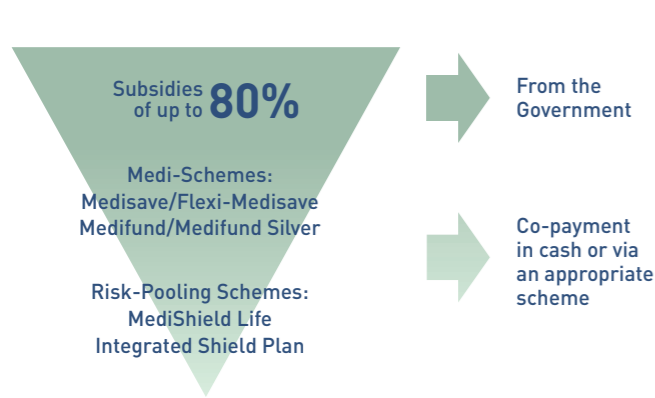
Source: Ministry of Health (2017) "Intermediate and long-term care (ILTC) services". Retrieved from https://www.moh.gov.sg/content/moh_web/home/our_healthcare_system/Healthcare_Services/Intermediate_And_Long-Term_Care_Services.html

Name of Hospital	Name of Programme/ Service	Service Partners	Key Features of Service
Central Region: National Healthcare Group (NHG)			
Khoo Teck Puat Hospital	Ageing In Place Community Care Team	Home Nursing Foundation TOUCH Community Services	<ul style="list-style-type: none"> Free service targeted at elderly patients. Support provided for 3–6 months with regular follow-up. Services include: assessing patient’s home environment, caregiver training, medical reconciliation during home visits, phone reminders to patients for follow-up appointments. Charged service offering personalised post-discharge care management for patients with complex and chronic medical conditions. Service available up to a period of six months. Involves a wide range of services provided by a team of doctors, nurses, physiotherapists, occupational therapist and speech therapist.
Tan Tock Seng Hospital	Transitional Care Programme	Ang Mo Kio-Thye Hua Kwan Hospital	<ul style="list-style-type: none"> Support provided to patients at their residences for 3–6 months after their discharge. Support provided until patients (1) no longer require follow-up (2) access step-down care services from Home Nursing Foundation or (3) obtain other home medical care providers for continual nursing care.
Eastern Region: Singapore Healthcare Services (SingHealth)			
Changi General Hospital	Hospital to Home Programme (H2H)	South East CDC	<ul style="list-style-type: none"> Comprises care coordinators with either nursing or social work training. Care coordinators will assess, plan, coordinate, monitor and evaluate the options and services required by patients with complex care needs in the hospital. They educate patients and their families, and provide them with the tools and support to promote independence and self-management of their medical conditions.
		North East CDC	
Home Nursing Foundation			
	Transitional Convalescent Facility (TCF)	Peacehaven	<ul style="list-style-type: none"> Aims to provide lower intensity rehabilitation for the frail elderly over a period of 3–6 months. Allows the elderly to regain maximum mobility before returning home to live as independently as possible.

Name of Hospital	Name of Programme/ Service	Service Partners	Key Features of Service
Singapore General Hospital	Transitional Home Care Programme	Home Nursing Foundation NTUC Eldercare	<ul style="list-style-type: none"> Service begins within one week of discharge from SGH, and will cover a three-month period. Charges depend on: (1) type of visit (medical, nursing or therapy) and (2) patient’s subsidy level. Services include integrated medical consultation by doctors, nursing care, medication management, physiotherapy, occupational therapy, speech therapy and social services
Western Region: National University Health System (NUHS)			
National University Hospital	NUH2Home (NUH2H) Service, under NUH Transitional Care Programme	NTUC Health Home Nursing Foundation Lions Befriender Caregiving Welfare Association	<ul style="list-style-type: none"> Service will cover up to three months. An individualised post-discharge care plan will be provided by a team of doctors and nurses before discharge. Consultation fee varies according to (1) type of care requirements (from doctor, nurse or allied health professional) and (2) patient’s subsidy level. Transitional care team needs to be informed at least one day before scheduled visit.
Ng Teng Fong General Hospital (integrated with Jurong Community Hospital)	Post-acute and Continuing Care Service (under Jurong Community Hospital)		<ul style="list-style-type: none"> Accepts referrals from other hospitals as well as general practitioners Provides a multi-disciplinary team approach to care management, focusing on rehabilitation after acute illness and surgery, senior citizen evaluation and management, preventive care, wound care and care reintegration

Sources: Ministry of Health (2017) “Reorganisation of healthcare system into three integrated clusters to better meet future healthcare needs”. Retrieved from https://www.moh.gov.sg/content/moh_web/home/pressRoom/pressRoomItemRelease/2017/reorganisation-of-healthcare-system-into-three-integrated-cluste.html; various hospital websites.

