HCA Hospice Care (HCA) was the largest home-based hospice care provider in Singapore, caring for 3,283 patients with life-limiting illnesses in the financial year ended March 2009. The charity had managed a successful turnaround from three years of operating deficits (2001-2003) to surpluses in the years that followed. However, as the general population grew older, demand for hospice home care services was expected to grow over and above HCA’s operating capacity.

At the beginning of 2010, HCA’s leaders were at a crossroad as the charity faced several resource constraints to growth. Firstly, the challenge was to raise sufficient financial resources needed to expand capacity. Secondly, an adequate pool of competent palliative professionals, especially doctors and nurses, were required to deliver the home-based hospice services. Finally, HCA would need ready managerial talent if operations were scaled up significantly.
A CHARITY AT A CROSSROAD

In 2009, HCA Hospice Care (HCA) was the largest home-based hospice care provider in Singapore. The charity had its beginnings in 1985 as a grassroots movement to assist and support cancer patients dying in pain and with symptoms inadequately relieved. With public hospitals in Singapore geared towards acute care, less priority was given to patients whose diseases were deemed incurable and death an imminent outcome.1

As this movement grew, HCA was registered as a charity in 1989 to provide palliative care to patients with life-limiting illnesses in their own homes. From then to 2009, the charity had delivered palliative care to almost 28,000 individuals at the end stage of their lives.

Each day, HCA's multidisciplinary teams comprising doctors, nurses, social workers, counsellors and volunteers travelled to the homes of patients who had been discharged from acute care hospitals and referred to HCA. HCA teams administered medical and nursing care as well as social, emotional, and psychological support to these individuals and their families in their home environments, with the goal of relieving the physical and mental pain as well as suffering faced in these circumstances.

Given Singapore's fast-ageing population, the demand for palliative care of patients with terminal illnesses was set to grow. Increasingly, palliative care was delivered in institutional settings such as hospitals or nursing homes. However, the demand for home-based hospice care was likely to increase as life expectancy increased and some elderly preferred to “age in place”.

HCA provided hospice home care services free to patients as it did not want patients and caregivers to reject or delay such services due to financial constraints, even for cases where the patients and their families had refused to undergo means testing.

People don’t know what is home palliative care. If we show them how to look after the patient, the first thing they ask is cost. So once we say it is XX dollars they will say, no thanks... As hospice funds are made up of donations from family members when their loved one dies, they might not feel obliged to do the same when a charge, however nominal, is involved.2

Dr Cynthia Goh
Head, Department of Palliative Medicine
National Cancer Centre, Singapore (2009)

In 2009, this policy presented a serious challenge to HCA's leadership team. To meet the growing demand for its services, HCA would have to scale up its operations, triggering an increase in the financial resources required to run the charity, as well as an increase in the number of home care teams it required.

The challenge of recruiting and retaining qualified healthcare professionals – mainly doctors, nurses, psychologists and medical social workers – able to deliver the full suite of home-based hospice care was becoming more pressing as the charity competed with other institutions for such talent who had a wide range of career options to choose from.

HCA's management team had successfully turned around a funding crisis that threatened the charity in 2001-2003. Any substantial increase in funding requirements was likely to be viewed with some degree of trepidation.

Dr R. Akhileswaran, CEO and Medical Director of HCA, was concerned at the pace of growth in demand:

Do we keep growing or cap growth? Where do we cap? We can’t turn down patients. Where will the patients turn to? We had thought about capping at 750 patients but we have grown to 900-950 on any given day. Human resources (doctors and nurses) are finite and reserves are limited. The quality of care will be affected when there are not enough resources. We have to try and make this sustainable in the long run.3

---

2 Most laud Medisave for home care; But hospices worry that charging for services may dry up donations. (2009, April 7). The Straits Times.
3 Dr R. Akhileswaran to Authors on 2 October, 2009.
Dr Seet Ai Mee, President of HCA, believed that it was critical to set the limit for HCA’s growth:

There is an effective size for a Voluntary Welfare Organisation (VWO). I don’t believe in dinosaurs. Nothing grows in the shadow of a Banyan tree. We are getting to a ‘silo’ situation. There is room for another home care hospice service provider. Competition is healthy.4

HOME-BASED HOSPICE CARE

Palliative care had its beginnings in the modern hospice movement in the United Kingdom in the 1960s.5 By 1990, the concept had spread to many other developed countries.

In 2002, the World Health Organisation (WHO) defined ‘palliative care’ as:

An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.6

The focus in palliative care in the West and Japan had been based largely on institutional delivery through hospices or nursing homes and in some cases, hospital-based palliative services. Hospice care was generally focused on pain and symptom control, enabling patients to spend their last days with dignity and to raise their quality of life.

In other parts of Asia, a different mode of hospice care emerged – based on home-based care, with family members involved in caregiving and working together with palliative care professionals. This meant that many of these patients died at home rather than in institutions.

In Singapore, institutional hospice care started in 1985 when St. Joseph’s Home opened its doors to the terminally ill with the provision of 16 beds. Two years later, with the support of the Singapore Cancer Society, the Hospice Care Group (which later became the HCA) was set up to provide hospice care at home. From these beginnings, home-based hospice care took off and this was reflected in the high percentage of home deaths of patients under hospice home care, reaching 70 percent in 1994.8 In 1996, the Singapore Government began providing some funding for hospice home care which was seen as relieving some of the strain on public hospital facilities and services.

However, as more adult family members joined the workforce, home care patients with complicated and multiple symptoms were being hospitalised. As such, the number of patients under hospice home care who died in hospitals rose from 27 percent in 1994 to 39 percent in 2003. Dr Cynthia Goh questioned:

Does this mean that the quality of home care is falling? How good the services are depends on whether they can attract good health professionals to work in these services. Is the quality of hospice home care falling because of a lack of doctors qualified to provide such care?9

Working with subsidies from various government agencies and donations from organisations and individuals, home-based hospice care (as well as institutional hospice care) was largely driven by the charity sector in Singapore and by and large, the scale of operations of these organisations were much smaller when compared with acute care public hospitals. (See Exhibit 1 for hospice care providers in Singapore.)

