



# Caring for an ageing population

## Recommendations from AWARE for Singapore Budget 2016



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### Contents

	<i>Page</i>
Executive summary	2
I. The problem	4
II. Proposed solution: investing in a care economy	9
III. Six recommendations for strategic social expenditure	11
IV. Conclusion	30
References	31

## Executive summary

1. We all know that the Singapore population is ageing. However, little attention is given to the disproportionate impact of this demographic trend on women. Society relies heavily on the unpaid work and substantial sacrifices of mostly-female family members to meet burgeoning eldercare needs. Government statistics suggest that at least ten times more women than men are out of the labour force due to care-giving provided to families and relatives. As a result, these family caregivers not only lose income, but themselves become the dependents of other working family members and very often have inadequate savings for old age. This negative economic impact is borne not only by them but also by society as a whole. The effects include labour shortages, impoverished older women, and a burden placed on limited family resources, thereby limiting the use of these for children and other family members.
2. **Singapore should therefore budget for care as a social good, rather than leaving its cost to families to address on their own.** By taking far sighted measures to invest in a care economy, we can achieve the following:
  - a. Meet the needs of older people in a timely, holistic and accessible manner, preventing the avoidable ballooning and escalation of social costs associated with eldercare
  - b. Ensure that women are not forced to drop out of employment to provide care-giving, thereby maximising labour force participation and overall societal economic output; and
  - c. Free up resources for children and the development of working adults, potentially reversing the decline in fertility that accelerates the ageing population.
3. Investing in a care economy will also reduce economic inequality, producing a fairer and more cohesive society. To this end, we make **six recommendations**:
  - a. **Create or designate a coordinating office so that older people receive coordinated, person-centric care.** Elderly persons have complex needs that require different services from different providers. Navigating the fragmented services demands substantial work from unpaid caregivers, who need time, an understanding of the care receiver's needs, knowledge of the service and subsidy landscapes, and English ability. This places a significant burden on caregivers and, moreover, carries the risk that care receivers receive haphazard, inefficient and inappropriate care.
  - b. **Provide free health screening and primary healthcare for chronic illnesses to ensure early intervention so that the overall care burden is reduced for caregivers.** We recommend that primary health screening be made free to encourage more early intervention, hereby reducing the need for acute care. This will tremendously reduce the care burden by addressing preventable outcomes well in time, e.g. avoiding amputation from diabetes, which requires a much greater level of round-the-clock care.

- c. **Provide holistic assessment of older people’s care needs and state support for adequate care-giving, including home care provision.** Successful models of comprehensive eldercare include AIC’s SPICE and AWWA’s care services. Ramping up the scale of their provision (or instituting new, similar programmes) would help to meet societal care needs on a wider scale. In addition, despite the efficacy and efficiency advantages of home care, it is not given enough financial support relative to the nursing home model, and even nursing homes remain unaffordable for many. Substantial state investment is needed on all these counts.
- d. **Support family caregivers through compensation, eldercare leave and flexible work arrangements.** The value of family care should be materially recognised by the state, so that those who provide it do not risk personal impoverishment. Whether through CPF credits or a state allowance, this support should be a collective responsibility, not a problem to be solved household by household. To enable more people to combine care-giving with employment, options for eldercare leave and flexible working should also be mandated and supported.
- e. **Means-test individuals, not households, for social and care assistance for Intermediate and Long Term Care (ILTC).** Exclusion of applicants from support based on gross household income or value of their residence is inappropriate, as that household income or property value may not translate into financial support for them. The Legal Aid Bureau uses a more nuanced form of person-centric means-testing, which could be adopted for social assistance for ILTC for greater inclusivity.
- f. **Invest in the care sector through Long-Term Care Insurance, better support for care workers, and training for family and non-family carers.** Medishield Life should cover non-catastrophic illness, rehabilitative services and medication diagnosed after discharge, as these have long-term care implications that families may not be able to address on their own. More investment in work conditions, pay, training and quality in the sector will also go to improving the quality of care enjoyed by older people and alleviate pressure on family carers.

