Chapter 5
Caring for Seniors: Holistic and Affordable Healthcare and Eldercare

Vision

Older Singaporeans in need of care have access to a seamless continuum of healthcare and eldercare services, ensuring that the dignity and quality of life of seniors are maintained. This is achieved by:

- A vibrant private sector providing a diverse and seamless spectrum of services catering to the different needs and means of the seniors of the future;

-A dynamic people sector, providing a spectrum of health and eldercare services within the community and catering to needy Singaporeans; and

- Efficient and cost-effective Government-subsidised healthcare and eldercare services that are easily accessible to seniors living in the community.

Introduction

1. The demographic trends point to a future of challenges and opportunities for Singapore. First, seniors with age-related chronic diseases and functional disabilities are expected to grow with the ageing of the population. In year 2005, an estimated 8,000[1] seniors had a high level of dependency in basic activities of daily living[2]. Second, the majority of post-war baby boomers, being better educated and more financially secure, will have higher expectations and demands on the type and quality of care. Third, a larger number of the future cohort of seniors will likely fall in the category of "old-old[3]", single and "living alone" seniors, as well as seniors with small families.

[1] National Survey of Senior Citizens, 2005

[2] For the purposes of the report, a high level of dependency is defined as dependency in at least 3 out of 6 activities of daily living, which include feeding, bathing, dressing, toileting, bed / chair transfers and continence. Seniors also made up a substantial proportion (28%)[2] of admissions at the hospitals.

[3] Old-old refers to seniors aged 85 years and over.

2. These trends collectively indicate that the demand and expectations for quality care will rise. The entire eco-system of care comprising the Government, the people sector and the private sector will have to work collectively to tackle these challenges.

Efforts over Last Five Years

3. The Inter-Ministerial Committee on the Ageing Population (IMC) in 1999 considered two key thrusts in the provision of care for seniors – developing a strong network of community-based services and ensuring long-term sustainability in provision of services.

4. A supportive care environment is instrumental towards our desired outcome of enabling care within the family and also "ageing-in-place", where seniors can continue living in the community they are familiar with. The IMC therefore emphasised the promotion of a strong network of community-based services to support families caring for older members.

5. A significant achievement has been the implementation of the Eldercare Masterplan – a blueprint for the development of a comprehensive network of community-based services. Implementation of the Masterplan has resulted in more service providers offering a variety of residential, centre-based and home-based care services for seniors (See Table 4.1). In terms of community-based facilities provided by MCYS, the number of clients served by the network of services increased by 52%. In terms of residential-based facilities, the number of licensed beds at sheltered homes and nursing homes increased by 10% and 45% respectively.

Table 5.1: Healthcare and Eldercare Services, 1998 and 2005

		Ministry	1998	2005
Health Care Services	Nursing Homes	MOH[4]	23 VWO Homes 24 Private Homes	28 VWO Homes 28 Private Homes
	Day Rehabilitation Centres	MOH	20 centres	25 centres
	Day Care Centres for Dementia	MOH	3 centres	6 centres
	Home Medical Services	MOH	3 VWOs	10 VWOs
	Home Nursing Services	MOH	2 VWOs	14 VWOs
Social Services	Sheltered Homes	MCYS	19 Homes	18 Homes
	Day Care Centres	MCYS	11 centres	18 centres
	Befriender Service	MCYS	1 VWO	1 VWO
	Home Help Services	MCYS	2 VWOs	8 VWOs

Source: MOH and MCYS

6. Second, with rising healthcare expenditure, particularly in an ageing population[5], the IMC also emphasised the need to ensure long-term sustainability in service provision. To this end, several measures have been put in place. The Eldercare Fund, an endowment scheme which complements Government's budget in providing operating subsidies to step-down healthcare services, was set up in 2000. To promote personal responsibility in financing long-term care needs, a long-term care insurance scheme, Eldershield, was introduced in 2002 to provide financial cover for severe disabilities.

[4] Ministry of Health (MOH).

[5] The Report of the 1999 IMC made reference to a National University of Singapore study which reported that National Healthcare Expenditure was expected to increase from 3% in 1999 to 7% of Gross Domestic Product in 2030.

CAI's Focus

7. The Committee on Ageing Issues (CAI) builds on the achievements over the last five years under the two strategic thrusts of the IMC, i.e. a strong network of community-based services and ensuring long-term sustainability in provision of services. Alike the IMC, we believe that the approach to meet the demographic opportunities and challenges is to enable care within the family and also "ageing-in-place", where seniors can continue living in the community which they are familiar with.

8. To further understand the challenges, the CAI feels that there is a need to differentiate between seniors' medical needs and personal care needs. In terms of medical needs, the majority of seniors will have periodic illnesses and are no different from the rest of the population. However, more of the seniors will have chronic diseases and we would have to help them manage their diseases carefully.

9. Then, there are personal care needs. The majority of older Singaporeans (about 95%[6]) are able to manage their personal care and daily activities; only 5% of seniors are dependant in one or more activities of daily living and will require assistance. However, such assistance often does not constitute medical attention or clinical treatments. Many of these seniors are best cared for by their immediate family members; for others, programmes and services may need to be provided to assist them whilst living within the community.

Eco-system of care – private sector, people sector and Government

10. To achieve the desired outcome of care within the family and 'ageing-in-place', the entire eco-system of care, i.e. private sector, people sector and Government, will have to collaborate and work strategically. The CAI's views on the eco-system are as follows:

[6] National Survey of Senior Citizens, 2005.

11. Private sector. The CAI is of the view that there is increasing business potential as well as increasing scope for the private sector to play a larger role in providing services to older Singaporeans. This 'silver' generation of well-educated and financially secure seniors will fuel an age-specific market for healthcare and eldercare services and products, and become a key consumer group. As evidenced by the experiences of other ageing societies, the 'silver' market (products and services designed for older persons) is already a burgeoning industry. They will expect a varied choice of products and services, and would be well-informed to demand quality as well as alternative and innovative options.

12. People sector. The people sector has served a pivotal role in the provision of healthcare and eldercare services in the community and should continue its important role in serving the needs of seniors. They can provide a complementary range and option of services for Singaporeans who need care. With their experience, they will be well placed to continue reaching out to those in need of but are unable to afford a reasonable level of care services.

13. Government. The Government must recognise and do its part to address these changing needs. First, in terms of financing, we acknowledge that not all older Singaporeans require financial assistance. Many have planned for their retirement needs, including their healthcare and eldercare needs. For them, the Government ought to facilitate the development of the private market whilst ensuring an equitable and competitive market structure so that market pressures can force product innovation and price-competitiveness to benefit Singaporeans.

14. However, there will also be Singaporeans who are needy and require financial assistance from Government. For these Singaporeans, the Government should partner the private and people sector to ensure that subsidised services are relevant, responsive to needs and delivered in a cost-efficient manner. A strategic overall plan in helping Singaporean seniors who can't afford care ought to be developed. Government should be judicious and deliberate so that subsidies given for this group of seniors (either directly or through assistance to VWOs) do not distort the market.

15. The Government's role also goes beyond financing the use of services. It also has a key role to play in terms of manpower development, regulations and the setting of standards for the sector. In addition, it should facilitate planning and development of the sector.

16. Specifically, the CAI proposes the following four key thrusts in providing a continuum of healthcare and eldercare services:

(i) Strengthen care services within the community;
(ii) Facilitate integrated service planning and delivery;
(iii) Enhance diversity and capability development within the sector; and
(iv) Ensure affordability of health and eldercare services.

Strengthen Care Services within the Community

17. In the last five years, a comprehensive slate of services has been developed aimed at supporting families in their care-giving roles (See Appendix E). While the breadth of services has grown over the last five years, there is still the need to strengthen the present framework of services, particularly to ensure continuity between acute care and community-based care, and to bolster care given by families.

Family physicians to play pivotal role in managing healthcare needs of seniors

18. Countries with ageing populations, such as the U.K., U.S. and Australia, have made "Healthy Ageing" a key goal of their health service planning. They have achieved healthy ageing of individuals and populations by promoting health, preventing illnesses, and minimising disabilities as a result of age and disease, and premature death.

19. Similarly, the demand for primary prevention, screening and maintenance of health is expected to increase as our future seniors will likely be healthier and more educated. Family Physicians (FPs) are in close proximity to seniors because they operate within the community. As such, they are best positioned to provide a holistic approach to primary prevention, maintenance of health and screening of diseases. The role of FPs as the main providers of family medicine and care for the elderly is expected to enlarge over time and their ability to care for a wide range of medical problems within the community would correspondingly need to increase.

20. **The CAI recommends that in its healthcare strategy, Government should adopt a holistic, FP-centered approach towards the management of healthcare needs for seniors**. Community-based FPs are best positioned to help ensure that seniors receive the most appropriate level of healthcare services and reduce the reliance on acute hospital services.

One-stop primary care centres for effective management of chronic diseases in community

21. The emphasis on health promotion and disease prevention would reduce the burden of chronic diseases. Nonetheless, there is still a high proportion of Singaporeans with chronic diseases such as diabetes, hypertension and high total blood cholesterol (Table 5.2). Reorganisation of the primary care delivery system will allow FPs to play a larger role in providing a continuum of care, and hence allow for optimal long-term outcomes for Singaporeans with chronic diseases.

Table 5.2: Proportion of Singapore Residents aged 65 to 74 years with Diabetes Mellitus (DM), Hypertension (HT) and High Total Blood Cholesterol (CL), 2004

	Proportion
With one or more of the following: 1)DM 2)HT 3)CL	85.5%
With DM	35.3%
With HT	66.2%
With CL	21.8%

Source: National Health Survey 2004

22. **The CAI recommends that the Government explore new models of primary care delivery, such as the development of one-stop primary healthcare centres.** The one-stop primary healthcare centre would support a network of private sector FPs and allow them to expand their role within the community. FPs could tap onto the resources available within one-stop centres and in so doing, shift the focus of chronic disease management from episodic care to continuing care in the form of disease management packages that are patient-centred and outcome driven.

FPs as the provider of end-of-life care

23. New advances in medical knowledge and technology create new choices for both patients and healthcare providers. Modern medical technology may prolong life in the final stages of a terminal illness, occasionally at the expense of the quality-of-life of the patient. When a patient enters into the final stages of a terminal illness, medical technology can never arrest the dying process. In such situations where further medical intervention would be futile, patients should have the right to receive care in an environment that is familiar to them, and with their loved ones close by their side.

24. **The CAI recommends that FPs provide first-line medical care for seniors in need of end-of-life care, whether within their own homes or in nursing homes.** Training of FPs could be enhanced to confer them an increased familiarity with end-of-life care. FPs could be organised into networks supported by the proposed one-stop primary care centres to provide the necessary care for patients within their homes. Nursing homes could also partner with these enhanced FP networks to ensure a good quality-of-life for patients.

Enhance support for "ageing-in-place"

25. There is an existing network of community based services to facilitate ageing-in-place. However, there will be a need to develop new models of community healthcare and eldercare services to meet the needs of an increasing population of seniors who are largely healthy, but limited in their independence due to age-related frailty. Such services should be affordable, accessible and financially sustainable in the long term.

26. Community-based nursing services meet the needs of seniors who require a high level of nursing care and who would like to continue residing within the community. However, such services, especially home nursing, are costly. More cost-effective models of community-based nursing services should be explored. Alternative approaches could be for home healthcare to be provided by healthcare assistants (HCAs) or for community-based nursing services to be located in centralised locations, e.g. Day Rehabilitation Centres (DRCs) and where transport services are provided where necessary. **The CAI recommends that Government partner the private and people sector to study and develop the range of community-based nursing services to allow 'ageing-in-place'.**

27. Similarly, community-based personal care services that are currently available to seniors are often limited and expensive. In this aspect, the people sector has provided and could look into providing even more community-based Home Help Services for the frail elderly in their own homes such as meal delivery, laundry service, help in personal care hygiene, transport and escort service to hospitals / clinics. HCAs could also serve as skilled caregivers and provide simple nursing care and assistance in activities of daily living for seniors who have higher and more complex care needs. The HCAs will also be able to coordinate the social support needs of seniors and to care for a pool of seniors living in the community. Such an initiative can be supported by liberalising the approach to foreign-trained HCAs, and training

more local HCAs. **The CAI recommends that Government partner the private and people sector to enhance the range of services available for the elderly who require assistance with personal care.**

Increase support for caregivers

28. A majority (85.5%)[7] of seniors live with their families and about 29% depend on a main caregiver[8] to care for their daily personal needs. Care-giving can be an overwhelming responsibility. Focus Group Discussions with caregivers held by acute hospitals, community hospitals, VWOs and case management agencies indicate the need for more coordinated and targeted carer support services. We feel that Government should step up efforts directed towards supporting caregivers.

29. **The CAI recommends that Government set up a Caregiver Centre to support families in care-giving.** The centre should build up information resources on the services available and connect caregivers with the relevant service providers. The centre could also initiate new research and programmes in support of caregivers.

[7] NSSC 2005.

[8] Main caregiver is defined as someone whom the senior depends on look after his daily personal needs, either due to health problems or inability to do routine personal care.

Feature Highlight : Elder Safety Demonstration Room

One of the ways in supporting caregivers would be through set up of teaching-cum-demonstration rooms to provide tips on safe and independent living for the elderly in the home environment. An example is the Home for Independent Persons (HIP) studio located at Alexandra Hospital. The room is approximately the size of a 45 square metres HDB studio flat.

Features to consider in a "lifetime home"

- Level floor surfaces
- Lifts and ramps
- Safe and accessible toilets and bathrooms
- Wheelchair accessibility
- Controls, switches, sockets and windowsills within reachable height
- Warden / security alarms to answer emergency calls

Integrated Service Planning and Delivery

30. Many community-based support services are in place and cater to different groups of seniors with varying levels of health, functional or social needs. However, seniors may have multiple needs which straddle across service types. Their level and type of needs may also change over time. The CAI recommends that Government, in partnership with the private and people sector, develop an overall strategy in integrating the care across service providers. The integration of care should be both vertical, i.e. from acute care to institutional and community-based care, and horizontal, i.e. within institutional and community-based care, so as to allow a more holistic and client centric delivery of services. Our specific recommendations are as follows:

Acute care to institutional and community-based care: Promote linkages between hospitals and community-based care

31. Caregivers face the most stress when the seniors are discharged from hospitals following a new illness or deterioration in their medical conditions. Creating a linkage between hospitals and the network of community-based care services would ensure that caregivers are guided closely and linked to proper follow-up care in the community. This would reduce the risk of readmission into hospitals or unnecessary admission into nursing homes. In 2000, the Community Case Management Service (CCMS) was started to assist caregivers of seniors with complex needs. **The CAI recommends that MOH and MCYS enhance the role of CCMS through closer integration with the hospital system and the community.**

32. Presently, the Integrated Care Services (ICS) facilitates the placement of patients to chronic sick facilities and nursing homes based on referrals from the hospitals. Some hospitals also have their own care management teams, e.g. Changi General Hospital's Community Care Management Programme where care managers assess inpatients' needs and make the necessary referrals during their admissions. **The CAI recommends that Government encourage all hospitals to collaborate with partner agencies such as ICS to put in place effective discharge planning systems** to facilitate the smooth transition and follow up of clients from hospitals to institutional and community-based support services.

Enhancing institutional-based care (I): Review of the classification system for residential care

33. Currently, the role of nursing homes[9] and sheltered homes[10] are not clearly defined. A strict division of residential care according to the Resident Assessment Form (RAF)[11] has posed operational difficulties and resulted in a service gap for seniors with minimal nursing care needs, but require assistance with personal care and activities of daily living (mainly Category II seniors). Service providers have also provided feedback on the need to improve the current system to allow seniors to "age-in-place" within the residential facility, even as their functional capability declines.

34. **The CAI recommends that MOH and MCYS jointly review the appropriateness of the RAF classification system in defining the clientele type for the respective homes**. Whether such a system impedes the evolvement of market-based models of service should also be studied. **Government should also study the longer term approach towards better integration of nursing homes and sheltered homes, in line with promoting a continuum of care**.

[9] Nursing homes provide residential care for seniors with high level of nursing care needs. Their need for nursing home care is assessed using the RAF which categorizes their level of nursing care needs.

[10] Sheltered homes are essentially housing options, catering to seniors without family or with estranged relationships with their family members. Admission and per head funding of clients admitted into sheltered homes are restricted to Category I clients.

[11] Residents of nursing homes are classified into 4 nursing care categories based on the scoring in 9 areas. In general, the 4 categories are as follows:

a) Category I: Physically and mentally independent;
b) Category II: Semi-ambulant; require some physical assistance and supervision in activities of daily living;
c) Category III: Wheelchair / bed-bound; need help in activities of daily living and supervision most of the time; and
d) Category IV: Highly dependent; require total assistance and supervision for every aspect of activities of daily living.

Enhancing institutional-based care (II): Address the service gap in intermediate residential care services

35. Feedback gathered from medical social workers and ICS revealed difficulties in discharging patients from hospitals in view of restricted places available to those with largely social and personal care needs (Category II clients). Pending the study on the RAF and clearly establishing the roles of nursing homes and sheltered homes, there is a need to address the current service gap in intermediate residential care.

36. To this end, **the CAI recommends setting up a new residential facility to provide intermediate residential care services**. For existing clients of Homes, in line with the principle of allowing seniors to age-in-place, **MCYS and MOH should review the guidelines to allow some level of flexibility for clients to remain in their present residential facilities** as far as possible, provided their care can be supported by the facility.

Enhancing community-based care: Promote integrated day care and rehabilitation centres

37. Another area for integration would be among the centres that support community care. The services available today range from full-day programmes such as those provided by Day Care Centres for Senior Citizens (DCCs) and DRCs, to more episodic home-based care services such as home help services and home nursing services.[12]

38. An increasing number of DCCs are incorporating maintenance rehabilitation programmes to attract clients as well as to maintain their clients' functional abilities. Caregivers' feedback show that being able to receive services at a single location according to the older persons' needs is useful. **The CAI recommends that MOH and MCYS work together to allow integrated models of day care and day rehabilitation centres to evolve based on market-driven needs**. Allowing flexibility in service models enables market forces to come into play in the sector, which in the long run will lead to greater cost-efficiencies and effective models of services.

[12] Currently, DCCs support caregivers by providing social care for frail seniors who require supervision when their family members are at work. These centres provide meals, maintenance programmes, social and recreational activities. DRCs provide active rehabilitation to improve the functional ability of seniors who live in their own homes.

Feature Highlight: Integrated day care and rehabilitation centres

Rehabilitation programmes help clients who suffer from medical conditions (such as stroke and fractures) and disabilities (e.g. following lower limb amputation) regain / improve their functional abilities through physiotherapy and occupational therapy.

An example of an integrated day care centre and day rehabilitation centre serving the needs of the local community in the heartland of Bedok HDB estate is the Salvation Army Bedok Multiservice Centre for Elderly and the Bedok Rehabilitation Centre. These adjoining centres provide a supportive environment for seniors to spend the day while their family members are at work. They run complementary programmes, ranging from active rehabilitation to maintenance exercises as well as social programmes to help seniors maintain their functional ability and continue to be socially engaged.

The programmes at the day care centre foster social interaction through group games and enrichment (such as music, dance and laughter) therapies and social outings.

Streamline administrative data requirements across agencies

39. At present, different support and care services come under the purview of either MOH or MCYS, and National Council of Social Service (NCSS) and service providers submit similar data on different formats to the various overseeing ministries and NCSS on a regular basis. **The CAI recommends streamlining and reducing data requirements across agencies so as to reduce the administrative work of service providers, freeing them to focus their energies on providing excellent services. In the longer-term, the Government could also explore further ways of streamlining data requirements across agencies using a common IT-based system.**

Enhance Diversity and Capability within Healthcare and Eldercare Sector

40. Private sector's involvement in the eldercare and healthcare sector has grown in the past five years. As the elderly population becomes more educated and wealthier, the CAI's view is that there is opportunity for the private sector to take on an even bigger role in providing a more diversified range of services. Over and above its regulatory role, the Government may also have to play an industry promotion role to facilitate the growth of the sector.

41. Concomitantly, it is also crucial to enhance capability in the healthcare and eldercare sector with the growing complexity of needs and expectations of clients. Beyond the medical expertise required for the healthcare sector, the eldercare sector involves a substantial amount of social and personal care services, requiring sensitivity to clients' expectations and adherence to professional standards in order to render good services.

Enhance and promote private sector growth and investment

42. The CAI's view is that there is potential for the private sector to expand beyond the current range of services that it provides. It should explore innovative ways of delivering eldercare services so as to allow seniors to benefit from different models of care. Some private sector players in the nursing home sector have also provided feedback that a few of the existing policies may be biased against private players. While they remained generally optimistic of the potential of the sector, they indicated that the distortions caused by the policies have resulted in an unlevel playing field, restricted them in the business opportunities and prevented them from making more investments into the sector. Based on the feedback, **the CAI recommends that Government review its policies to facilitate private sector participation and innovation in the intermediate and long-term care[13] sector and to conduct regular fora with the private and people sectors to chart the course for the industry.**

Enhance manpower development

43. Care services are labour intensive; the quality and professionalism of the staff contribute significantly to the quality of the care service. The manpower needs in the healthcare and eldercare sector span a range of professions from specialist geriatricians, primary care physicians, nurses, therapists, healthcare assistants / aides and eldercare service workers. Several measures have been put in place in availing basic training as well as providing part funding for training through initiatives such as the VWO Capability Fund training grant, administered by the NCSS.

44. Survey data[14] and feedback from service providers highlighted that several challenges remain, in the areas of recruiting and retaining staff due to unattractive salaries, lack of a career path, as well as limited training opportunities. This is especially the case for lower-skilled workers such as healthcare attendants. Also, 47% of staff in the eldercare sector comprises foreign workers, the bulk of whom are healthcare attendants or nursing aides.

[13] Intermediate and long-term care institutions refers to residential facilities (e.g. community hospitals, nursing homes, chronic sick units) and community-based facilities (e.g. day rehabilitation centres and dementia day care centres) which provide intermediate and long-term care.

[14] Survey on Manpower in VWOs and the Community Sector, 2005.

45. **The CAI recommends that Government develop a holistic manpower development plan for the healthcare and eldercare sector –** ensuring systematic manpower projections to ensure that supply grows in tandem with increased demand in an ageing population, development of progressive training roadmaps and clear career pathways for the various professions in the sector. There should be opportunities for professionals in the sector to continually upgrade their knowledge and skills.

Enhance service standards

46. The eldercare industry in Singapore is growing. With growing diversity of service providers as well as expectations of seniors, there is a need to ensure consistent and progressive standards at a national level**. The CAI recommends that Government work with stakeholders to put in place a comprehensive service quality framework to raise service standards for the eldercare sector.** This initiative should be largely driven by stakeholders so as to ensure relevance and ownership by the eldercare sector.

Affordability for health and eldercare services

47. For healthcare needs, we acknowledge that affordability for most of the elderly is generally ensured through a robust multi-tiered safety net, comprising Government subsidy especially for Class B2 / C wards, Medisave, MediShield, and Medifund.

(i) Medical costs at Class B2 and C wards of public hospitals are heavily subsidised by the Government. Government subsidy can be as high as 80% of actual cost in Class C wards and patients only pay for a small fraction of the cost.

(ii) Significant numbers of seniors are currently covered under MediShield. As at end-December 2004, 82% and 60% of those in their 60s and 70s were covered under MediShield and other types of Shield products. The CAI supports the raising of the MediShield maximum coverage age from 80 to 85 so that seniors will be able to enjoy greater financial protection against large medical bills during old age.

(iii) Working members in the 56 – 65 age group have an average Medisave balance of $20,500. This is enough to cover 15 times the average Class C hospital bill for seniors (about $1,000), as well as annual MediShield premiums (of around $5,360) after retirement.

Refinements to the 3M structure

48. However, there are other older Singaporeans who still require assistance, particularly for the current cohort of seniors above age 65. This group of seniors has small Medisave balances of $5,300 (on average). The low average balance could be attributed to the shorter period of time available for these members to build up their Medisave sums (since the scheme has been in place for only 20 years) and the higher usage in old age. The amount is barely sufficient to cover MediShield premiums of $5,075 from age 65 – 79 (average life expectancy). For these Singaporeans, **the CAI recommends that Government top-up Medisave accounts of less well off Singaporeans when there are budgetary surpluses** to ensure that seniors have the means to afford healthcare services.

49. Currently, Medisave cannot be used for many chronic outpatient treatments, such as diabetes, hypertension. As a result, many seniors may forego these treatments, leading to more serious diseases later, e.g. diabetes leading to kidney failure. It may be more cost effective for seniors to be able to use their Medisave to manage their chronic diseases earlier. **The CAI therefore recommends that MOH review its Medisave policy to allow Medisave withdrawals for the treatment of some common chronic diseases.**

Review ElderShield

50. One of the key achievements of the 1999 IMC was the establishment of the disability insurance scheme, ElderShield. Launched in June 2002, ElderShield provides basic insurance coverage to Singaporeans who require long-term care in the event of severe disability.

51. As ElderShield has been in place for more than three years, a review should be conducted to look at its effectiveness. There is also feedback that the ElderShield benefits, $300 per month up to a maximum of 60 months, are inadequate, especially in relation to the amount of premiums that policyholders have to pay. So far, the claims experience has been relatively low. Out of 710,000 policyholders, only 1,350 policyholders have benefited from ElderShield payouts. **The CAI therefore recommends that the MOH review the ElderShield scheme, with the aim to improve the coverage for older Singaporeans who require long term care.**