APPENDIX 10 Singapore Healthcare Financing Structure



Singapore’s healthcare financing system uses the following risk-pooling insurance schemes to keep hospital bills affordable:

- Integrated Shield Plan comprises the basic MediShield Life component and optional private insurance that provides additional benefits for hospitalisation and choices not covered under MediShield Life. The private insurer provides reimbursement or pays out for private hospital stays, or Class A, B1 or B2 wards in government hospitals.
- ElderShield is a severe disability insurance that Singaporeans above 40 years old can participate in through Medisave payments (there is an opt-out clause). ElderShield Supplements allow policyholders to purchase additional disability benefits coverage beyond the basic ElderShield product. To receive payment through ElderShield, a person has to be unable to fulfil at least three of the six activities of daily living (ADL), which include being able to wash, dress and feed themselves. Those who enrolled between September 2002 and August 2007 are entitled to a monthly payout of \$300 for five years. Those who joined after September 2007 are eligible for a monthly payout of \$400 for six years.
- CareShield Life will replace ElderShield from 2020. The committee tasked with reviewing ElderShield recommended making the severe disability insurance scheme compulsory for all Singapore Citizens and Permanent Residents aged 40 and below in 2020; increasing payout rates to \$600 per month for claims made in 2020 (with future increases to be reviewed regularly); and removing the six-year cap on payments. The Government also announced that severely disabled Singaporeans will be able to use up to \$200 per month of their own or their spouse’s Medisave account to pay for long-term care, subject to maintaining a minimum Medisave balance of \$5,000. Second, a newly established ElderFund will enable lower-income Singaporeans (aged 30 years old and above) who are severely disabled to apply for and receive lifetime payouts of up to \$250 per month.
- MediShield Life is a basic universal health insurance plan, administered by the Central Provident Fund (CPF) Board, to pay for large hospital bills and selected costly outpatient treatments. All Singaporeans are covered under MediShield Life, which provides coverage for life and includes pre-existing conditions. MediShield Life payouts are pegged at subsidised bills incurred at Class B2/C wards and subsidised outpatient treatments/day surgery at public hospitals. For those aged 80 and below, the deductible is \$1,500 for stays in Class C wards, and \$2,000 for stays in Class B2 and above wards. For those above age 80, the deductible is \$2,000 and \$3,000 for stays in Class C and B2 and above wards respectively. Patients are responsible for the deductible and co-insurance pegged at 3–10 per cent as the hospital bill increases. Premiums for MediShield Life can be paid via Medisave.

Source: Compiled from various government websites.

APPENDIX 11 Relevant Legislation on Intermediate and Long-Term Care (ILTC) Services

Legislative Act	Administrator	Purpose
Charities Act — Cap 37 • Institutions of Public Character • Code of Governance	Ministry of Culture, Community & Youth • Charity Portal	An Act to make provision for the registration of charities, the administration of charities and their affairs, the regulation of charities and institutions of a public character, the regulation of fundraising activities carried on in connection with charities and other institutions and the conduct of fundraising appeals, and for purposes connected therewith.
Companies Act — Cap 50	Accounting & Corporate Regulatory Authority	The Companies Act applies to all companies incorporated in Singapore, and contains provisions relating to the life cycle of companies, from incorporation to management to winding up.
Workplace Safety & Health Act — Cap 354A • Regulations, directives and guidelines issued under WSHA	Ministry of Manpower	An Act relating to the safety, health and welfare of persons at work in workplaces. It emphasises the importance of managing workplace safety and health proactively by requiring stakeholders to take reasonably practicable measures to ensure the safety and health of workers and other people that are affected by the work carried out.
Infectious Diseases Act — Cap 137	Ministry of Health & National Environment Agency	An Act relating to quarantine and the prevention of infectious diseases.
Allied Health Professions Act 2011	Ministry of Health	An Act to provide for the registration of prescribed allied health professionals for the protection of the health and safety of the public and for purposes connected therewith. It also establishes a regime for complaints management, inquiry, investigation and discipline of cases involving registered allied health professionals.
Medical and Elderly Care Endowment Schemes Act — Cap 137A	Ministry of Health	An Act to reconstitute the Medical Endowment Fund and to establish the ElderCare Fund for the purpose of endowment schemes providing financial assistance in connection with medical and health care in Singapore and for matters connected therewith.
Nurses and Midwives Act	Singapore Nursing Board	An Act to establish the Singapore Nursing Board, to provide for the registration and enrolment of nurses, the registration of midwives and the certification of Advanced Practice Nurse and for matters connected therewith.

Source: Agency for Integrated Care (AIC) "Introduction to Singapore healthcare". Retrieved from [https://www.aic.sg/sites/aicassets/AssetGallery/HC%20Information%20Kit_book1_FA-5\(online\).pdf](https://www.aic.sg/sites/aicassets/AssetGallery/HC%20Information%20Kit_book1_FA-5(online).pdf)