HCA – THE CHARITY

In 1989, HCA began operations from the home of its Special Medical Advisor, Dr Anne Merriman10, with

---

4 Dr Seet Ai Mee to Authors on 9 November, 2009.
5 Dame Cicely Saunders established the first modern hospice, St. Christopher’s Hospice, in 1967 in London.
7 The home death rate is one of the audit tools used to assess the efficacy of home-based hospice care.
10 Dr Anne Merriman was then a specialist in geriatric medicine and senior teaching fellow at the Department of Community, Occupational and Family Medicine, National University of Singapore.
a full-time team of one doctor, two nurses, a social worker and an administrator. From these beginnings, HCA grew to become the largest hospice home care provider in Singapore.

According to Dr Rosalie Shaw, Medical Director of HCA in 1995, the mission of the charity was “to improve the quality of their (patients’) lives and make whatever time they have left more comfortable.”

During its first decade, the number of patients with HCA grew from 221 in 1991 to 2,759 in 2002. Its medical team grew from one doctor and two full-time nurses in 1991 to two full-time doctors (supplemented with locum doctors) and 13 nurses in 2000. By 2007, the number of full-time doctors had risen to five while nurses’ strength grew to 24.

However, staffing the home care teams remained a critical problem. Palliative care was not regarded as an attractive career option by doctors and nurses and even more so in the case of work that required the delivery of home-based hospice care. This challenging recruitment environment was further aggravated by a funding crisis in 2001-2002 which resulted in higher staff turnover.

Leadership Renewal

In Financial Year (FY) 2001, HCA recorded a deficit of S$690,000 compared to a surplus of S$1.06 million in the previous year. There was a sharp drop in public donations that year. The charity was also ill-prepared for changes in the funding policies of HCA’s major funding sources, namely, the National Council of Social Services (NCSS) and the Ministry of Health (MOH), which affected the quantum of funds it received from them. In the following two years, HCA recorded deficits of S$20,000 in FY 2002 and S$71,000 in FY 2003.

In 2003, alarmed by the consecutive deficits, HCA’s past presidents, Dr Cynthia Goh and Mr Reggie Thien, persuaded Dr Seet Ai Mee to take on the role of President of HCA, in order to provide the leadership to pull it out of its financial crisis.

Dr Seet was one of the founders of Dover Park Hospice, the first purpose-built inpatient hospice (accommodating up to 40 patients) in Singapore set up in 1992. She was then Vice-Chairman of the Dover Park Hospice Governing Council. Dr Seet stated:

> I have worked in community service for several decades and one of the scenes which depresses me most is that of old folks’ homes and speaking to elderly people who have not been visited by their children and grandchildren for months. There is sadness in their eyes and a longing in their voices which carry over to my own heart.  

Dr Seet immediately set to work with a new team of board members (see Exhibit 2), and HCA’s Medical Director, Dr Akhileswaran. They went through all aspects of HCA operations, with the goal of turning around the deficit situation within two years. This included taking on operational management roles where necessary, in order to implement changes deemed essential for the survival of the charity.

Managing the Turnaround

To ensure that the charity would be viable in the long run, major changes to the charity’s organisational systems and practices were needed. Many of these changes were overarching and would require the staff, especially those involved in home care service delivery, to adopt new work practices including how they worked and interacted with each other, as well as with external stakeholders.

To Dr Seet, the biggest challenge was “to win over staff across all levels – in order to change their thinking”.

One major change identified was the working hours of home care teams. Previously, the teams were on a five-day work week similar to that of office workers. This meant that when home care staff visited patients, they had little opportunity to meet those family members who were at work. This could result in missed opportunities to work together with family members on patient and caregiver problems.

13 Mak Mun San. (2006, April 12). No looking back in anger; Her exit from politics was unexpected and swift but Dr Seet Ai Mee has moved on. The Straits Times.
14 Dr R. Akhileswaran, a specialist in radiation oncology and palliative medicine, joined HCA as Medical Director in 2001 and was promoted to Chief Executive Officer in 2007.
Communication between administrative staff and medical teams was lacking and this did not help in resolving administrative issues related to subsidies that had been a major cause of operating deficits. Dr Seet saw this as the result of a ‘silo’ mentality that had taken root in the organisation and which had to be resolved if change strategies were to work.

The Finance and Administration functions were also reorganised with the setting up of a Human Resources (HR) department seen as essential. This underlined the need to focus on the critical manpower issues and some retrenchments were made to streamline the organisational structure. A grant was obtained from NCSS to put systems and processes under a proper governance structure.

The new leadership team took action simultaneously on several fronts:

• Funding: HCA sought and secured agreement from NCSS and MOH, to give the charity a free hand in implementing changes needed to align operational practices with the new funding policies. A pressing issue that required attention was whether to charge for services rendered and associated with this, was the impact of means testing requirements set by funding agencies. (See Exhibit 3 for details of means testing.)

• Talent recruitment and retention: HCA’s attractiveness as an employer was identified as key to attract well-trained and committed staff capable of delivering quality care. The charity’s HR policies and practices were scrutinised and changes instituted, including staff compensation, training and welfare, as well as cross departmental communication and operational leadership.

• Organisation and work re-design: This was crucial to improve efficiency in resource allocation in the face of growing manpower expenditure as salaries were adjusted upwards to factor in market norms. Furthermore, an urgent review of how work was organised in home care delivery was undertaken, brought about by a change in the computation of subsidies by MOH to one based on the number of home visits.

Among the changes were:
- A new organisational structure with new positions to provide leadership and support at the operational level.
- Although staff worked a 5-day week, HCA introduced a roster for Saturdays and one afternoon shift for every nurse, once a week. This increased opportunities to meet patients’ family members during their visits. Nurses had a morning free, in lieu for working six days which they could use at their own convenience and this made the work changes more acceptable.
- All doctors, including the medical director, were put on weekday and weekend after office hour call duties.
- A new administrative support function, the Social Work Assistant, was introduced. This relieved the home care teams of some of the administrative workload and facilitated efficient administration of the procedures required for MOH’s mandatory means testing.