# Caring for an ageing population

## Recommendations from AWARE

### I. The problem: increased needs for care in an ageing population

1. Singapore's population is ageing. Those aged 65 years and over made up 11.8% of population in 2015, up from 6.0% in 1990 (Department of Statistics 2015). Life expectancy has increased: in 2015, life expectancy at birth was 82.8 years – 80.5 years for men and 84.9 years for women. “Health adjusted life expectancy” has also increased – from 70.4 (2004) to 73.3 (2010) for men and 73.7 (2004) to 77.7 (2010) for women – with people staying healthy longer (Ministry of Health [MOH] 2015a).
2. The ageing population is expected to result in increased need for care. Minister of State for Health and Manpower, Dr Amy Khor, said (Khor 2013):

By 2030, about one-fifth of Singaporean residents will be 65 years and older. This alone will lead to a significant increase in healthcare demand, as the elderly are not only more likely than younger citizens to be hospitalised, they are also more likely to stay in the hospital longer.

Life expectancy minus the health adjusted life expectancy indicates at least 7.2 years of care needed by both men and women at the end of their lives (MOH 2015a). Fong Ngan Phoon (February 2016: personal communication) has estimated that at least 60,325 community-dwelling (that is, non-institutionalised) adults aged 60 years and above<sup>1</sup> require human assistance in at least one of six Activities of Daily Living (ADL).<sup>2</sup>

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<sup>1</sup> His estimate is based on figures published by the Department of Statistics, Table 8.6 of MCYS 2011 Survey on Senior Citizens (<http://www.tablebuilder.singstat.gov.sg/publicfacing/createDataTable.action?refId=315>) and from an MCYS commissioned report from 2012 on “Survey on Informal Care-giving”, and estimates from the National Health Survey 2010: 83-88. The method used is as follows:

#### *Over 75 years*

- **21.6%** (\*1,211 out of 5,607) community dwelling adults aged 75 years above required human assistance in at least 1 of 6 ADLs (taking a bath/shower, walking inside the house, dressing up, standing up from a bed/chair, using the toilet in the house, eating).
- Extrapolating this to Singapore resident population in \*\*June 2015: **37,726** (174,659 x 0.216)

\*Figures obtained from page 4 of MCYS commissioned report of “The Survey on Informal Care-giving” ([http://app.msf.gov.sg/Portals/0/Informal%20Caregiver%20Survey%20Summary%20Report%20\(upload\).pdf](http://app.msf.gov.sg/Portals/0/Informal%20Caregiver%20Survey%20Summary%20Report%20(upload).pdf))

\*\* Figures obtained from Department of Statistics, Singapore (<http://www.tablebuilder.singstat.gov.sg/publicfacing/createDataTable.action?refId=315>)

#### *60 to 74 years*

- If we estimate the figure of community dwelling adults aged 60 – 74 requiring human assistance in at least 1 of 6 ADLs to be 1/5\*\* of those above 75 years → **4.3%**
- Extrapolating this to Singapore resident population in \*June 2015: **22,599** (525,549 x 0.043)

\* Figures obtained from Department of Statistics, Singapore

3. AWARE has conducted qualitative research on 20 elderly low-income women) and 54 single mothers.<sup>3</sup> Both projects offer evidence of women dropping out of the workforce to provide care, resulting in lost income in their earning years, and consequently impoverishment in old age.
4. There is a shrinking old-age dependency ratio in Singapore: in 2015, there were 4.9 working adult citizens per elderly persons, a decrease from 10.4 in 1990 (Ong 2015). The ratio may shrink to 2.1 by 2030 (NPTD 2015). In 2005, around 80% of elderly persons received some income from children (Ng 2015). Among persons aged 55 or older with married children, the average amount of contributions received in 2008 from all children was SGD 445 per month (Housing and Development Board 2010). There was an increase in the prevalence of CPF income (from 3% to 12%) from 1995 and 2005 as income from children fell, due – at least in part – to the shrinking old-age dependency ratio (ibid).
5. This ratio is affected by women who drop out of the labour force to care for dependent family members. AWARE’s research offers evidence of women dropping out of the workforce to provide care, resulting in them losing income in their earning years, and in their impoverishment in old age.<sup>4</sup> This finding is borne out in government statistics. The female Labour Force Participation Rate (LFPR) in 2015 was 60.4%, while the male LFPR was 76.7% (Ministry of Manpower 2015a). There are 0.67 million other women outside the labour force,<sup>5</sup> who are not looking for jobs. As reported by the Ministry of Manpower [MOM] (2015: 40):

Women formed the majority (64% or 0.67 million) of residents outside the labour force, many of whom cited family responsibilities (housework, childcare, care-giving to families/relatives) (41%) as their main reason for not participating in the labour force.

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<http://www.tablebuilder.singstat.gov.sg/publicfacing/createDataTable.action?refId=315>

\*\* Estimated from Table 8.6 of MCYS 2011 Survey on Senior Citizens

Figures also correlate with estimates from National Health Survey 2010, pg 83-88

**Total = 60,325 (37,725 + 22,599)**

<sup>2</sup> The extent of disabilities is measured by the number of Activities of Daily Living (ADLs), a standard widely used by private insurers which offer severe disability insurance schemes. The 6 Activities of Daily Living (ADL) used in Singapore are washing, dressing, feeding, toileting, mobility, and transferring. ADLs are distinct from Independent Activities of Daily Living (IADLs), which allow individuals to live independently in a community e.g. housework, preparing meals, taking medications as prescribed, and managing finances. This number is **12.9%** higher compared to his earlier estimate of 53,395 in Fong NP (2013).

<sup>3</sup> AWARE’s projects are “Women Ageing into Impoverishment” and “Single Parents’ Access to Public Housing”.

<sup>4</sup> “Women Ageing into Impoverishment” interviewed 20 elderly low-income women. “Single Parents’ Access to Public Housing” interviewed 54 single mothers.

<sup>5</sup> The Ministry of Manpower (2015b) defined those outside the labour as “persons aged 15 years and over who are either employed (i.e. working) or unemployed (i.e. actively looking for a job and available for work) during the reference period. These persons are not in the labour force.”

MOM's 2015 *Labour Force Survey* provides more detailed figures for two age groups – those aged 25 to 54 (prime working years) and those aged 55 to 64.<sup>6</sup>

**Table 4: Main Reason for Not Working and Not Looking for a Job by Selected Age Groups and Sex, June 2015<sup>7</sup>**

	<b>(A) Aged 25 to 54</b>		
	<b>Total</b>	<b>Males</b>	<b>Females</b>
<b>No. of Residents Outside the Labour Force</b>	<b>220,500</b>	<b>35,800</b>	<b>184,700</b>
Main Reason for Not Working and Not Looking for a Job (%)	100.0	100.0	100.0
Family Responsibilities	68.9	13.3	79.6
<i>Housework</i>	30.2	0.9	35.8
<i>Childcare</i>	25.2	2.7	29.6
<i>Care-Giving to Families/Relatives</i>	13.5	9.7	<b>14.2</b>
Poor Health/Disabled	10.5	26.2	7.5
Taking a Break	7.5	21.8	4.7
Education/Training-*Related	6.3	24.0	2.9
Have Sufficient Financial Support/Mean	1.8	2.5	1.7
Retired	1.6	4.4	1.1
Discouraged	1.6	4.6	1.0
Others	1.8	3.2	1.5

<sup>6</sup> Figures for those aged 15-23 are not given in the 2015 *Labour Force Survey*, but these can be calculated. Presumably people in this age group are outside the labour force because they are still studying.

<sup>7</sup> Ministry of Manpower (2015: 42).

(B) Aged 55 to 64

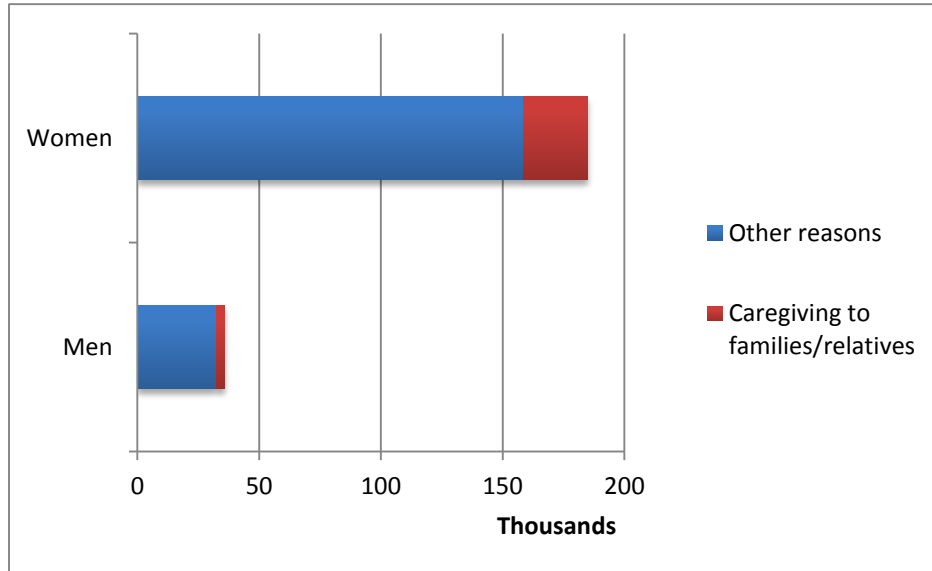
	Total	Males	Females
<b>Number of Residents Outside the Labour Force</b>	<b>165,800</b>	<b>45,700</b>	<b>120,100</b>
Main Reason for Not Working and Not Looking for a Job (%)	100.0	100.0	100.0
Family Responsibilities	47.8	8.1	62.9
<i>Housework</i>	32.1	0.8	44.1
<i>Childcare</i>	4.5	0.5	6.0
<i>Care-Giving to Families/Relatives</i>	11.2	6.8	12.9
Poor Health/Disabled	22.5	36.0	17.4
Taking a Break	20.9	38.9	14.0
Education/Training-Related	3.6	7.8	2.0
Have Sufficient Financial Support/Mean	2.0	2.4	1.8
Retired	1.7	4.3	0.7
Discouraged	1.6	2.6	1.2
Others	<b>165,800</b>	<b>45,700</b>	<b>120,100</b>

Those providing “care-giving to families/relatives” are likely more numerous than these figures suggest. Family care may also be provided by others who have cited “family responsibilities” (a category encompassing three sub-categories – housework, childcare, and care-giving to families/relatives.) Carers, who cite “housework” and “childcare” as their main reason for dropping out of the workforce, may also be providing care to their families/relatives alongside other care-giving, even if they have not cited this as their main reason for not working. As many as 147,021 women aged 25-54, (79.6% of 184,700 women in this age group) cited “family responsibilities”, plus some 75,543 women aged 55-64 (62.9% of 120,100 women in this age group). Combining the two age groups, about 222,564 women (aged 25-64), comprising 73% of 304,800 women, cited “family responsibilities” as their main reason for being outside the labour force.

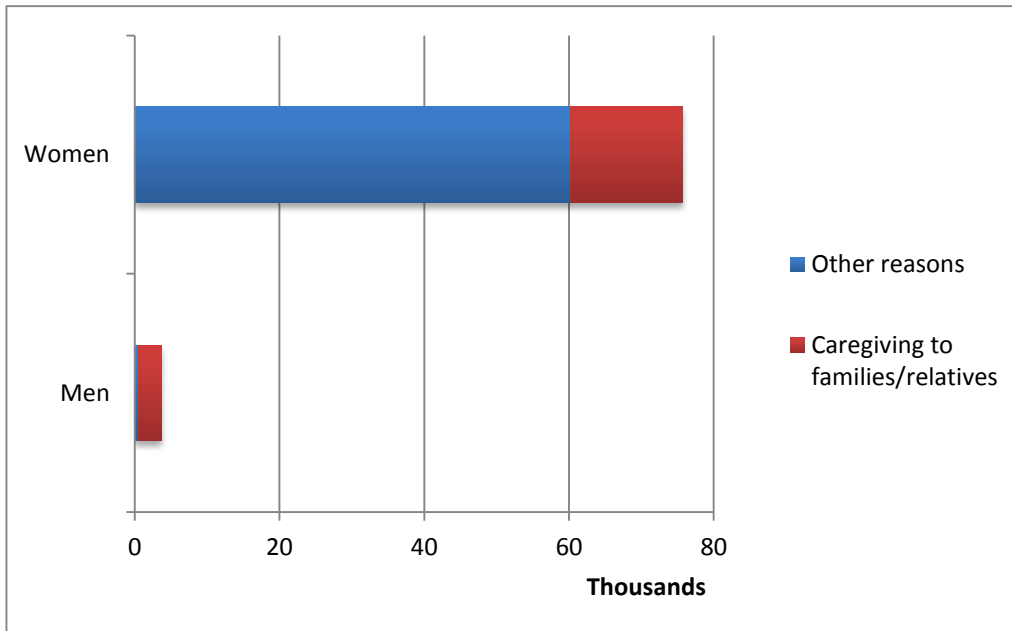
6. The figures indicate that **an increasing need** for women to leave the labour force to provide “care-giving to families/relatives”. According to MOM’s *Labour Force Survey* (2014: 42), in 2014, 11.3% of women outside the labour force, aged 25–54, cited care-giving to families/relatives as their main reason for dropping out of the workforce. In 2015, 14.2% of this age group cited this reason.
7. Clearly, “care-giving to families / relatives” is a gendered responsibility that falls mainly on women. In 2015, the 36,175 female care-givers of “families / relatives” outnumbered the 3701 male care-givers by almost ten (9.77) times.
8. When this data is presented graphically (see tables below), we can see that a much larger absolute number as well as proportion of women (compared to men) cite “care-giving to

families/relatives” as their main reason for being outside the labour force. Moreover, this pattern is especially pronounced for the age group 25-54.

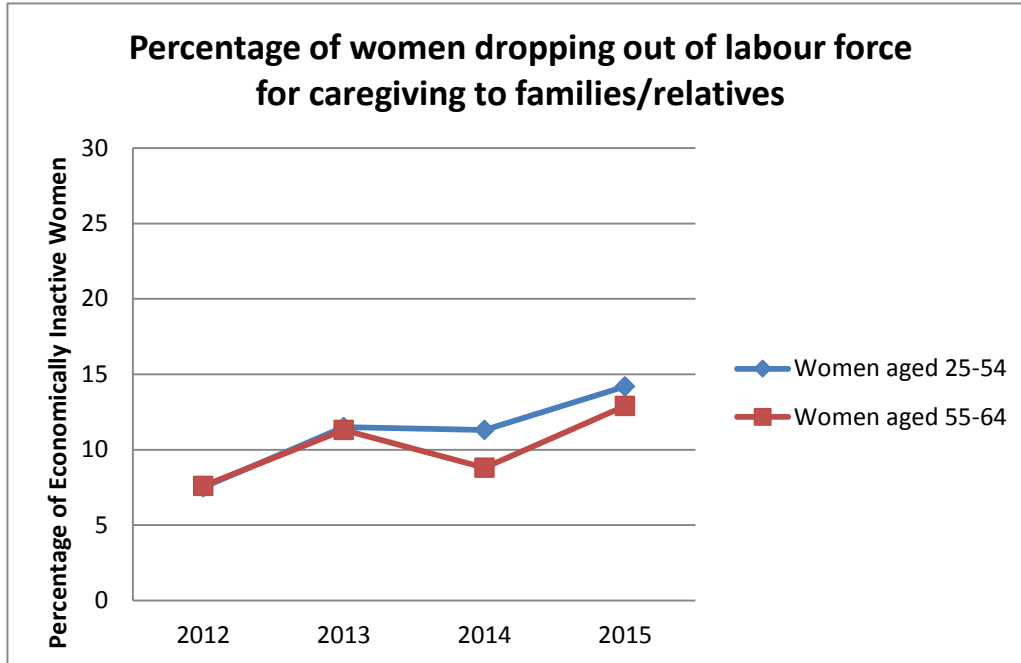
### Persons aged 25-54 outside the labour force



### Persons aged 55-64 outside the labour force







Source: MOM Report: *Labour Force in Singapore 2012, 2013, 2014, 2015*

9. This gender asymmetry may be even more pronounced if we add employed women who also provide care to families and relatives. This can impact negatively on women’s economic situation. Without adequate work-life balance, they may be hindered in career development. Or if unemployed, they become the dependents of other family members and have insufficient savings for themselves as they age. Our research shows that this problem is especially acute for single women, especially if they are divorcees who, for various reasons, must care for children without the financial support of ex-spouses.
10. AWARE’s recommendations focus on the betterment of these burdened care-givers who are overwhelmingly female, especially those outside the labour force. Budgetary allocations for measures to achieve this purpose are urgently needed as an investment that will benefit society as a whole. Despite the personal sacrifices made by female care-givers, there is still a significant gap between need and provision of care.

## II. Proposed solution: investing in a care economy

11. The care economy is a missing market in Singapore. In 2014, the Singapore GDP at current market prices was about SGD 390 billion. However, this figure excludes the unpaid care sector, where women perform much of the work of caring for children, elderly and disabled relatives. A longitudinal study (Bridgman et al 2012) of household production in the National Accounts of the US economy (1965–2010) showed that “incorporating the value of nonmarket household production raises the level of nominal GDP ... [by] 26 percent in 2010.” While no such study has been done for Singapore, as early as 1986, household work performed by Singaporean women had been estimated to

be worth approximately 16% – 17% of GNP, based on opportunity cost analysis (Quah et al 1993: 125). No such study seems to have done since then. While we are unable to cite more recent studies, the findings of the 1986 study may remain indicative.

12. Care-giving should not be regarded as a free resource that can be drawn on infinitely without investment. Like other resources, care-giving is finite. Human beings who provide care have a limited amount of time and energy. As discussed above, women who provide care work without compensation are affected economically as a result.
13. The provision of care should be adequately budgeted for as a social good that produces positive externalities, rather than left to families to address on their own. In her paper “Not everyone has ‘maids’”, Teo (2016: 4) characterises “Singapore’s work–care regime” as seeking “solutions to care needs that are individualized and market-based rather than universal and publicly provided.” Current approaches are not adequately addressing the problems they were meant to solve. A shift is needed, requiring a whole-of-government framing of policies, as the care of our ageing population is a complex issue that cannot be relegated to families to solve on their own with limited resources. Sharing the costs of care for the elderly will lighten the burden on families, lower the overall cost of living, and encourage couples to have children or more children.
14. Singapore already experiences high levels of economic inequality and decreasing social mobility. In 2014, Singapore’s Gini coefficient was 0.478, one of the widest amongst developed countries (The Straits Times 2014). Care-giving in low-income families hinders women in these families, from upward social mobility. In fact, they face the risk of becoming increasing impoverishment.
15. We give six recommendations below as suggestions for strategic social expenditures – which may take the form of cash transfers or the direct provision of goods and services (OECD 2003). These are strategic because they can result in the following long-term macro-economic benefits:
  - a. Reduction of healthcare costs through preventive health screening and early interventions so that illnesses do not develop catastrophic emergencies, resulting in an increased care burden for families.
  - b. Reduction of the percentage of women dropping out and staying out of the workforce, thereby preventing the shrinkage of the workforce, by ensuring the availability and accessibility of care-giving alternatives that meet the care needs of the elderly.
  - c. Limiting and even reversing the demographic ageing of our population by releasing the family’s time and financial resources used for care of the elderly, thereby encouraging couples to have children or more children, thus potentially reducing the dependency ratio.

16. On the other hand, failure to invest in care-giving will have negative economic and social consequences, including a low female labour force participation rate (LFPR),<sup>8</sup> the impoverishment of elderly women, an increasingly unequal society, and a perpetuation of the low working adult-dependent elderly ratio.

### **III. Six recommendations for strategic social expenditure**

#### **A. Create/designate a coordinating office to coordinate care for the elderly**

17. To systematise the eldercare system in Singapore and to alleviate the care burden that falls disproportionately on women, there should be an office to coordinate all care-giving bodies, including restructured hospitals, community hospitals, nursing homes, VWOs and other relevant organisations. Such an agency would fulfil the following functions:
- a. Assessment of the care receiver's needs
  - b. Coordinating the provision of all requisite services to meet the care receiver's needs
  - c. Coordination of the training and accreditation of care-givers
  - d. Investigation of and appropriate intervention when the needs of elderly persons are not met appropriately, including cases of abuse or neglect
  - e. