

SDD-SPPS PROJECT WORKING PAPERS SERIES:  
LONG-TERM CARE FOR OLDER PERSONS IN ASIA AND THE PACIFIC

# Long-term Care of Older Persons in Singapore

A perspective on the current delivery of health and long-term  
care for older persons in Singapore

BANGKOK, 2015

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## List of acronyms

<b>ACTION</b>	Aged Care TransitiON Project	<b>SCOPE</b>	Self-Care on Health of Older Persons in Singapore
<b>ADL</b>	Activities of daily living	<b>SGD\$</b>	Singapore dollar
<b>AIC</b>	Agency of Integrated Care	<b>SPICE</b>	Singapore Programme for Integrated Care for the Elderly
<b>APO</b>	Ageing Planning Office	<b>TFR</b>	Total fertility rate
<b>CCR</b>	Continuity of care record	<b>VWO</b>	Volunteer Welfare Organization
<b>CHAS</b>	Community Health Assist Scheme	<b>WDA</b>	Workforce Development Agency
<b>DALYs</b>	Disability adjusted life years	<b>WHO</b>	World Health Organization
<b>FDW</b>	Foreign domestic worker	<b>WSQ</b>	Workforce Skills Qualifications
<b>FMC</b>	Family medicine clinics	<b>YLD</b>	Years lost due to disability
<b>GP</b>	General practitioner	<b>YLL</b>	Years of life lost
<b>HDB</b>	Housing Development Board		
<b>HPB</b>	Health Promotion Board		
<b>ILTC</b>	Intermediate and long-term care		
<b>MOH</b>	Ministry of Health		
<b>MSF</b>	Ministry of Social and Family Development		
<b>NEHR</b>	National Electronic Health Record		
<b>NGO</b>	Non-governmental organization		
<b>PACH</b>	Post-acute care at home		
<b>PG</b>	Pioneer Generation		
<b>RHS</b>	Regional Health Services		

## Executive Summary

**By 2050, 28.6 per cent of Singapore's population will be aged 65 years and above, nearing Hong Kong's 29.2 per cent and Japan's 36.4 per cent (United Nations, 2001).**

This paper attempts to outline the development, functioning and financing of the health and social care system in Singapore. It focuses on long-term care services and the challenges it faces in meeting the needs of changing demographics. As such this paper reviews key areas of the health system including its financing, implementation and overall policy direction as well as exploring some of the critical agencies involved in providing care for older persons. Further, it highlights the need for Singapore to establish a more holistic long-term care system. In particular the paper suggests that the Government should work towards developing a strong community-based care management service as an important care integrator; adopting a national care needs assessment framework to ensure appropriate allocation of resources; scaling up services (such as number of hospital beds and caretakers) to meet demand; and increasing the income security of older persons. As Singapore continues to age a transition from an acute care focus to a long-term care perspective will do much to support the growing older population.

# 1 Demographic trends in Singapore: An ageing and shrinking population

**Singapore commemorated its first 50 years of nationhood in 2015.** Economic, social and medical progress over that period has catapulted the city state to the status of a developed country with a vaunted record of longevity and good health. The World Health Statistics 2014 released by the World Health Organisation (WHO) placed Singapore fourth among countries with the highest life expectancy at birth, with men averaging 80.2 years and women averaging 85.1 years (WHO, 2014). In the same year, it topped Bloomberg's ranking of the most efficient healthcare systems in the world (Bloomberg, 2014).

However, the rapid ageing of the Singapore population poses multiple challenges, not least in the provision of healthcare for an increasing proportion of older persons. In 2015, out of a resident population of 3.9 million, there were 459,700 persons, or 11.7 per cent, aged 65 years and over (Singapore Department of Statistics, 2016).

It is expected that, by 2030, one in five Singaporeans will be aged 65 years and over due to rising life expectancy and falling birth rates.

## 1.1 Falling total fertility rate (TFR) and increasing share of older persons

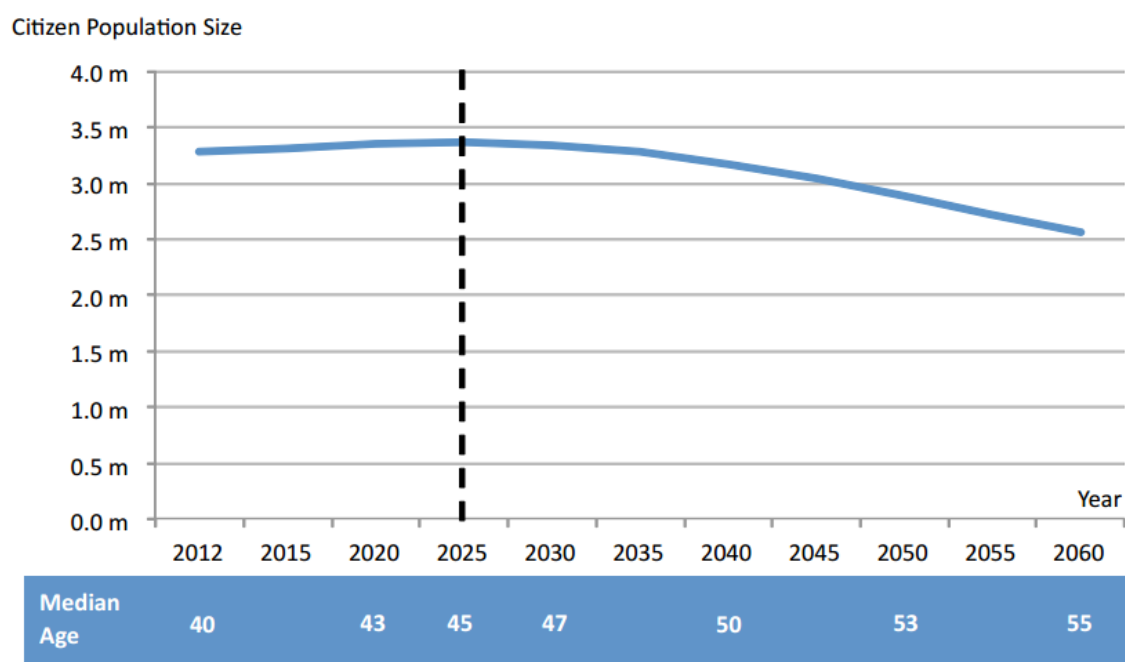
In 2014, the total fertility rate was 1.19, well below the replacement rate of 2.1. With currently increasing life expectancy, and assuming TFR and immigration rates do not increase, the country will have a shrinking and ageing citizen<sup>1</sup> population, as figure 1 shows. Singapore's citizen population is projected to decrease from approximately 3.4 million in 2015 to 2.5 million by 2060.

As per current projections, the proportion of older persons will continue to increase, resulting in an inverted population pyramid with a narrow base of younger ages and broad top of older age groups.

## 1.2 Declining old-age support ratio

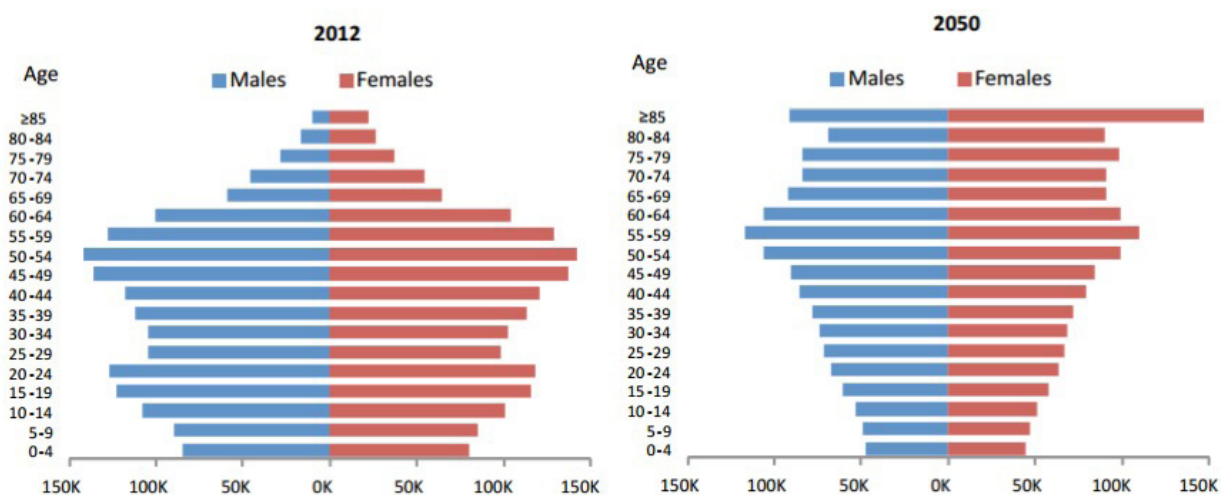
The old-age support ratio (computed as the ratio of the working-age population per older person aged 65 years and over) will therefore decrease in the coming decades unless mitigated by higher total fertility rates and immigration. However, TFR has decreased over the past three decades and has proven hard to reverse, while the influx of immigrants has become

<sup>1</sup> Citizens are those who have obtained Singaporean citizenship through birth, descent or registration. It does not include permanent or temporary residents.

**FIGURE 1. SHRINKING AND AGEING CITIZEN POPULATION, SINGAPORE, 2012 - 2060**

*Assuming current birth rates and no immigration from 2013 onwards*

**Source:** National Population and Talent Division, Prime Minister's Office (2013).

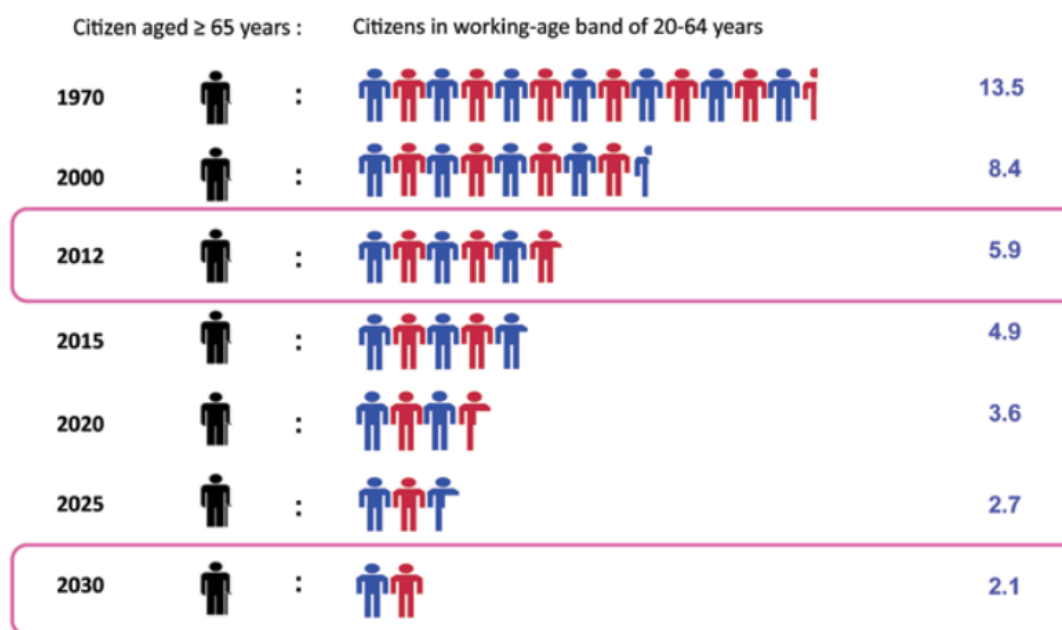
**FIGURE 2. CHANGING AGE STRUCTURE, SINGAPORE, 2012, 2050**

**Source:** National Population and Talent Division, Prime Minister's Office (2013).



socially controversial and the Government is pressed to slow down its expected increase. This has led to concerns that expenditure on healthcare will be driven up by the demands of an ageing population amid slower economic growth, given the assumption that older people are less productive than younger working adults.

**FIGURE 3. DECLINING OLD-AGE SUPPORT RATIO, SINGAPORE, 1970 - 2030**



*Assuming current birth rates and no immigration from 2013 onwards*

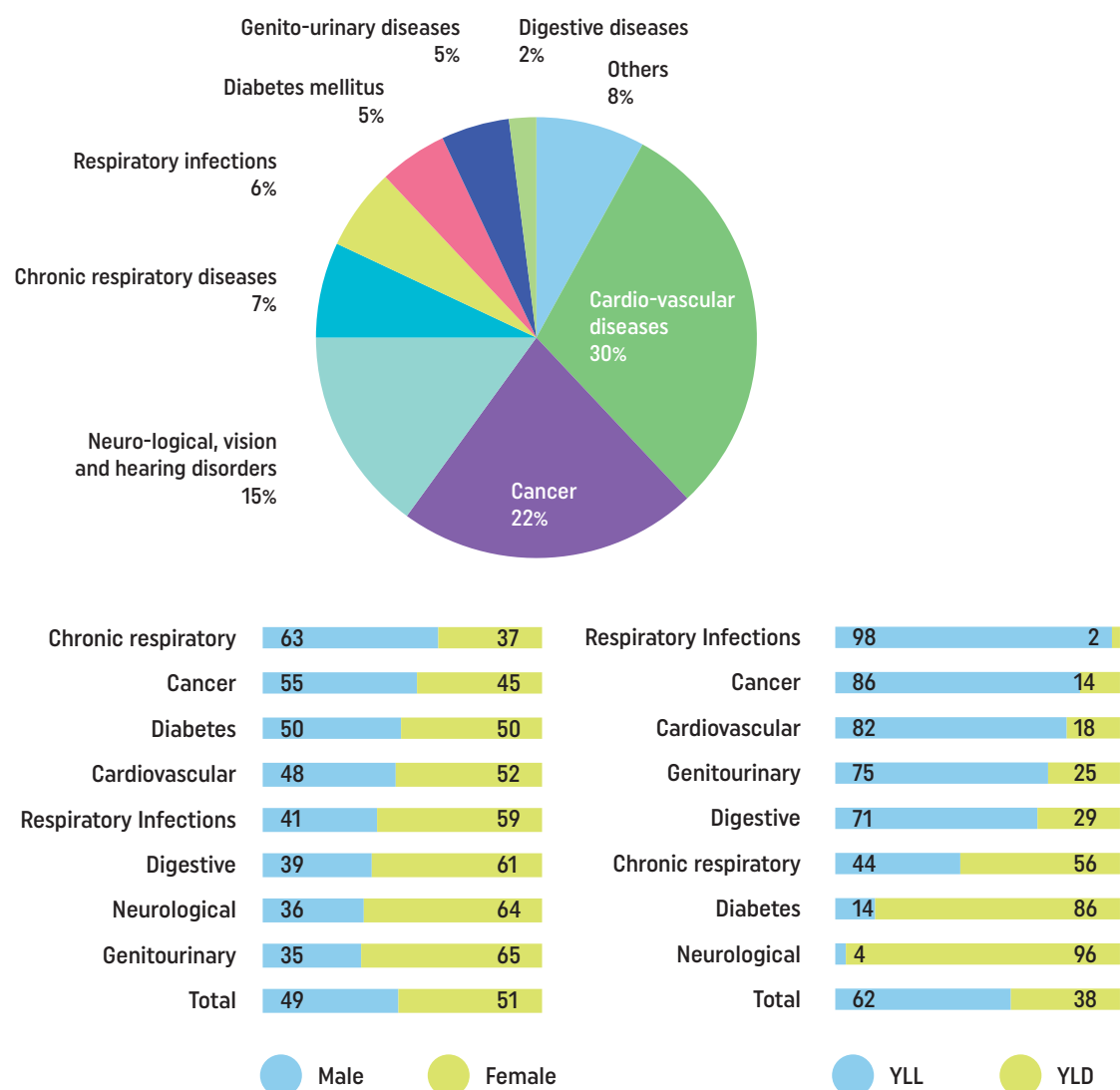
**Source:** National Population and Talent Division, Prime Minister's Office (2013).

### 1.3 Disease burden

According to the Singapore Burden of Disease Study:

*Adults aged 65 years and above experienced 35.5% of the entire burden of disease and injury in Singapore in 2010. Cardiovascular diseases (30%; mostly ischaemic heart disease and stroke) were the major contributor of the burden in these elderly, followed by cancers (22%; top three specific cancers being lung cancer, colon & rectum cancer, liver cancer) and, neurological and sense disorders (15%; mostly Alzheimer's and other dementias, vision disorders and adult-onset hearing loss). The overall size of the burden in elderly women was just slightly higher than the burden in elderly men (5.5% more) (Ministry of Health, 2014b).*

**FIGURE 4. DALYS (DISABILITY ADJUSTED LIFE YEARS) IN THOSE AGED 65 YEARS OLD AND OVER BY BROAD CAUSE GROUP EXPRESSED AS: (A) PROPORTIONS OF TOTAL AND (B) PROPORTIONS BY SEX, AND (C) PROPORTIONS DUE TO YLL (YEARS OF LIFE LOST) AND YLD (DISABILITY BURDEN), SINGAPORE, 2010**



Source: Ministry of Health (2014b).

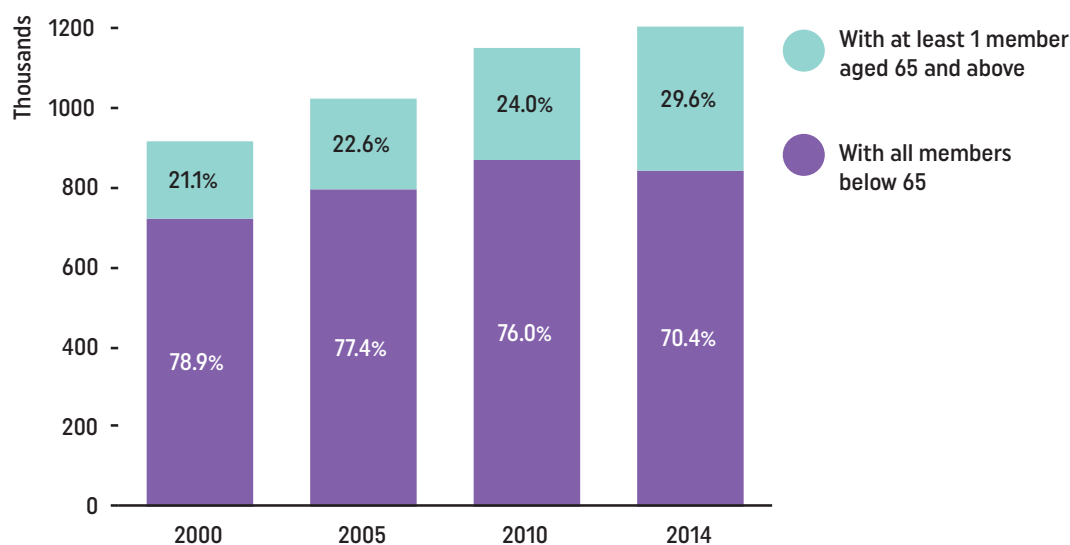
The report mentions that the top five leading specific causes of burden among men aged 65 and over were ischaemic heart disease, diabetes, stroke, lung cancer and adult-onset hearing loss, whereas, among women, burden due to diabetes was the greatest followed by breast cancer, ischaemic heart disease, adult-onset hearing loss and rheumatoid arthritis (Ministry of Health, 2014b).

In addition, a simulation study projecting the activities of daily living (ADL) needs of Singaporeans aged 60 and above conducted by researchers in the Duke-NUS Graduate Medical School concluded that the number of older Singaporeans with one or more ADL limitation would increase from 31,738 in 2010 to 82,968 in 2030, which will make up 7 per cent of the total population aged 60 and above (Thompson, et. al 2014). This demonstrates the need and the rising demands for long-term care services in the community.

## 2 Changing family structure and its implications for care of older persons

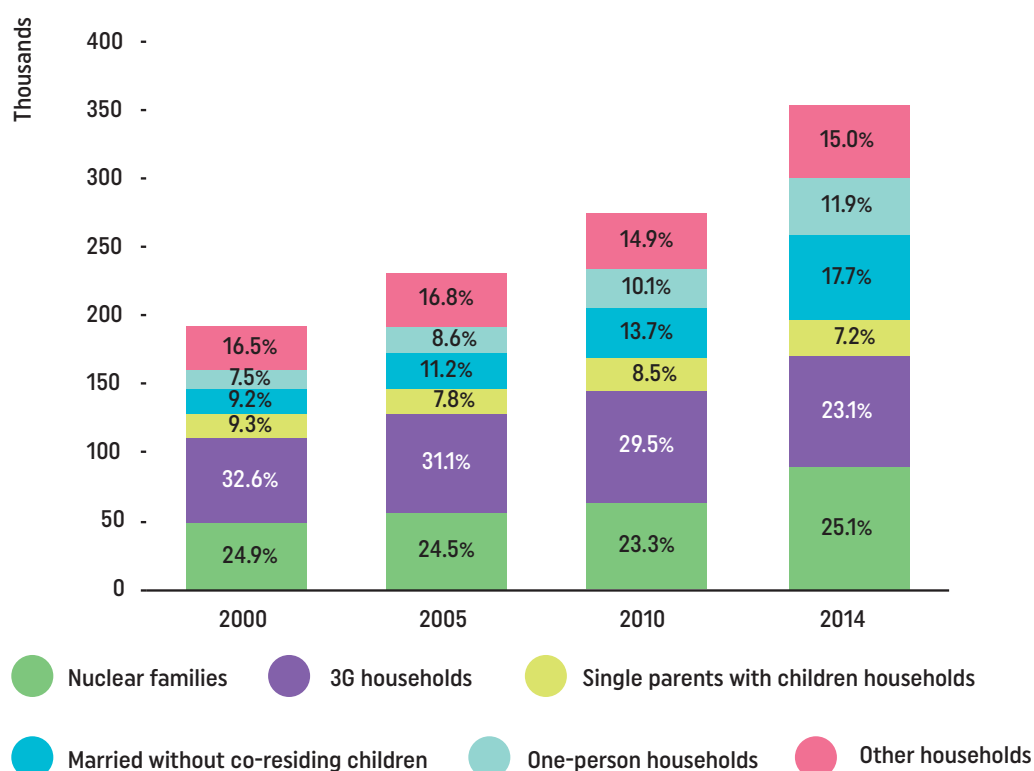
In addition to changes in population structure, Singapore also faces far-reaching changes to the structure of families. Traditionally, families have been the bulwark of physical, financial and emotional care for older persons, and this too is being challenged by demographic trends, changing values and lifestyles. The number of resident households with at least one member aged 65 and above has increased steadily over the years, as shown in figure 5. Further, as figure 6 highlights, there is also an increasing number of single-elder households and households of older couples with no children or children living apart from them. This is in spite of schemes in public housing to incentivise children to live with or near their parents.

**FIGURE 5. RESIDENT HOUSEHOLDS BY PRESENCE OF MEMBER AGED 65 YEARS AND ABOVE, SINGAPORE, 2000-2014**

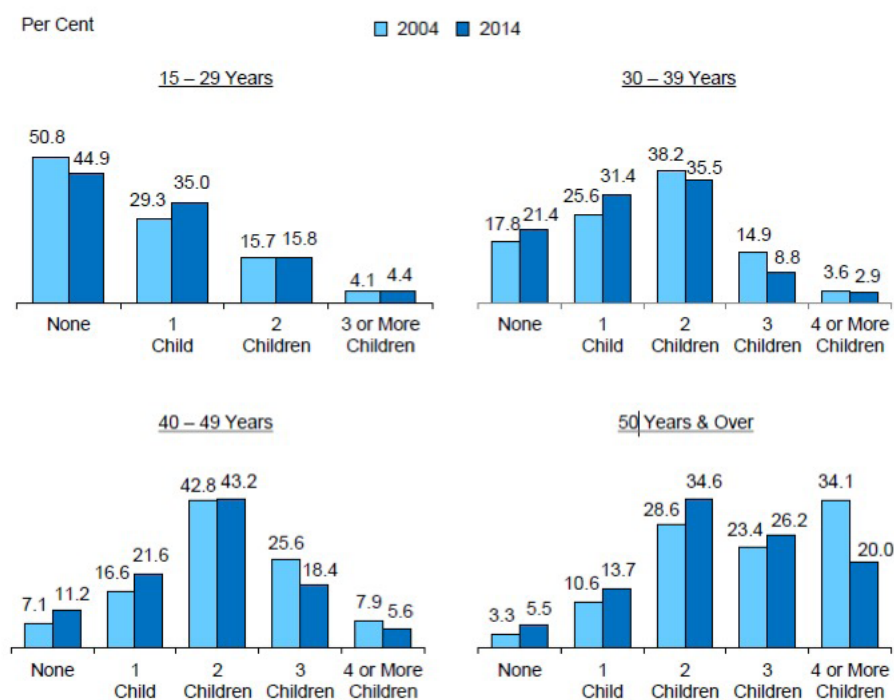


Source: Ministry of Social and Family Development (2015).

Importantly, there has also been a shift in the number of children per family. While two-child families remain the norm, there is an increasing proportion of ever-married women with one or no children, as shown in figure 7.

**FIGURE 6. AGED RESIDENT HOUSEHOLDS BY HOUSEHOLD STRUCTURE, SINGAPORE, 2000-2014**

Source: Ministry of Social and Family Development (2015).

**FIGURE 7. RESIDENT EVER-MARRIED FEMALES BY AGE GROUP AND NUMBER OF CHILDREN BORN, SINGAPORE, 2004, 2014.**

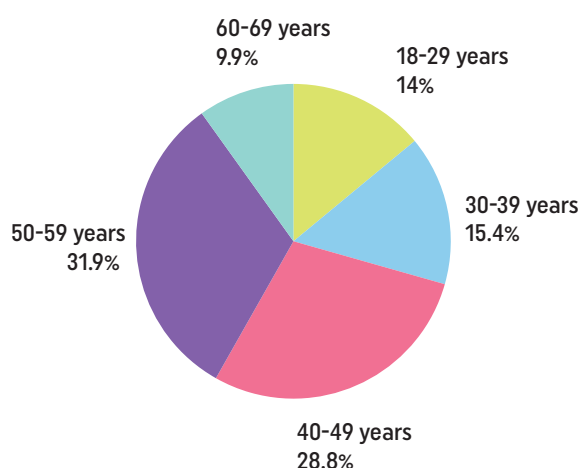
Source: Singapore Department of Statistics (2015).

## 2.1 Family caregiving for older persons

These changes in family structure and in particular the increase in the number of single elder households and families with only one or no children will have far reaching consequences for family caregiving. The National Health Survey in 2010 shows that most care recipients are 64 years and over, and the majority of caregivers (42 per cent) are aged 50 years and over. The National Health Survey also found that:

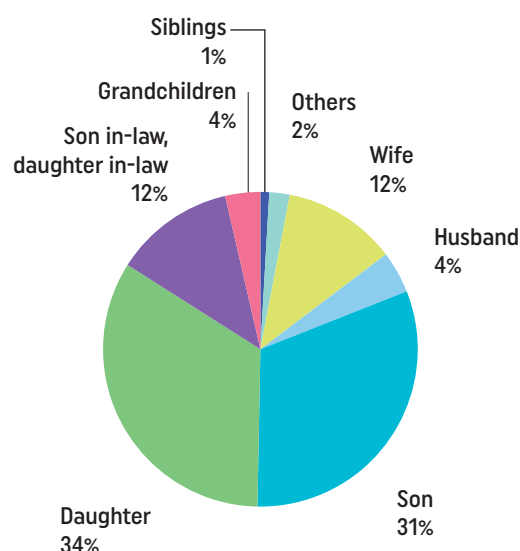
*8.1 per cent of Singapore residents aged between 18 to 59 years old indicated that they provided regular care or assistance to friends or family members. Some 37 per cent of caregivers reported that they had been providing care to their care recipients for over a decade. On average, they provided around 6.8 hours of care per day in a typical week. (Ministry of Health, 2010).*

**FIGURE 8. PROFILE OF CAREGIVERS, SINGAPORE, 2010**



Source: Ministry of Health (2010).

**FIGURE 9. PROFILE OF INFORMAL CAREGIVERS, SINGAPORE, 2013**



Source: Chan, et. al (2012).

Moreover, the majority of informal caregivers are members of the older person's family, with 65 per cent of caregivers composed of the care recipients' children and 16 per cent of spouses. Additionally, a 2012 survey of 1,982 informal caregivers found that (Chan, et. al):

- 1 Caregivers are predominantly female;
- 2 49 per cent of Singaporean families hire foreign domestic workers (FDWs) to provide care for their elders, aided by Government discounts on the FDW levy, making this a prevalent 'care solution';
- 3 50 per cent of FDWs do not have experience/formal training in caring for older persons;
- 4 The average number of hours spent on caregiving for older persons per week is 38 hours.

With such a large responsibility placed on families to provide care for their older members, many frequently suffer from stress and depression. The majority of these issues are related to:

- Work commitments;
- Younger ages;
- Negative reactions to caregiving;
- Number of caregiving hours;
- Low caregiver self-esteem;
- Low socio-economic status;
- Being a spouse caregiver;
- Presence of memory and behaviour problems among care recipients;
- Absence of a domestic worker.

Adding on to these pressures, a significant proportion of family caregivers and hired domestic workers have received no formal training on caregiving. While training is available, it is focused mostly on physical care, with few providing training on psycho-emotional care. As a result, caregivers' support groups focus more on information-giving than on providing emotional support, as there are fewer therapy groups. Further, there is currently no single integrated blueprint on how best to support caregivers and, considering that they are the unpaid, unseen workforce caring for our elders, such lack of support is deeply concerning.

Clearly, with shrinking family size, the burden on family caregivers is growing, and in the long run, the heavy reliance on family as the primary caregiver is unsustainable. While national policy does and should respect and encourage family caregiving as foundational care, more must be done to enhance the resources of caregivers in the course of their duties, and for the future when they themselves need care. Steps such as a future credit scheme in cash and services for family caregivers could be given more consideration. As such, boosting the role of the Government and public institutions in caregiving will be a critical measure in reducing both the heavy costs and burdens placed on families.

### 3 Overview of acute, intermediate and long-term care in Singapore

**Singapore has a wide spectrum of health care services answering to acute, intermediate and long-term needs.** Recent years have seen a rapid development of these three sectors as the country braces itself for the onset of population ageing. Managed by public and private providers, some service segments are more developed than others and linkages between services can be weak.

While 80 per cent of hospital care is provided by 8 public hospitals (6 acute, one for women and children and another for mental health) and 20 per cent by private operators, 80 per cent of primary care is provided by some 2,000 private practitioners and 20 per cent by 18 Government polyclinics (Ministry of Health, 2015c).

As such, the provision of health care services and programmes can be broadly grouped into institutional and non-institutional care, with the state primarily responsible for in-patient institutional care, supplemented by some private sector organizations. Non-institutional care composed mainly of out-patient services are provided primarily by Volunteer Welfare Organizations (VWO), private companies or private practitioners. This divide between primarily state-led institutional care and community-based non-institutional care is shown in figure 10.

**FIGURE 10. CURRENT ACUTE, INTERMEDIATE AND LONG-TERM CARE IN SINGAPORE**

INSTITUTIONAL	NON-INSTITUTIONAL	
Emergency in-patient care	Outpatient primary care	
Emergency long term in-patient care	Outpatient specialized care (including day surgery)	
Community hospital	Traditional Chinese medicine	
<ul style="list-style-type: none"><li>• sub-acute</li><li>• rehabilitation</li></ul>	Centre-based care	
In-patient specialist care	<ul style="list-style-type: none"><li>• senior activity care</li><li>• Senior Care Centres: social, dementia and rehabilitation</li><li>• hospice day care</li></ul>	<ul style="list-style-type: none"><li>• Psychiatric Day rehabilitation</li><li>• weekend respite care integrated comprehensive care</li><li>• integrated comprehensive care</li></ul>
Short-term respite		
Sheltered homes	Home care services	
Assisted living	<ul style="list-style-type: none"><li>• medical</li><li>• nursing</li><li>• dementia</li></ul>	<ul style="list-style-type: none"><li>• palliative</li><li>• rehabilitation (physiotherapy, speech therapy, occupational therapy)</li></ul>
	Home personal help services	
	<ul style="list-style-type: none"><li>• health monitoring</li><li>• elder sitting</li></ul>	<ul style="list-style-type: none"><li>• medical reminder</li><li>• meals delivery, personal hygiene, housekeeping, escort services etc.</li></ul>

**Source:** Singapore Silver Pages (2016) and Keong (2009).

### 3.1 Types of Long-Term Care: Definitions and Direction

This division in the overall health care landscape also occurs in current long-term care services available in Singapore. Here, long-term care is divided into residential and non-residential services, operated by a mix of voluntary welfare organizations (VWO) and private companies with the Government offering support through financing and patient subsidies. Figure 11 below summarizes the range and types of care available and highlights the dichotomy between service types.

**FIGURE 11. AVAILABILITY OF LONG-TERM CARE SERVICES, SINGAPORE**

Setting	Background	Services
<b>RESIDENTIAL SERVICES</b>		
	These are stay-in facilities that cater to seniors who are unable to care for themselves or cannot be cared for in their own homes.	Nursing homes Community hospitals Chronic Sick hospitals Inpatient hospice care Respite care
<b>NON-RESIDENTIAL</b>		
Home-based services	Home-based services are provided within the homes of frail and home-bound elderly. The services address the health and social needs of the person and support families and caregivers in the care of their loved ones at home.	Home medical care Home nursing care Home personal care Home therapy Home palliative care Meals-on-Wheels Transport/escort services
Centre-based services	Centre-based healthcare services cater to older persons who require care services during the day, usually on a regular basis. These centres are mostly located within the community, enabling those in need to receive services in a familiar environment close to their homes, while their family caregivers are at work.	Rehabilitation services Dementia day care services Day care services Nursing services

Source: Ageing Planning Office (2014).

Typically, these long-term care services are:

- Operated by VWOs, with mainstream funding provided by the Ministry of Health (MOH);
- Applied through the AIC, except for the Senior Activity Centres operated by the Ministry of Social and Family Development (MSF) (drop-in centres which provide socio-recreational care for low-income, vulnerable elders);
- Payable and means-tested.



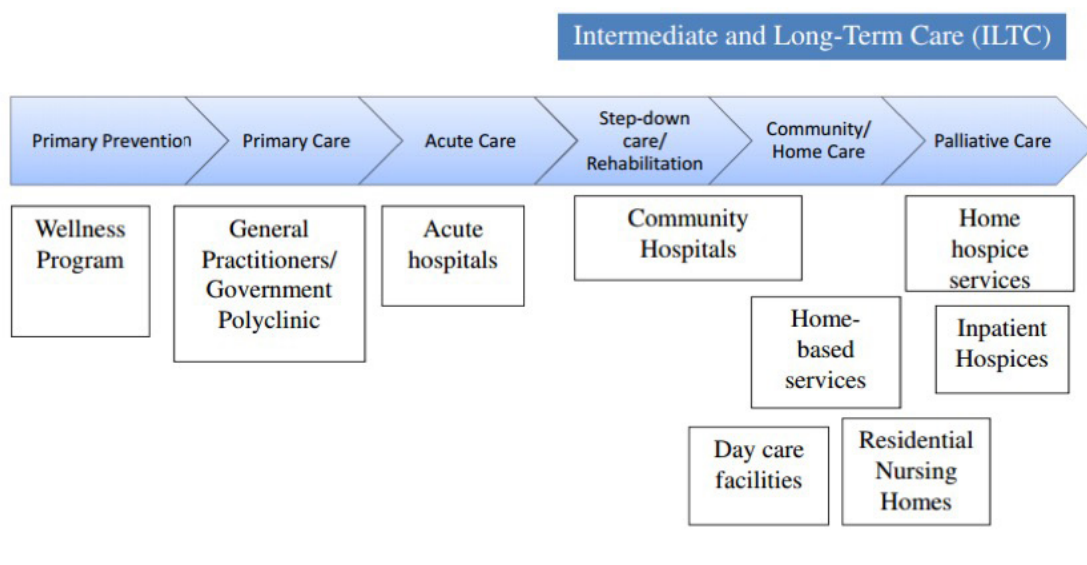
To standardize care delivery, the Government has published guidelines for centre-based care and nursing homes, with those for homecare services still in development. Importantly, the Government has put forward a definition of long-term care which describes long-term care as:

*A range of social and healthcare services to support the needs of people who are unable to care for themselves for an extended period of time due to their chronic health conditions. Long-term care is mainly for persons who need further care and treatment after being discharged from an acute hospital as well as community-dwelling seniors who may be frail and need supervision or assistance with their daily activities (Ageing Planning Office, 2014).*

Aside from providing definitions, guidelines and regulations for long-term care, the Government of Singapore also sets the overall direction of aged care. In this regard the State has placed a strong emphasis on an ageing-in-place philosophy which underlines the desire to continue to keep older persons in their communities for as long as possible. In this way, ageing in place further stresses the role of families in ensuring that older persons remain at home for care and utilize non-residential services which ease the burden on institutional healthcare facilities (Teo, Chan and Straughan, 2003). Thus the Government has sought to promote centre-based programmes which provide day services yet allow older persons to remain in their own homes and communities. However, historically, these centre-based programmes have operated independently, apart from the rest of the healthcare system and it is unclear how they are to be incorporated into the ecosystem for enabling ageing in place.

Any effective discussion of long-term care needs to be done within the larger context of a system of care continuum, as illustrated below, that includes preventive care, acute care and primary care. Hence, while the implementation of long-term care services in Singapore will be discussed, this paper will also touch on the other components of this care continuum.

**FIGURE 12. "CONTINUUM OF CARE" – INTERMEDIATE AND LONG-TERM CARE (ILTC)**



Source: Chin (2012).

## 4 Financing long-term care and the role of the family, the community and the State

**The Government's expenditure on health is projected at SGD\$8b in 2015, twice as much as in 2011, and to reach \$12b come 2020 (Saad, 2014).** So far, compared to other developed countries, Singapore's expenditure on health has been modest. In 2013, public health expenditure made up 12.5 per cent of total Government expenditure in Singapore, compared to 18.3 per cent in Norway, 22.1 per cent in Switzerland, and 20.7 per cent in the Netherlands, for example – all relatively small countries with high per capita income (World Bank, 2016). With health care costs further expected to rise as the population ages, Singapore has sought to spread these costs among private individuals, the broader community and the State.

As such, in order to finance long-term care services within Singapore, the Government has adopted a 'many helping hands' approach that seeks to emphasize the primacy of the family as the chief caregiver. This approach, first developed in 1982 by the Ministry of Health's Committee on the Problems of the Aged, has come to define healthcare financing, payment and service delivery for Singaporeans. It sets personal and family resources as the first source of funding for healthcare payments, followed by aid from NGOs and concerned individuals, with public assistance at the last. Seen as being consistent with the Asian/Confucian values of its people, a move away from state overreliance, and a means to optimise limited resources, this 'many helping hands' approach is enforced through various mechanisms and legislation that ensure co-payment by end users and other stakeholders.

For example, means testing for the amount of subsidies available to an older person needing long-term care takes into consideration his/her household's (inclusive of spouse and children) rather than personal income (Ministry of Health, 2013). The family's financial contribution is legally enforceable through the Maintenance of Parents Act (1996), whereby a person aged 60 years and above who cannot adequately provide for him or herself may claim for maintenance from his/her children who are in a position to make a contribution.

In the area of healthcare planning and policy, the Government faces a challenge in providing accessible, affordable, efficient, and sustainable healthcare for an increasing number of older people, who can be expected to experience multiple and chronic medical conditions over a long period of time, frequently accompanied by social and psycho-emotional stress. Its contributions include means-tested subsidies for medical expenses, partial funding for approved programmes conducted by non-profit VWOs, investments in infrastructure, health education and training, and a regulatory role in healthcare financing, standards and provision.

## 4.1 Paying for health: The 3Ms and more

In order to facilitate the ‘many helping hands’ approach to health care financing, the Government of Singapore has established three main methods of ensuring that health care costs are met. Known as the 3Ms, this system of governance provides a guarantee that the majority of the population will have access to, at the very least, basic health care. These three approaches to financing are listed below:

- Medisave is a personal medical savings account into which every working Singaporean contributes 8 to 10.5 per cent of his/her monthly salary (depending on age group), which can be withdrawn, subject to limits, to pay for his/her own or immediate family member’s hospital, day surgery or approved outpatient expenses (Central Provident Fund Board, 2016). Subsidies provided by the Singapore Government to citizens and permanent residents offset some costs, with patients co-paying the remaining portion using Medisave. As regards long-term care, subsidies available are dependent on household income levels and patients must apply for and be eligible to receive these subsidies. Medisave can also be used to defray the cost of insurance premiums (see below). The scheme will be refined in 2016 but the principle of maintaining a minimum sum in this account that cannot be withdrawn for retirement purposes remains.
- Medishield/ Medishield Life was a voluntary medical insurance plan that provided basic health insurance to offset large costs from unexpected catastrophic illnesses that Medisave was inadequate to cover. Premiums could be paid from Medisave accounts and in 2004 80 per cent of Singaporeans were covered under the scheme (Lim, 2011). At the end of 2015, the Government launched Medishield Life which replaced the previous Medishield scheme and made it compulsory for all Singaporeans. Medishield Life seeks to better serve the needs of an older population by extending insurance coverage to the end of life and allows for the inclusion of persons with pre-existing illnesses (Ministry of Health, 2015e). Critically, premiums will be higher for this new scheme but the Government provides subsidies to indigent, low income and some middle income families. Additional private insurance plans can be purchased to supplement coverage and extend care to other preferred areas. Premiums are paid through Medisave or in cash. In essence, Medishield Life is a low-cost basic medical insurance scheme with co-payment features designed to guarantee individuals and especially older persons have the funds to pay for treatment.
- Medifund is a Government endowment fund accessible at selected institutions for those who cannot afford the subsidised bill charges despite Medisave and Medishield Life. Medifund provides a subsidy only to indigent members of the population and is a financial safety net of last resort. There were 290,000 beneficiaries of Medifund in 2006 of which close to 96,000 were over the age of 65 (Ministry of Health, 2008). Due to this large portion of older persons receiving Medifund, in 2007 the Government introduced Medifund Silver, to specifically target this older segment. Medifund Silver thus includes support for intermediate and long-term care services.

In addition to the coverage provided by the 3Ms, the state has also sought to improve the affordability of health care to older persons through the provision of Eldersshield. Eldersshield is a severe disability insurance scheme under which all Singapore citizens and permanent residents who have a Medisave account are automatically covered from 40 years of age. The insurance itself is provided by three private companies, with premiums paid for through Medisave accounts or through cash (Ministry of Health, 2015b). To be eligible for the scheme individuals must be unable to perform at least three out of six basic activities of daily living. The scheme provides a SGD\$ 400 payment for a maximum of 72 months to help pay for associated medical costs. Those who prefer higher coverage can take up an Eldersshield Plus plan from an approved insurer.

Further schemes offering support for older persons include the Pioneer Generation (PG) Package launched in 2015 by the Government of Singapore to mark 50 years of nation-building by persons born on or before 31 December 1949 (Government of Singapore, 2016). In substance, it is a package of health subsidies for persons aged 65 and above, which includes automatic top-ups to Medisave accounts, 50 per cent discounts off subsidised fees at polyclinics and specialist outpatient clinics, and special subsidies under the Community Health Assist Scheme (CHAS) which are available at approved GP and dental clinics. While appreciated for making healthcare more affordable among older Singaporeans, it was criticised for being a reward mainly accessible only in ill health.

One departure that the Pioneer Generation Package has made from previous subsidies is that its availability is tied to age and not economic status. Means testing for other subsidies relevant to older persons take into consideration household rather than personal income, although that is already an improvement from the past when family income was the yardstick for eligibility. In some schemes, type of dwelling is also used as a proxy for assessing capacity to pay.

Other healthcare grants and subsidies relevant to older persons exist, but these options provide financing directly to health care providers rather than individuals (Ministry of Health, 2016b).

While the health care schemes described above do offer a broad range of coverage and help at least in part to ensure that older persons are able to access basic health care, the current system of financing does face several challenges:

- The system is skewed towards benefiting high-cost health services, with subsidies concentrated in specialist care and hospitalisation. Daily expenditure on necessities for living in the community, such as food, diapers and transport have comparatively less recourse to Government help, and access to this needs to be improved;
- The ‘many hands approach’ that distributes responsibility, resources and costs for the individual’s healthcare across the State, community, family and personal levels also makes parents into a cost-centre for families, with all its potential and actual relationship stressors –older persons are known to refuse or self-restrict their healthcare use for fear of

burdening their families; others have been counselled to sue their children for support, as that is the next step of sanctioned recourse before State help;

- Families who are asset-rich in terms of the property value of their homes are pressed to find the cash to pay for their parents' care as well as for themselves, which is resulting in a 'middle class squeeze';
- Fear that healthcare will be unaffordable is one of the foremost concerns among Singaporeans (Government of Singapore, 2015).

More needs to be done to improve the personal financial security of older persons, and especially women, who have longer life expectancy, less opportunities for income and wealth accumulation, and can expect healthcare costs to escalate towards the end of their lives. Increasing retirement age (currently at 67), incentivising business to employ older workers, and assigning State funds to provide grants to older persons to learn new employable skills are all steps in a positive direction.

## 5 Implementing long-term care: Three service integrators and primary prevention

Since 1982, with the first national committee on population ageing, that developed the ‘many helping hands approach’, a vast plethora of initiatives and supporting groups have been established with the goal of analysing and developing policy to prepare for and support Singapore’s older persons. These committees, departments and advisory groups have strived for a coordinated strategy to address the wide impact of population ageing, among them the Inter-Ministerial Committee on the Ageing Population (Inter-Ministerial Committee, 1999). Of particular significance are the Agency for Integrated Care (AIC), established in 2009 as an independent corporate entity under the Ministry of Health for the enhancement and integration of the country’s long-term care sector; the Regional Health Services (RHS), set up in 2009 to create a regional health and wellness ecosystem across life stages from preventive health to end-of-life care; and the Ageing Planning Office (APO), a ‘super agency’ established in 2011 under the Ministry of Health (MOH) to bridge all relevant Government services in the planning and implementation of new initiatives towards successful ageing.

These three care integrators coordinate long-term care services in Singapore and seek to place them within the larger context of integrated health and social care including preventive care, acute care and intermediate care. Their differing roles and mandates are described below:

### 5.1 Agency of Integrated Care (AIC)

The responsibility of implementing and integrating long-term care services in Singapore sits largely on the shoulders of the Agency of Integrated Care (AIC), which has the mandate to:

- Act as the “glue” for integration of healthcare services;
- Implement national care assessment framework;
- Undertake referral to intermediate and long-term care services;
- Undertake case management for complex cases;
- Develop primary care and community care services;
- Improve quality of long-term care services (Kadir, 2011).

Further the AIC is also tasked with developing and operating key initiatives which seek to support the elderly population in navigating health care services and uphold the ageing in

place philosophy. In this regard the AIC has so far established programmes which manage the transition of older persons as they move from acute care towards long-term care. The Aged Care TransitiON (ACTION) project, which supports recently discharged older persons by providing referrals to community and home care services, enables the AIC to help reduce the use of acute care resources and provides a framework for coordination of disparate health services.

Another key programme implemented by the AIC to improve the transition to long-term care services is the Singapore Programme for Integrated Care for the Elderly (SPICE). SPICE is a multi-disciplinary team composed of doctors, nurses and other health professionals who work to “enable frail elderly who have high care needs and are eligible for admissions into nursing homes, to recover and age within the community” (Agency for Integrated Care, 2014). By actively providing home and centre-based care, SPICE works to develop tailored care programmes that extended beyond the hospital and into their households.

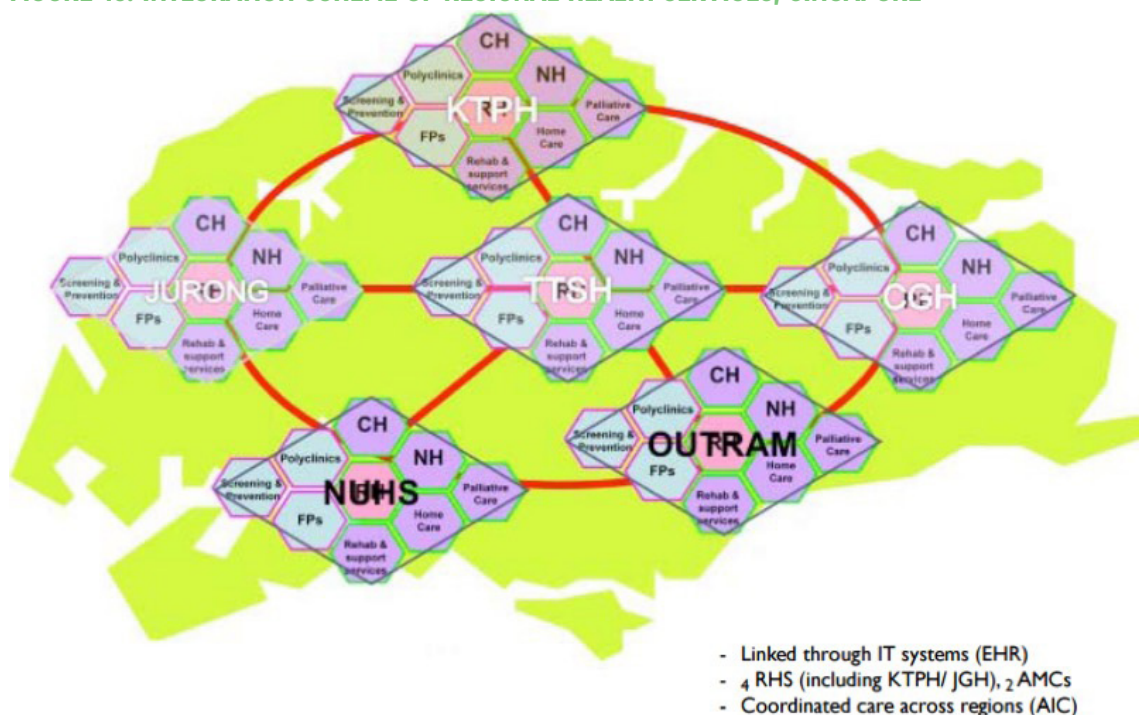
## 5.2 Regional Health Services (RHS)

Simultaneously, the development of the Regional Health Services (RHS) across Singapore from 2009 would complement the AIC’s mandate by creating a complete regional health and wellness ecosystem across life stages from preventive health to end of life care as illustrated in the care continuum mentioned in figure 12. Traditionally, public investment in health delivery has focused on episodic care in acute hospitals. The RHS arose from the recognition that this does not serve an ageing population that needs a broad range of integrated services across care settings.

Each RHS is anchored by a restructured hospital<sup>2</sup> that is intended to work in partnership with the community hospitals, nursing homes, home-based healthcare services, general practitioners and allied healthcare providers in its locality for better health outcomes among older persons who are more likely to have complex, multiple, and chronic health conditions. As figure 13 shows, the RHS seeks to link health care providers within a region and throughout Singapore. Utilizing mechanisms such as electronic health records, the RHS intends to bridge the gap between public, private, community and home-based health services to provide person-centred care using a multi-disciplinary team rather than a doctor-centric approach (National Healthcare Group, 2012).

<sup>2</sup> In the Singapore context, restructured hospitals are wholly owned by the Government but run as private companies, albeit not for profit, so that they will have the management autonomy and flexibility to be more responsive to patient needs.



**FIGURE 13. INTEGRATION SCHEME OF REGIONAL HEALTH SERVICES, SINGAPORE**

**CH** = Community hospitals  
**NH** = Nursing homes  
**FPs** = Family practitioners  
**NUHS** = National University Health System  
**TTSH** = Tan Tock Seng Hospital  
**CGH** = Changi General Hospital  
**KTH** = Khoo Teck Puat Hospital  
**Jurong** = Geographical region in West Singapore  
**Outram** = Geographical region in East Singapore.

**Source:** Kadir (2011).

### 5.3 Ageing Planning Office (APO)

The setting up of the Ageing Planning Office, which “oversees the planning and implementation of strategies to respond to the needs of Singapore’s ageing population,” effectively establishes a ‘ministry of ageing’ cutting across the health and social divide (Singapore Government Directory, 2016). It is deemed as a coordinating Ministry by many and seeks to provide an oversight role in the designing and implantation of ageing policy. It further works to enhance the capacity and capability of aged care.

While improvements to these bodies still need to be made, the development of these three coordinating offices at the very least prepares the ground for the goal of achieving an integrated health and social care system.



## 5.4 Primary prevention

In addition to the above care integrators which seek to oversee older persons currently in long-term care, the Government of Singapore is also actively engaged in designing programmes to improve health before such care becomes necessary. As such, health promotion plays a critical role in engendering healthy lifestyles and empowering self-care in a nation to prevent disease and maintain health and independence into old age. In Singapore, this role falls mainly on the Health Promotion Board (HPB), but there are various initiatives across the island state to encourage healthy ageing, commonly referred to as ‘active ageing’. Few, though, are gender-specific within the target older age group.

Some notable examples are the:

- “Mental First Aid Kit” programme (by HPB) – aimed at over 50s, a 12-week activity programme to help reduce the risk of dementia that was first launched in October 2011;
- “Health Ambassador Network” programme (by HPB) – a programme originated from the Tsao Foundation, where seniors learn and spread the word about healthy lifestyles, and which reportedly had engaged 1,100 seniors as ambassadors by 2014 (How, 2014);
- Community Functional Screening Programme (by HPB) - to help seniors detect early signs of functional decline so that they can seek appropriate treatment and lifestyle changes;
- Falls Prevention Programmes (by HPB) – comprising public talks and workshops;
- National Wellness Programme – to encourage physical activity and social interaction among older persons, launched in 2012 and available through the nation-wide People’s Association community network;
- ‘Self-Care on Health of Older Persons in Singapore’ (SCOPE) – a programme developed by the Tsao Foundation that uses an elder-centric training methodology, including peer-monitoring, to encourage the adoption of a healthy lifestyle (Tsao Foundation, 2013b).

With this promotion of active ageing and the associated programmes designed to encourage such lifestyles, the Government of Singapore is hoping to minimize the health service use of future older persons. While data on the effectiveness of these programmes is so far unavailable, the recognition for the need for these types of services does, at least in part, highlight the commitment of the Government to take population ageing seriously.

## 6 Issues in the current provision of long-term care and measures by the Government to address them

**The current care services landscape in Singapore is vibrant with a multitude of experiments and pilot programmes aimed to test programme models and work processes, all as part of the making of this integrated care system.<sup>3</sup>**

However, within the current blooming of services, the following four issues need to be addressed:

### 6.1 Weak community-based care management services

Currently there is a predominance of hospital-based care management services, such as the transitional care programmes, of which the most well-known is the previously discussed Aged Care TransITION (ACTION) project established in 2008. These services aim to help patients make the transition from hospital into their home or community by streamlining and coordinating care services, thereby optimizing patients' outcomes throughout and following an episode of illness (Kadir, 2011). These Action Team care coordinators are either nurses or social workers working within the acute hospital setting. There are also other transitional care teams based on different programme designs amongst the different acute care hospitals in Singapore such as the Post-Acute Care at Home (PACH) programme:

*Which primarily targets patients that require higher acuity of care; these patients are generally home-bound patients who have more complex chronic diseases or patients who develop frequent exacerbation of diseases (Bingzhu, 2012).*

However, community care management—the counterpart to care coordination in hospitals—is not as well developed. Currently, AIC runs a pilot community care management project and the Ministry of Social and Family Development (MSF) provides a 'cluster support' service through its Senior Activities Centres aimed at vulnerable older persons living in rental housing or senior public housing (Ministry of Social and Family Development, 2014).

<sup>3</sup> The range of long-term care services available and the means of accessing these services can be seen on the AIC's Silver Pages website (<https://www.silverpages.sg/>)

## 6.2 Primary care service not serving as 'medical home' for vulnerable older persons

Characterized by its “first-point-of-contact” setting, primary healthcare in Singapore was delivered by 18 polyclinics and about 1,500 private medical clinics in 2015, according to the Ministry of Health (Ministry of Health, 2015d).

Most Singaporeans seek primary care at private general practitioner (GP) clinics rather than at polyclinics, and it is for chronic diseases, which are so costly to manage, that they tend to turn to the latter (Qing Si, 2010). Neither at private clinics which are pressed for time, nor at polyclinics, where patients are not under the consistent care of any one physician, are conditions conducive for the seamless integration of healthcare across care settings. Yet it is this integrated and consistent approach that is required for meeting the needs of an ageing population.

The Government is taking steps to improve the service delivery at polyclinics and to bring the independent GP clinics into the fold. In late 2011, the Ministry of Health announced that it was looking into team-based care for better health management and to support GPs by:

- Working with GPs to set up Family Medicine Clinics (FMC) to provide team-based care for patients;
- Setting up Community Health Centres to support GPs and provide allied health services for their patients;
- Developing Medical Centres to provide community-based services for patients who require day surgery and less complex outpatient specialist services; and
- Providing portable subsidies to patients under the Community Health Assist Scheme (CHAS) so that they can enjoy subsidised services at private GPs and FMCs (Ministry of Health, 2011).

Despite the improvements underway, it is unclear as to whether there is alignment in the understanding and practice of primary healthcare, now widely accepted to be person-centred, continuous over time, comprehensive, coordinated with other relevant services, community-oriented, and considerate of the client's family and cultural environment and capacity (Johns Hopkins Bloomberg School of Primary Health, 2016). In 1996, the Tsao Foundation set up the Hua Mei (Seniors) Clinic, adopting these practice principles to empower ageing in place. It provides a life course approach to holistic health management, from health promotion to chronic disease management. It was selected by the WHO in 2004 as a pilot site for its age-friendly primary care centre. At the time of writing, the clinic's age-friendly ethos and practice, carried through to the details of its layout, fittings, and scheduling, is the only one of its kind in Singapore.

### 6.3 Lacking national care assessment framework

What is currently missing is the national adoption of a needs assessment instrument whereby problem identification, care planning and monitoring can facilitate quality assurance and resource management for complex long-term care. Beyond personal care, the information generated will also be useful to policymakers to better understand needs and allocate resources effectively. Currently, different care settings use a different assessment tool. For example, for applications to nursing homes, the Resident's Assessment Framework is used (Ministry of Health, 2002).

The tools are insufficient in facilitating care planning and resource utilisation. However, the matter is currently under consideration by the Ministry of Health working with AIC, and the Tsao Foundation has moved away from the use of the InterRAI assessment in Singapore.

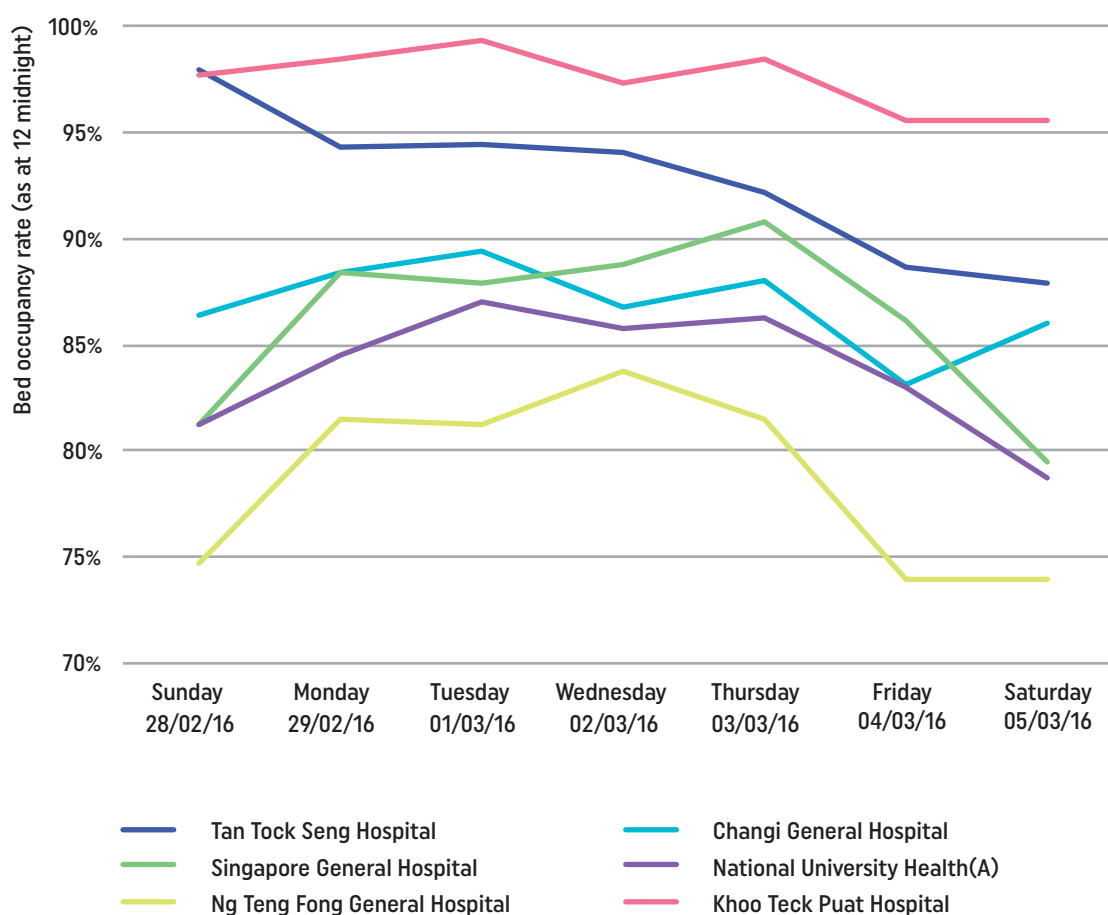
### 6.4 Mismatch between demand and supply of services

By 2015, five Regional Health Services (RHS) have been established across the country. The RHS vision should result in a system that provides the right care, in the right amount, at the right time, and reduce the unnecessary use of costly hospital stays and avoidable early institutionalisation of care. This is of a particular concern due to the current shortages in health care services in Singapore, which have resulted in delays in care.

#### 6.4.1 HOSPITAL BED CRUNCH

Acute hospitals have been facing a bed crunch year after year, resulting in beds being parked along hospital corridors and under tents pitched for temporary shelter on hospital grounds. The national daily, reporting on the phenomena in 2010, wrote that a significant number of hospital admissions were elders and frail persons with chronic ailments, and many of them were also re-admissions, with the National University Hospital finding that one in five elderly patients with chronic ailments was re-admitted "within weeks" (Khalik, 2010). Four years later, generalized frustration could be seen in the Straits Times journalist voicing a sense of déjà vu with the unresolved problem (Khalik, 2010). Figure 14 highlights the high bed occupancy rates for March 2016 and suggests that meeting demand for hospital beds in the future will be a key challenge for some hospitals and health care providers.

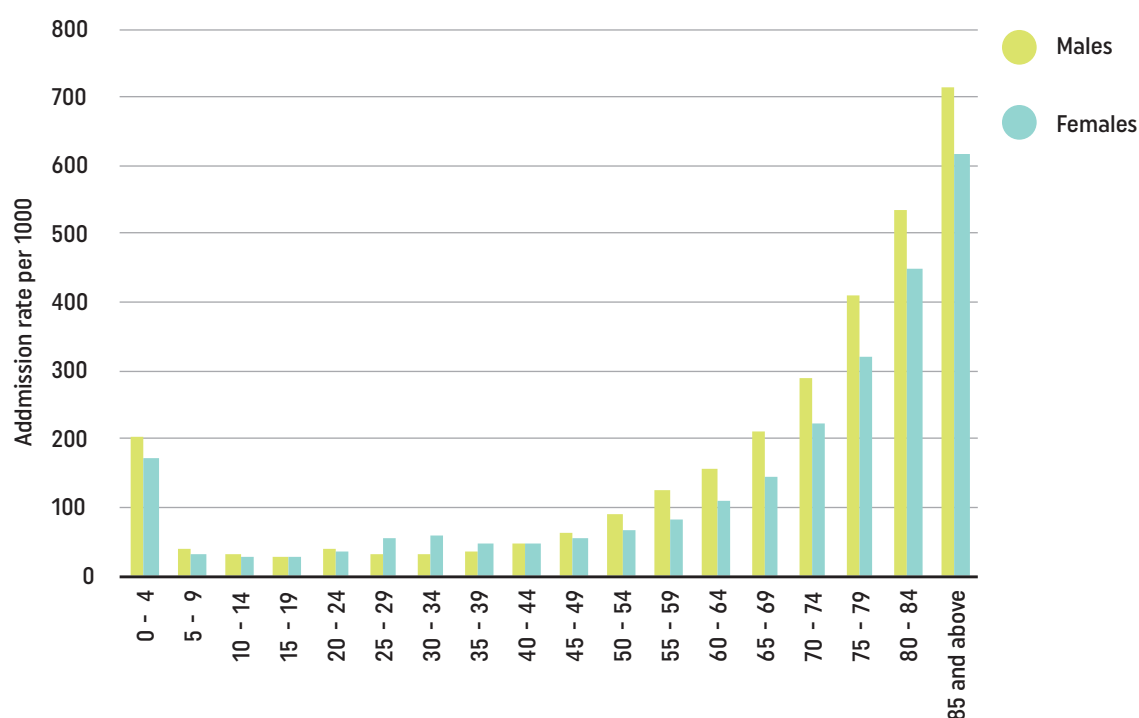
FIGURE 14. BED OCCUPANCY RATES FROM LATE FEBRUARY TO EARLY MARCH 2016



Source: Ministry of Health (2016).

The problem has persisted despite counter-measures by the Government and hospitals, such as yearly increases in hospital beds, increasing day surgeries to reduce overnight stays, and the assignment of care managers and non-medical interventions, such as a (means tested) reduction in the levy on domestic helpers serving in households with an older person.

Between 2009 and 2014, hospital admissions increased only for one age group: 65 years and above. From 25.2 per cent of 423,249 admissions in 2009, the figure rose steadily to 29 per cent of 499,076 admissions in 2014 (Ministry of Health, 2015a). Figure 15 below shows the public sector admission rates for 2014, of particular note is the high proportion of the 65 years and older who account for the majority of admission.

**FIGURE 15. PUBLIC SECTOR ADMISSION RATES PER 1,000 OF RESIDENT POPULATION IN 2014**

Source: Ministry of Health (2014a).

The average length of stay of these older adults also lengthened from 7.8 days in 2010 to 8.2 days in 2013 (Kim Yong, 2014b). While the readmission rate of the 65+ group has been stable in recent years - at around 19 per cent between 2011 and 2013, it is a significant number adding to the hospital bed crunch (Kim Yong, 2014a).

Besides the type of illness and health circumstances, readmissions are attributable to the transition to and the quality of primary and community-based care, follow-up and rehabilitation care, home conditions and the state of family support. A thorough national investigation of which factors are the most critical causes of the readmission rates has yet to be undertaken.

In its Healthcare 2020 plan, the Government pledged to build one acute or community hospital each year from 2012 till then. Recognising that this alone will not address the problem of the hospital bed crunch, the Minister of Health, Mr Gan Kim Yong, stated,

If we are able to implement the Healthcare 2020 capacity development plan, [and] at the same time, restructure and change our care model to one that is less reliant on acute hospital beds [but] more reliant on community care as well as home care ... we will have sufficient capacity going forward (Channel NewsAsia, 2014).

#### 6.4.2 NURSING HOME BED CRUNCH

At the other end of the spectrum of acute care, the country is also grappling with a nursing home bed crunch. Again, despite the yearly increase in bed capacity, waiting time for a subsidised bed at a nursing home can be several months. This and issues of affordability have seen an increasing number of Singaporeans admitting their older persons into nursing homes in the neighbouring Malaysian state of Johore. In one Johore-based nursing home set up by an established Singapore operator, 40 per cent of the 150 residents were Singaporeans (Tai and Chuan, 2015 and Tai, 2015).

The country's Healthcare 2020 plan aims to increase the number of nursing home beds from the current 10,780 to 17,150 by 2020 (Ministry of Health, 2012). In addition to the considerations of high capital cost in a land-starved city state, there is also the issue of skilled labour becoming available in a sector where there already is a shortage and a marked reliance on expatriate staff.

A more critical question is whether all older persons in nursing homes are appropriately placed. At the point of writing, there are no assisted living facilities in Singapore for those who require some help with daily activities of living, medical monitoring and household chores, or amounting to nursing home care. Neither are there 'retirement villages', intentional communities where facilities and resources are pooled to meet elder-centric needs and interests. Various home help services do exist, but they are discontinuous or rigidly packaged, and there are further barriers in terms of cost and eligibility criteria, making them difficult to understand and access without the help of a care professional, such as a care manager or social worker. As a result, the current situation limits the capacity for older persons to live independently and out of institutional care.

Critically, the reliance on nursing homes does not meet the common aspiration among Singaporeans to age in place amid the familiarity of family and community. The recently released Housing Development Board's (HDB) Sample Household Survey of 2013, for instance, shows that over 80 per cent of older residents aged 65 and above want to age in place – a figure more significant as over 80 per cent of the Singapore resident population lives in public housing under the jurisdiction of the HDB (Housing & Development Board, 2014).

Government support for ageing-in-place has emerged and strengthened only in recent years. Between 2011 and 2015, the number of home care places increased by 2,700 (71 per cent), home palliative care places by 1,200 (32 per cent) and day care places by 1,000 (48 per cent). The plan is to have 10,000 home care places, 6,000 home palliative care places and 6,200 day care places by 2020 by opening up the provision of subsidised home and community care services to private enterprise in 2015. Guidelines for their practice and delivery are in development at the time of writing (Khor, 2015).

The goal of service integration across settings is being aided by IT developments. First introduced in 2012, the National Electronic Health Record (NEHR) has become accessible to all community hospitals, 56 community healthcare providers and some 40 per cent of GP

clinics by 2015. In development is a Continuity of Care Record (CCR) functionality that aims to enable institutions to share patients' problem lists and care plan, resulting in a seamless integration with hospital EMR systems (Kim Yong, 2015).

#### 6.4.3 INSUFFICIENT NUMBERS AND CAPACITY OF CARETAKERS

In a 2012 Occasional Paper on projected manpower needs, it was found that to meet the needs of the ageing population and to provide more holistic care in a community-setting, Singapore would have to expand its professional healthcare workforce comprising doctors, dentists, nurses, pharmacists and allied health professionals by about 70 per cent to 78,000 staff by 2030 (National Population and Talent Division, Prime Minister's Office). For support staff such as healthcare assistants and nursing aides, a 220 per cent increase to 13,000 workers was needed, while 300,000 foreign domestic workers would have to be recruited.

Government efforts are underway to attract, train, retain and develop workers in the eldercare sector, especially in intermediate and long-term care, and to incentivise the participation of Singaporeans and permanent residents, in particular.

These measures include:

- At the entry level to the sector, recognising work life experience as a qualification for training, e.g., Singapore Workforce Skills Qualifications (WSQ) courses available through the Singapore Workforce Development Agency (WDA) (Singapore Workforce Development Agency, 2015);
- Providing grants and subsidies for training, from entry to advanced professional levels, for example, through the WDA and AIC (Agency for Integrated Care, 2011);
- Setting career development pathways and wage increases for professions, like nurses and social workers, with others on the way; and
- Setting and developing service standards – undertaken by various task forces and committees.

There has been some backlash against the inflow of foreign workers, but in any case, the supply of foreign labour from countries within the region as low paid, semi-skilled workers and foreign domestic workers is under pressure as their home economies develop (Tan, 2015). As such, additional measures should be taken to develop Singaporeans as care professionals as well as to step up the innovation and roll-out of labour-saving smart tools, and the Government is looking into these areas. As regards smart tech in healthcare, developments are piecemeal and mostly driven by private enterprise, and there is as yet no quality assurance framework.



Training for caretakers is also an area that requires further strengthening. Currently, training trends towards institutional setting, practitioner-to-practitioner training programmes in community-based eldercare, such as that offered by the Tsao Foundation's Hua Mei Training Academy, are uncommon. The academy draws on the expertise of its professional care team in the Hua Mei Centre for Successful Ageing, which is a collective of primary health, social and psycho-emotional care services for community-dwelling elders to enable ageing in place. It needs to be recognised that healthcare practice in a community setting has a different set of demands, resources and conditions than in an institutional environment, and training needs to be appropriately contextualized.

## 7 Conclusions and recommendations

**Based on the description and analysis of long-term care service provision in Singapore, the following issues are identified and recommendations suggested for improvement:**

- 1 The policy shift in Singapore to build an integrated system of medical and social care across care settings and to invest more in community-based care is heading in the right direction. However, this drive towards integration is not helped by the division between biomedical care and social care that are currently administered by two different ministries, the Ministry of Health and the Ministry of Social and Family Development respectively. This complicates programme planning, funding, access and integration.

What would help is a fundamental re-envisioning of primary care to encompass and deliver care that is person-centred, comprehensive, continuous, coordinated with other relevant services, community-based as well as considerate and inclusive of the older person's personal, familial, and cultural capacities and environment.

- 2 Under the national 'integrated care' approach, there is also limited recognition and support for the part played by non-pharmacological psycho-emotional healthcare in the total wellbeing of the older person.

Therefore, there is a place for community-based gerontological counselling that specifically addresses the psycho-emotional needs of older persons and this has to be enabled from the point of view of service planning to programme funding, along with the setting of quality standards and training.

- 3 Moreover, integration is hampered by limited care management of older persons, especially in the community setting, whereby services provided are often fragmented and difficult to comprehend and access by elderly citizens with lower literacy skills.

In this regard, there is a need to recognize the important role of care management as an essential integrator across the various service sectors in eldercare and build up its capacity at the community-level. Critically, care management can facilitate the building of a care continuum to meet multiple and complex bio-psycho-social needs in an ageing population.

- 4 Currently, and as mentioned earlier, different care settings use different needs assessment tools geared towards their own individual requirements. These tools are also insufficient for facilitating long-term care planning and resource utilisation.

Much can be gained by taking a decisive step towards the national adoption of a robust needs assessment instrument for use in problem identification, profiling, care planning and monitoring. This would enable appropriate and quality care provision as well as better

resource management in complex long-term care. Beyond the delivery of individual care, the data collected will also aid policymaking.

- 5 The options for older persons in Singapore to live independently and out of institutional care are limited. There are no assisted living facilities in Singapore for those who require some help with daily activities of living, but not amounting to the level of nursing home care. Neither are there 'retirement villages' or other communities catering to elder-centric needs and interests.

More policy support and economic incentives need to be provided to NGOs and private enterprise to widen options in elder housing and assisted living facilities. This would facilitate right siting (i.e. prioritizing the management of chronically ill older persons in primary care settings, as oppose to specialised care settings), enable Singaporeans to age in place amid the familiarity of family and community, and relieve the acute pressure for beds in nursing homes and acute hospitals.

- 6 The Government is acting swiftly to set and enhance service standards and build capacity in the eldercare sector. But most training in health and allied care is hospital-centric. More has to be done to enhance capacity in community-based gerontological skills so as to enable ageing in place and improve health outcomes.
- 7 Government subsidies for healthcare focus mainly on hospital utilisation and the treatment of prevalent chronic diseases. Financial support for long-term care in the community, which incurs personal expenses on transport, food, diapers and so forth, falls short of needs and particularly stresses the lower socio-economic groups. The current system appears to 'reward disease' in the availability of service subsidies for disease management and hospital care.

There is, therefore, a need for more investment and support in the area of long-term community care as well as greater promotion and incentive for good health and self-efficacy as a vital part of the national drive towards ageing in place.

- 8 While Singapore's 'many hands approach' in healthcare provision has served to regulate use and distribute the cost burden across personal, family, community and state, it also makes parents into a cost-centre for families with all its potential relationship stressors, and older persons have been known to self-restrict their healthcare use for fear of burdening their families. Means testing in Singapore uses type of dwelling as an indicator of the means to pay for healthcare, placing cash-strapped families in a bind. In short, fear that healthcare will be unaffordable remains one of the foremost concerns among Singaporeans (Government of Singapore, 2015).

The Government has delayed the retirement age to 67 years and is also providing incentives to businesses to employ older workers. In 2015, it also started a modest grant to enable Singaporeans to continuously upgrade their skills.<sup>4</sup> However, much more needs

4 See Skills Future at <http://www.skillsfuture.sg/>

to be done to improve the personal financial security and independence of older persons, especially in view of the cost of long-term care.

- 9 Measures to improve the situation of older persons have, in the large, lacked a gender dimension. Bold and concerted policy action is needed to empower women, who have longer life expectancy and fewer opportunities for income and wealth accumulation, and whose healthcare expenditure can be expected to continue over a longer number of years and escalate over time. Given that the majority of family caregivers for older people are women, some kind of credit scheme for their own healthcare use could be considered along with other necessary steps to improve the overall financial security of older persons.
- 10 There are new national initiatives to create elder-friendly and dementia-friendly communities, which include service, infrastructure, housing and transport development. While these take care of the 'hardware', a more intransigent problem is in dismantling ageist perspectives in broader society so that the value, contribution, potential and participation of older persons are given recognition and support.

## Annex: About the Tsao Foundation<sup>5</sup>

The Tsao Foundation, a family non-profit, was inceptioned in 1993 to enhance the health, participation and independence of older persons in a society for all ages, with guidance taken from the MIPAA and the WHO's active ageing frameworks (Tsao Foundation, 2013c).

Its objective is to advance a positive transformation of the ageing experience through mindset and systemic change by implementing innovation in community-based eldercare, training and education, policy relevant research, collaboration and advocacy.

The Foundation has three principal initiatives to focus development in each area and to leverage their collective expertise, especially to enable ageing in the community:

- Hua Mei Centre for Successful Ageing (HMCSA) which enables ageing-in-place by pioneering replicable, community-based, integrated health and psychosocial age care service models grounded in person-centred principles;
- Hua Mei Training Academy (HMTA), dedicated to capacity building in professional community-based age care, informal and family caregiving, as well as personal development and community action in successful ageing through providing practitioner-driven training, education and consultancy services; and
- International Longevity Centre Singapore (ILC-S), which supports policy, practice, advocacy and community development through initiating high impact research and collaborative platforms in population ageing issues and related action, and is part of the global think tank, the International Longevity Centre.

5 See Tsao Foundation at <http://tsaofoundation.org/>

Recognized as the country's earliest advocate of ageing-in-place, the Foundation is, today, a collective of eight pioneering community-based programmes offering integrated comprehensive health, social and psycho-emotional care. These strive to:

- Provide person-centred care, empowering elders in decision-making, independence and self-efficacy;
- Practice a bio-psycho-social model for holistic health over the age continuum;
- Adopt a community-based “patient-centred medical home” (PCMH) approach;
- Embed care management within its practice so as to facilitate the delivery of right service at the right time and in the right amount, harnessing available resources and advocating for service and policy improvement;
- Include data collection and research in its programme models to assess outcomes and efficacy for learning, advocacy and replication;
- Include and support caregivers as part of care ecosystem, and to encourage their proactive ageing.

### CONNECTING THE DOTS – THE COMSA PROJECT

The Foundation's latest project – the Community for Successful Ageing (ComSA) – located in Singapore's Whampoa constituency, is attracting attention for its public health, population-based and community-wide approach to successful ageing (Tsao Foundation, 2013a). It leverages the skills and knowledge accumulated by its three initiatives over the decades.

ComSA's main features:

- Creating an integrated care management system which at the core would connect the disparate services across care settings and thereby, reach out to vulnerable community dwelling elders at bio-psycho-social risk, facilitate proactive health management over the life course, avert elders 'falling through the cracks', using acute hospital care unnecessarily, or prematurely entering into institutional care, and promote ageing-in-place;
- A concurrent community development agenda to empower older persons, restore their voice and contribution in the social space for their value to be recognised, galvanize volunteer support and build inter-generational solidarity to counter ageist attitudes;
- ComSA aspires to work with urban planners and housing authorities to combine efforts in creating a space that supports the common aspiration to age in the community, to have fuller, healthier lives and a secure old age lived in dignity;
- Secure old age lived in dignity.

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