• Management of external relationships: HCA’s leadership felt the need to articulate and communicate the role of HCA in the delivery of home-based care to multiple constituencies in the community. This included building greater awareness in suburban housing estates so that family caregivers could identify HCA and have easier access to HCA’s staff. Another need identified was for closer liaison with other non-governmental organisations to increase patient access to a wider range of services (such as home nursing) and to avoid duplication of services. Also, more networking with doctors and healthcare providers in the community were seen as essential.

Dr Seet was emphatic about improving the image of HCA’s nurses. Previously, nurses were not required to wear uniforms when on home visits because it was felt that the family might not want their neighbours to know that a family member had a terminal illness. However, Dr Seet felt that nurses ought to project a professional image to caregivers and patients:

> In our society there is an association and it is important. Imagine – it is like policemen not wearing uniforms. Nurses must wear uniforms and shoes when visiting patients. We got a professional designer to design the uniforms. 

• Increase funding from public donations: Although the HCA Board had taken the decision to provide

15 Dr Seet Ai Mee to Authors on 9 November, 2009.
home care services free of charge, it also encouraged voluntary giving from patients and their families, on a ‘pay as you can’ basis. In this regard, communication between the home care team and patients’ families was critical. By re-arranging hours for home visits to cover late afternoons as well as Saturdays, nurses had more opportunities to meet face-to-face with patients’ families and to share with them HCA’s message on voluntary giving. This also provided an opportunity for nurses to explain the relationship between the information needed from family members for the means tests required by MOH and the amount of funding received by the charity.

In the financial year ended March 2004, the charity recorded an operating surplus of S$263,163. HCA’s new leadership team had turned around the deficit of the previous three years in 13 months, well within the targeted 24-month time frame it had set.

**HCA IN 2009**

Most patients at HCA were referred by government hospitals as well as private hospitals and other hospices. The public hospitals were the main source of referrals (about 95.3 percent) and there was a significant increase in referrals from the National Cancer Centre and Changi General Hospital.16 (See Exhibit 4 for source of referrals.)

The charity operated a range of services for patients, as well as their primary caregivers. These were:

(a) **Home Care Services** for individuals with life-limiting illnesses which included:

- Provision of nursing and medical treatment to manage patients’ pain and symptoms.
- Provision and administration of medical prescriptions.
- Coaching and training family members on how to care for patients at home.
- Render emotional and social support to families to cope with death, grief and loss.

HCA also provided a 24-hour patient care helpline to support caregivers in case of emergencies at home.

These services were delivered through five satellite centres: one at the charity’s headquarters and the other four based in public housing estates in the city-state. (See Exhibit 5 for the location of HCA satellite centres in Singapore.) The charity had a total of six doctors and 22 nurses operating this service. Patient visits by home care teams ranged from once a month to several times a week, depending on the severity of the patient’s condition.

There were about 112 home care volunteers who attended to the patients’ requests. (See Box for the major types of help provided by volunteers.)

(b) **Day Care Centre** for patients who were able to walk or were safely mobile in a wheelchair and did not require 24-hour nursing care. Located at the same building as HCA’s corporate office, the centre provided a social and rehabilitative programme to enrich and improve such patients’ quality of life. Activities were tailored to the interests and abilities of each patient and included light exercises and physiotherapy, singing and music therapy, arts and crafts, pet therapy, and outings for ambulatory

### VOLUNTEER SERVICES RENDERED AT HCA

- Haircut
- Befriending/temporary companion
- Housekeeping
- Transport service for medical appointments
- Delivery of medical equipment
- Outings to Fo Guang Shan Temple, Orchid Garden, Changi Museum, Sentosa Underwater World, Singapore Flyer and Singapore Garden Festival
- Trips to movies/birthday parties and mind-mapping games
- Events – supported by MediaCorp during Chinese New Year and Standard Chartered Marathon Run 2008
- Corporate giving


---

16 Changi General Hospital was a regional government hospital catering to the healthcare needs for approximately 1.3 million Singaporeans living in the eastern part of Singapore.
patients and caregivers. Many of these activities were organised by volunteers including groups from various community associations, societies, clubs, schools and other educational institutions. Day care patients were charged a fee of S$15 per day for therapy programmes, two-way transportation and meals.

(c) Palliative Caregiver Programmes were conducted regularly at HCA headquarters as well as at the satellite centres and included training sessions on how to care for the patient at home. A total of 52 sessions were conducted in FY2009 for 458 caregivers. Besides such training, HCA also ran several caregiver support programmes, with support networks for current caregivers to share their experiences with each other, bereavement support for caregivers, and the children’s support group. In addition, public talks were organised to raise community awareness of palliative care in general.

(d) Educational/Outreach programmes: HCA partnered with primary and secondary schools and tertiary institutions in running a Student and Youth Education Programme to raise the awareness of the younger generation on caring for the elderly.

Outputs and Outcomes (2009)

About 90 percent of hospice care by HCA was provided to patients in their own homes. In FY 2009, 3,283 patients were cared for by HCA’s home care teams, who made a total of 36,593 home visits (including 8,418 doctor visits). The number of referrals from private and government hospitals, other hospices, and institutions was 2,549. An average of 22 patients per day participated in HCA’s day care activities with a total of 717 patients cared for during the year. Subsidies totalling S$45,400 were given to needy patients to encourage them to attend day care activities regularly. The number of cases handled by the psychosocial department was 644 (including 359 new referrals) with 1,362 home visits made by psychosocial workers. (See Exhibit 6 for HCA patient numbers and age profiles.)

Home deaths increased to 56.7 percent as compared to 55.9 percent in the previous year (see Table 1).

### Table 1 – HCA Patients: Deaths by Place of Occurrence FY2008

<table>
<thead>
<tr>
<th>Place of death (FY2008/09)</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>1066</td>
<td>56.7</td>
</tr>
<tr>
<td>Government and Restructured Hospitals</td>
<td>785</td>
<td>41.8</td>
</tr>
<tr>
<td>Private Hospitals</td>
<td>4</td>
<td>0.2</td>
</tr>
<tr>
<td>Overseas</td>
<td>2</td>
<td>0.1</td>
</tr>
<tr>
<td>Others</td>
<td>23</td>
<td>1.2</td>
</tr>
</tbody>
</table>


Key Financials

In FY2009, HCA recorded a surplus of S$989,950, with total income of S$5.1 million received against expenditure of S$4.1 million (see Table 2).

### Table 2 – HCA Income and Expenditure (FY2009)

<table>
<thead>
<tr>
<th>Income</th>
<th>S$</th>
<th>%</th>
<th>Expenditure</th>
<th>S$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grants from MOH</td>
<td>2,041,000</td>
<td>40</td>
<td>Personnel Costs</td>
<td>2,656,000</td>
<td>64</td>
</tr>
<tr>
<td>NCSS Funding</td>
<td>1,327,000</td>
<td>26</td>
<td>Centre Costs</td>
<td>564,000</td>
<td>14</td>
</tr>
<tr>
<td>Donations and Fund-raising</td>
<td>1,327,000</td>
<td>18</td>
<td>Other Operating Expenses</td>
<td>574,000</td>
<td>14</td>
</tr>
<tr>
<td>HCA Satellite Centres</td>
<td>935,000</td>
<td>12</td>
<td>Premises Costs</td>
<td>291,000</td>
<td>7</td>
</tr>
<tr>
<td>Investments</td>
<td>599,000</td>
<td>3</td>
<td>Fund-raising Expenses</td>
<td>29,000</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>50,000</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,108,789</strong></td>
<td><strong>100</strong></td>
<td><strong>Total</strong></td>
<td><strong>4,118,839</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>


---

17 HCA Hospice Care Annual Report 2008/09.
KEY ISSUES AND CHALLENGES

In 2009, HCA spelt out its mission:

- Ensuring the best quality of life for patients through the delivery of professional palliative care and provision of compassionate support for their families, and
- Nurturing dedicated individuals who make HCA’s work possible and serving the community through continued learning and development.18

HCA was often regarded as the “last resort” by referral organisations, such as acute care hospitals and other hospices, for terminal patients who lacked the resources to manage their illnesses.

With a fast-ageing population, the number of patient referrals was expected to grow and with this, the pressure to scale up HCA’s operations. Set against this was the problem of resource constraints in funding as well as human capital, especially that of healthcare services personnel and management bench strength.

HCA depended on government agencies and public donations to fund its activities. As it had experienced in 2001-2003, a fall in public subsidies and donations could significantly impact HCA’s operational sustainability.

The 2004 turnaround had brought with it operational efficiencies that could be severely tested if operations were scaled up. This was especially so with regard to its critical resource – competent healthcare professionals needed to staff the home care teams. The human capital issues that HCA faced were recruitment, retention, and operational efficiency of home care delivery.

To improve the quality of professional care and support and to develop an adequate pool of healthcare professionals, HCA made the decision to adjust staff compensation at all levels on par with that of government health service organisations, so as to compete and secure appropriately qualified professional and management talent.

As the cost of delivering such care increased, the challenge was in the scalability of its current operations, given HCA’s mission of providing free services to all who needed it.

Funding

HCA’s home care programme was partially funded by MOH and NCSS. Between 1990 and 1996, MOH gave HCA fixed grants. From 1997, the funding was based on the number of patients cared for annually.

NCSS’ earlier funding model based on deficit funding, made it difficult for HCA to build up reserves as excess funds raised by HCA could not be retained but had to be used to offset NCSS’ funding for that year.

MOH also changed its mode of funding for HCA in 2002, from one based on the number of patients treated per year to one based on the number of home visits made by HCA doctors or nurses. These changes increased HCA’s financial problems, and the charity incurred operating deficits in FY2001-2003.

The funding problems caused some level of uncertainty and insecurity among employees, resulting in high staff turnover and a drop in the quality of care.

In January 2002, MOH also instituted means testing as part of the funding requirements. The home care doctors and nurses were originally tasked to carry out the means tests. However, a 2002 survey revealed that only 30 percent of patients were successfully means tested and this resulted in an almost 50 percent reduction in funding from MOH.

One of the first actions taken by the new leadership was to achieve more efficient and effective administration of the means test. A new job position, Assistant Social Worker, was created and the work hours of these employees were designed such that they worked primarily afternoon shifts (afternoon to night) and could meet up with family members who were often unavailable during office hours. With this new arrangement, the success ratio for means testing reached 80 percent.

As MOH’s funding policy was based on patient visits, the total number of home visits by doctors and nurses was a key component for HCA’s financial sustainability. In 2002, HCA doctors and nurses made an average of four home visits per day. To secure more funding, clinical staff were encouraged to increase the visits, with targets set at an average

18  HCA Hospice Care. Celebrating 20 years. HCA publication 2009.
of 5.5 home visits per day by nursing staff and six home visits per day by each doctor.

With the implementation of these changes, the subsidies from MOH increased significantly and in 2004, HCA recorded a surplus compared to a deficit in the previous three years.

However, the challenge for the future was to sustain and improve on this performance. It was open to question the extent to which the number of visits per staff could be increased without affecting employee work satisfaction and effectiveness, as well as the overall quality of care.

**Human Capital**

Dr Akhileswaran observed that:

*This field is not as glamorous as others. Doctors and nurses drawn to it must have a passion for this kind of work. And with the passion or compassion, you still need competence.*

**Doctors**

Since the establishment of hospices in Singapore, there had been a shortfall of medical professionals involved in the delivery of palliative care services. From the mid-1980s, many doctors working in hospices were recruited from overseas, mainly from the Philippines, India and Thailand.

HCA had hoped to tap on the general practitioners (GPs) practising in suburban housing estates to help in the delivery of home care to HCA patients living in their clinics’ vicinity. However, HCA’s efforts to generate interest among GPs regarding palliative care and hospice home services had not been successful. Although more than 5,100 GPs were registered with the Singapore Medical Council in 2009,23 few expressed interest in moving into community or home-based palliative care.

GPs, especially those who had invested in setting up suburban clinics, were likely to evaluate the opportunity cost of making a home visit relative to the number of clinic consultations during the time spent on a home visit. Considerable training investment was also required to be effective in this field:

*For a GP to become competent in palliative care, it could take 2-3 years. It is not just about knowledge but learning from experience in handling such patients on your own. The approach cannot be purely clinical. One must be willing to extend and expand beyond clinical aspects.*

Dr Dennis Dignadice
Medical Officer
HCA Jurong Centre, 2009

**ADAPTING A NEW GRANT FUNDING MODEL**

In 2005, HCA opted for the 25 percent Grant Funding model from NCSS. This meant that NCSS funded up to a maximum of 25 percent of HCA’s operating costs. HCA received 40-45 percent funding from MOH. For the remaining 30-35 percent, HCA sought public donations and any excess funds could be retained as reserves in an endowment fund.19

By 2009, patient-related donations had gone up to S$40,000-50,000 per month from S$10,000-13,000 per month prior to 2003. The number of patients under HCA at any given time increased from 350 in 2003 to 900 in 2009, resulting in more home visits by doctors and nurses. The number of day care patients and attendances also increased over these years. NCSS funding for home care and day care almost doubled from 2003 to 2009.20

<table>
<thead>
<tr>
<th>NCSS Funding</th>
<th>Mar 2003</th>
<th>Mar 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home care</td>
<td>720,166</td>
<td>1,327,260</td>
</tr>
<tr>
<td>Day care</td>
<td>134,010</td>
<td>355,975</td>
</tr>
<tr>
<td>Total</td>
<td>854,176</td>
<td>1,683,235</td>
</tr>
</tbody>
</table>

Funding from MOH also increased as more subsidies were received, given higher success arising from better administration of means testing. At the end of March 2009, HCA had achieved a surplus of almost S$1 million, resulting in total reserves of S$7.57 million.21

20 Data provided by HCA Hospice Care, Singapore.
24 Dr Dennis Dignadice to Authors on 13 October, 2009.
Palliative Care Nurses

Most of the nurse managers at HCA were experienced senior nurses who had previously worked as midwives, neonatal intensive care nurses, industrial nurses or at private nursing agencies.

HCA had 22 full-time nurses in 2009, but Dr Akhileswaran felt that this was still below the optimal number of nurses needed to look after the 3,283 patients:

Currently, HCA nurses look after 35-40 patients at any given time. The ideal nurse to patient ratio would be 1:25. The supply has not kept pace with the demand.25

Recruitment of nurses remained a challenge for HCA, as palliative care was not an attractive nursing career choice, even after salaries were adjusted in line with the public health sector.

I would say the main challenge is managing the stress of a heavy workload while handling the diverse needs of patients. Not every family allows us into their environment. I need to gain their trust and build rapport to win them over and help them in their journey to the end… There have been cases of emotional burnout.26

Debbie Low
Senior Nurse and Satellite Manager
HCA Jurong Centre, 2009

At the same time, demand for healthcare professionals with palliative care training and experience was growing. In the second half of 2008, HCA experienced high turnover among its nursing staff, which fell from 24 in 2007 to 16 in September 2008. This resulted in a 3.3 percent drop in home visits during the year. Dr Akhileswaran elaborated:

As more palliative care services are started in the public and private sectors, HCA becomes the favourite hunting ground for trained doctors and nurses.27

In response, HCA embarked on an intensive recruitment exercise for part-time as well as foreign nurses. HCA’s efforts paid off and its clinical team stabilised with 23 full-time nurses, one part-time and one locum nurse. However, HCA management knew that the talent shortfall would worsen. Dr Seet noted:

It has taken us half a decade to build up our teams and hone their professional and organisational skills. With growing need in the elder health and palliative care areas, we have seen good, trained staff move to green fields in these sectors.28

Medical Social Workers and Psychosocial Counsellors

Studies had shown that psychosocial services were important and patients would live longer if they had access to these services. HCA believed that holistic care was important and considered psychosocial aspects of patient care as an integral part of hospice care. However, the shortage of medical and social counsellors was even more acute and HCA was exploring the possibility of buying services from other institutions. Dr Seet explained:

We are subsidised by the government for doctors and nurses only. Social workers, medical social workers, counsellors and psychosocial staff costs are not subsidised.29

CHANGING ATTITUDES TOWARDS PALLIATIVE CARE

Singapore’s Health Minister Khaw Boon Wan acknowledged that the MOH had been ‘hesitant’ in supporting palliative care with its institutional memory “coloured by that of the Sago Lane death houses.”30

25 Quah, M. (2009, October 30). Crying out for palliative care; There are just four hospices in S’pore with a total of 125 beds, far short of what’s needed as the population ages. The Business Times.
26 Debbie Low to Authors on 12 November, 2009.
29 Dr Seet Ai Mee to Authors on 9 November, 2009.
30 In the 1960s, Sago Lane in Chinatown of Singapore was known for its ‘death houses’ where the poor waited out their last days.
PALLIATIVE CARE TRAINING

As a field, Palliative Medicine had expanded beyond cancer patients to include patients with other life-limiting illnesses, such as dementia and lung, kidney and heart failure.

Many doctors currently working in hospice and palliative care in Singapore were either self-taught from the early days of pioneering for hospice, or apprenticed while working at an established hospice. Until mid-2005, there was no accredited training pathway in Singapore to train doctors to work in this field.

In 2006, MOH recognised palliative medicine as a sub-specialty and the first batch of palliative medicine specialists graduated in March 2009. Entry to sub-specialty training was possible via Internal Medicine, Geriatric Medicine, Paediatric medicine, Medical Oncology or family medicine.

\[\text{The mission for specialist palliative care is to push back those frontiers of knowledge and skills, so that people in our community can benefit from the best care available within our knowledge and resources.}\]

\text{Cynthia Goh}

\text{Head, Department of Palliative Medicine}

\text{National Cancer Centre, Singapore (2005)}

In 2006, the first-ever doctors’ and nurses’ hospice and palliative care scholarships and fellowships in Singapore were given out by the Lien Foundation (a charitable trust) through the Singapore Hospice Council. The goal was to train 10 local doctors, 20 local nurses, and 20 doctors in the Asia Pacific region over a period of 5 years. A campaign was also launched to raise public awareness of hospice palliative care in Singapore.

In the same year, National Cancer Centre Singapore launched Singapore’s first academically accredited qualifications in palliative care – APHN Diploma in Palliative Care with Australia’s Flinders University. The one-year course, designed for doctors and nurses from Southeast Asia, provided a structured evidence-based framework for holistic care of people living with life-limiting illnesses.

In 2007, four HCA nurses had enrolled in the course. Some of HCA’s doctors had also undertaken the Flinders programme, as part of a fellowship scheme for foreign doctors. HCA was also planning to conduct a nursing exchange program with a Perth-based non-profit organisation, Silver Chain, one of the largest providers of community, clinical, and health services in Western Australia.

where the dying spent their last months in misery and neglect. Hospice and palliative care was commonly misunderstood as a service provided for patients staying permanently at the hospice. Health Minister Khaw stated:

\[\text{In the care of the dying, we are underperforming. We have not done as well as say, Australia or UK. Past history has something to do with it. The care of the dying became assigned, by default, to a couple of VWOs and the kind-hearted souls running them. Fortunately, the limited support from MOH has not been disastrous, as our population is still young. But we cannot stay young forever.}\]

32 ibid.
33 The Singapore Hospice Council and Lien Foundation collaborate on S$2m project to help the dying. (2006, April 6). Lien Foundation press release.
36 Ensuring a good death. (2008, October 14). Speech by Mr Khaw Boon Wan, Minister for Health, at the opening of Lien Centre for Palliative Care.
In 2005, community hospice services provided care for 72.4 percent of cancer deaths (cancer deaths in 2005 was 4,281) and 20.1 percent of total deaths in Singapore.\(^37\)

A survey in March 2005 by the Singapore Hospice Council found that 65 percent of the 1,008 respondents had no idea that there were special services in Singapore that provided comfort to the terminally ill.\(^38\) Of those who knew, close to half (46 percent) said hospices had ‘something to do with death’.

However, Dr Anne Merriman, a pioneer of hospice home care, felt that the greatest obstacle was the medical profession itself:

> Traditionally, we are trained as doctors to cure and [to perceive] death as a failure – that means palliative healthcare workers have a 100 percent failure rate. We need to be taught not only to cure but to care.\(^39\)

**Public Health Policy – Moving Towards Step-down Care**

In 2008, Singapore was forecast to become the world’s third fastest ageing country\(^40\) with over 65-year-olds estimated to represent 19 percent of the population by 2030.\(^41\) This compared to 7.2 percent of the population in 2000.\(^42\) Within the next 20 years, the number of people aged 65 and older would treble from about 300,000 to 900,000.\(^43\) (See Exhibit 7A for Median Age and Exhibit 7B for Population Ageing in Singapore.)

Most of the elderly would have health conditions requiring long-term chronic care, rather than short-term acute hospital care. According to Health Minister Khaw:

> Preparing for the silver tsunami\(^44\) goes beyond simply expanding the hospital sector. GPs and polyclinics will play important roles in the care of the elderly sick. We need many more doctors, nurses, and allied health professionals. Failure to strengthen the long-term care sector will end up with the elderly patients seeking treatment in the more costly hospital sector, often with worse health outcomes, less satisfactory service level, and larger bills. We have 10 to 15 years to put the policies, systems and infrastructure in place, so that we can face the silver tsunami with confidence.\(^45\)

The policy makers’ response was to grow the long-term care sector quantitatively and qualitatively to meet the expected rise in demand, with inpatient hospice and home-based palliative care as integral parts of the overall health care delivery system. (See Exhibit 8 for the Integrated Care Delivery System in Singapore and Exhibit 9 for approximate charges at various medical facilities.)

In 2007, Health Minister Khaw also reiterated the need to attract more healthcare professionals to work in palliative care and geriatrics:

> The first step is to make palliative medicine an attractive sub-specialty – something many doctors had been lobbying for many years. This way, we can start thinking about the needs and demands of this sub-specialty, such as how many more people we need to train. Palliative care will also be extended beyond cancer to other terminal stage chronic conditions.\(^46\)

---


\(^{44}\) In 2008, the American Geriatrics Society coined the term “silver tsunami” to sound the alarm on the enormous healthcare challenges facing the United States as their post-war baby boomer generation entered retirement. The ageing of their baby boomers, combined with a rise in life expectancy and a drop in birth rate, was expected to place tremendous strain on the US healthcare system.


\(^{46}\) Tan, J. (2007, September 8). Dying at home: Ministry to look into changing rules. The Straits Times.
The costs of palliative care could be a major issue. Up till then, the care of terminally-ill patients at home was provided free by various charitable organisations. However, as the patient numbers grew, Health Minister Khaw raised the issue of payment for palliative care:

_We welcome the free service of charities for certain sectors of the population, but if you really want to grow this sector, you know that it cannot be free all around, then you need to raise a lot of money. So I think there is scope for paid palliative care._

GOING FORWARD

At the beginning of 2010, HCA’s leaders were at a crossroad. They had managed a successful turnaround and re-established the charity as the leading home-based hospice care provider in Singapore. Success had brought with it new challenges as demand for its services outpaced its existing organisational capacity. At the same time, social and public policy changes in the long-term care of the aged in Singapore would also impact on its operations and available resources at hand.

The charity stood at the brink of several possible futures:

1. Should HCA continue its current path of organic growth as shaped and constrained by the availability of critical resources such as funds and human capital, and focus on efficiency measures to improve outputs and outcomes? Or should it focus on the holistic care of a niche group of patients?

2. Should HCA scale up its operations by securing and broadening its funding sources and increasing its human capital pool? Could this place the charity in a more competitive position to attract competent and qualified human capital? Who should fund this expansion?

3. Is scale needed to bring the social change that HCA’s fundamental mission is about – i.e. improving the patient’s quality of life/dying at home?

4. Which criteria should HCA use in assessing the three options?

---

## EXHIBIT 1

### VOLUNTARY WELFARE ORGANISATIONS – MAIN PROVIDERS OF PALLIATIVE CARE IN SINGAPORE

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Year Started</th>
<th>Funding</th>
<th>Patients (2008)</th>
<th>Home Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisi Hospice</td>
<td>1988</td>
<td>70 percent of the funds are dependent on public donations. The rest is funded by the subsidy through means testing by MOH and from what families can afford to reimburse.</td>
<td>1,088</td>
<td>4,740</td>
</tr>
<tr>
<td>• Day Care for adults and children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospice Home Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• In-patient Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Joseph’s Home and Hospice</td>
<td>1985</td>
<td>N.A.</td>
<td>39</td>
<td>N.A.</td>
</tr>
<tr>
<td>• Inpatient Hospice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bright Vision Hospital</td>
<td>2002</td>
<td>N.A.</td>
<td>Not Available</td>
<td>N.A.</td>
</tr>
<tr>
<td>• In-patient Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dover Park Hospice</td>
<td>1995</td>
<td>Dover Park Hospice (DPH) needs about S$4 million each year to provide subsidised and often free care for its patients. Financial assistance from MOH funds about 35 percent of its annual operating expenditure. The shortfall is met through fund-raising and donations. By 2009, DPH had helped over 6,000 terminally ill patients.</td>
<td>437</td>
<td>N.A.</td>
</tr>
<tr>
<td>• In-patient Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Singapore Cancer Society</td>
<td>1987</td>
<td>SCS does not receive funding from the Community Chest or the NCSS and is dependent on public donations.</td>
<td>186</td>
<td>900</td>
</tr>
<tr>
<td>• Hospice Home Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agape Methodist Hospice</td>
<td>1989</td>
<td>N.A.</td>
<td>142</td>
<td>N.A.</td>
</tr>
<tr>
<td>• Hospice Home Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1 locum doctor, 2 nurses, team of volunteers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metta Hospice Care</td>
<td>2000</td>
<td>Funded in part by the MOH and NCSS.</td>
<td>170</td>
<td>N.A.</td>
</tr>
<tr>
<td>• Hospice Home Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA Hospice Care</td>
<td>1989</td>
<td>N.A.</td>
<td>3,283</td>
<td>36,593</td>
</tr>
<tr>
<td>• Day Care for adults</td>
<td></td>
<td>(Home care)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospice Home Care</td>
<td></td>
<td>(Day care)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Created by Authors
### EXHIBIT 2

**HCA COUNCIL (2003)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Seet Ai Mee</td>
<td>President</td>
</tr>
<tr>
<td>Reggie Thein</td>
<td>Vice President</td>
</tr>
<tr>
<td>Lim Hsiu Mei</td>
<td>Hon Secretary &amp; Chairman, Executive Committee</td>
</tr>
<tr>
<td>Khoo Kah Yin</td>
<td>Hon Treasurer</td>
</tr>
<tr>
<td>Katherine Yeo</td>
<td>Asst Hon Secretary</td>
</tr>
<tr>
<td>Clive Heng</td>
<td>Asst Hon Treasurer &amp; Chairman, Fund-raising Committee</td>
</tr>
<tr>
<td>Chan Ying Lock</td>
<td>Council Member &amp; Chairman, Patient Welfare &amp; Volunteers Committee</td>
</tr>
<tr>
<td>Ruby Chen</td>
<td>Council Member &amp; Chairman, HR &amp; Education Committee</td>
</tr>
<tr>
<td>Yim Sau Kit</td>
<td>Council Member &amp; Chairman, Medical &amp; Professional Audit Committee</td>
</tr>
<tr>
<td>Yong Lum Sung</td>
<td>Council Member &amp; Chairman, Public Relations, Public Education &amp; Membership Committee</td>
</tr>
<tr>
<td>Dr Lau Waun Kei</td>
<td>Council Member</td>
</tr>
<tr>
<td>Dr Cynthia Goh</td>
<td>Co-opted Member</td>
</tr>
<tr>
<td>Anne Lim</td>
<td>Co-opted Member</td>
</tr>
<tr>
<td>Lavinia Waterhouse</td>
<td>Co-opted Member</td>
</tr>
</tbody>
</table>

EXHIBIT 3

MEANS TESTING

The Singapore Government recognised that the step-down care services could be expensive because patients had to be cared for over a longer period of time. Step-down care referred to selected services such as:
• Community Hospitals
• Nursing Homes
• Hospices
• Day Rehabilitation Centres
• Home care services such as home nursing and home medical

Means testing has been defined by Singapore’s Ministry of Health (MOH) as “a way to focus limited resources for needy Singaporeans, by channelling it to those who need it most.” 1 Means testing, applicable for Singapore citizens or permanent residents, was implemented at government-funded nursing homes in July 2000 and at the other intermediate and long-term care facilities in 2001. As a result, community hospice (home care) and palliative care services (hospice day care and in-patient hospice) were partially supported by government subsidies.

Means Test provided a method to calculate the subsidies that an elderly would get if he/she needed step-down care services. Being an income assessment framework, it took into consideration:
• Gross income of the patient (before CPF deductions), his/her parents, his/her spouse, and his/her children
• Number of family members
• Ownership of major assets such as private property of patient
• Patient’s rental income, insurance claims, savings

The 3-tier subsidy rate provided a higher subsidy to lower-income patients. (See Table 1 for the means test quantum.) The subsidy was paid directly to the service provider upon admission and/or usage of the services.

<table>
<thead>
<tr>
<th>Levels of Subsidy</th>
<th>Rate of Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Capita Income (S$)</td>
<td><em>rate of subsidy</em></td>
</tr>
<tr>
<td>$0 to $330</td>
<td>75%</td>
</tr>
<tr>
<td>$331 to $800</td>
<td>50%</td>
</tr>
<tr>
<td>$801 to $1300</td>
<td>25%</td>
</tr>
<tr>
<td>More than $1300</td>
<td>0%</td>
</tr>
</tbody>
</table>


### EXHIBIT 4

**HCA NUMBER OF PATIENTS BY SOURCE OF REFERRALS**

<table>
<thead>
<tr>
<th>Source of Referrals</th>
<th>FY 2007/08</th>
<th></th>
<th>FY 2008/09</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No of cases</td>
<td>%</td>
<td>No of cases</td>
<td>%</td>
</tr>
<tr>
<td>Alexandra Hospital</td>
<td>102</td>
<td>4.13</td>
<td>92</td>
<td>3.61</td>
</tr>
<tr>
<td>Changi General Hospital</td>
<td>85</td>
<td>3.45</td>
<td>104</td>
<td>4.08</td>
</tr>
<tr>
<td>Kandang Kerbau Hospital</td>
<td>59</td>
<td>2.39</td>
<td>51</td>
<td>2.00</td>
</tr>
<tr>
<td>National Cancer Centre</td>
<td>388</td>
<td>15.73</td>
<td>468</td>
<td>18.36</td>
</tr>
<tr>
<td>National University Hospital</td>
<td>362</td>
<td>14.67</td>
<td>340</td>
<td>13.34</td>
</tr>
<tr>
<td>Singapore General Hospital</td>
<td>795</td>
<td>32.23</td>
<td>838</td>
<td>32.88</td>
</tr>
<tr>
<td>Tan Tock Seng Hospital</td>
<td>515</td>
<td>20.88</td>
<td>518</td>
<td>20.32</td>
</tr>
<tr>
<td>Other Govt. Hospitals</td>
<td>13</td>
<td>0.52</td>
<td>18</td>
<td>0.71</td>
</tr>
<tr>
<td><strong>Subtotal of referrals</strong></td>
<td><strong>2319</strong></td>
<td><strong>94.00</strong></td>
<td><strong>2429</strong></td>
<td><strong>95.30</strong></td>
</tr>
<tr>
<td>from Restructured &amp; Govt. Hospitals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospices</td>
<td>41</td>
<td>1.66</td>
<td>29</td>
<td>1.13</td>
</tr>
<tr>
<td>Private Hospitals</td>
<td>47</td>
<td>1.91</td>
<td>52</td>
<td>2.04</td>
</tr>
<tr>
<td>Others</td>
<td>60</td>
<td>2.43</td>
<td>39</td>
<td>1.53</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2467</strong></td>
<td><strong>100.00</strong></td>
<td><strong>2549</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>


### EXHIBIT 5

**LOCATION MAP OF HCA CENTRES IN SINGAPORE**

Source: Created by Authors
EXHIBIT 6
HCA PATIENT NUMBERS AND AGE PROFILE

<table>
<thead>
<tr>
<th>Year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Patients</td>
<td>2,484</td>
<td>2,547</td>
<td>2,759</td>
<td>2,676</td>
<td>2,778</td>
<td>2,927</td>
<td>2,805</td>
<td>3,202</td>
<td>3,236</td>
<td>3,283</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20</td>
<td>0.12</td>
</tr>
<tr>
<td>20-40</td>
<td>2.16</td>
</tr>
<tr>
<td>41-60</td>
<td>22.87</td>
</tr>
<tr>
<td>61-80</td>
<td>52.02</td>
</tr>
<tr>
<td>&gt;80</td>
<td>22.83</td>
</tr>
</tbody>
</table>

Source: HCA Annual report FY 2008/09.

EXHIBIT 7A
MEDIAN AGE FOR SINGAPORE (1970-2030)

<table>
<thead>
<tr>
<th>Census Year</th>
<th>Median Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>20</td>
</tr>
<tr>
<td>1980</td>
<td>24</td>
</tr>
<tr>
<td>1990</td>
<td>29</td>
</tr>
<tr>
<td>2000</td>
<td>34</td>
</tr>
<tr>
<td>2010</td>
<td>37</td>
</tr>
<tr>
<td>2020</td>
<td>39</td>
</tr>
<tr>
<td>2030</td>
<td>41</td>
</tr>
</tbody>
</table>

EXHIBIT 7B

POPULATION AGEING IN SINGAPORE


EXHIBIT 8

INTEGRATED CARE DELIVERY SYSTEM AND RIGHT SITING OF CARE

EXHIBIT 9

CHARGES AT VARIOUS MEDICAL FACILITIES (2009)

<table>
<thead>
<tr>
<th>Facilities / Services</th>
<th>Approximate Charges</th>
<th>Descriptions</th>
</tr>
</thead>
</table>
| Community Hospitals         | Per day charges     | 1-bedder: $250 - $380  
2-bedder: $220 - $260  
4-bedder: $190 - $290  
6-bedder: $90 - $150  
8-bedder: $50 - $90  | These institutions cater to those who require longer inpatient stay for rehabilitative and sub-acute care after treatment in the acute hospitals. |
| Chronic Sick Hospitals      | Per day charges     | 1-bedder: $240  
2-bedder: $220  
4-bedder: $120 - $180 | These institutions generally provide care for older persons with complex long-term medical and nursing care needs.                                |
| Inpatient Hospices          | Per day             | $85 - $210                                                                                                                                     | These institutions provide terminally-ill patients with palliative care, including pain and symptom relief and emotional and spiritual support. |
| Nursing Homes               | Per month           | $1,000 - $4,500                                                                                                                               | These institutions provide long-term nursing and personal care for older persons who do not have families or caregivers to look after them at home, or the caregiver is unable to provide the level of care required. |
| Day Rehabilitation Centres | Per session         | $15 - $40                                                                                                                                     | These centres provide rehabilitation services such as physiotherapy and occupational therapy to older persons who may suffer from conditions such as stroke, fractures and other conditions that impair functional and mental abilities. |
| Dementia Day Care Centres   | Per day             | $30 - $36                                                                                                                                     | These centres provide specialised, supervised care and planned social and physical activities for people with dementia (mild to moderate). |
| Hospice Day Care Centres    | Per day             | $15                                                                                                                                            | These centres provide rehabilitation, social and recreational activities for patients in the early stages of terminal illness. |
| Home Medical Services       | Per visit           | $100 - $200                                                                                                                                  | This service caters to homebound older persons who need medical care for chronic or acute medical conditions. |
| Home Nursing Services       | Per visit           | $50 - $70                                                                                                                                     | This service caters to homebound older persons who need nursing care such as wound dressing, injections and stoma care. |

Notes: Only indicative range of charges set by the service providers, and were subjected to change. Actual charges by the service providers may fall outside range. All charges in Singapore dollars.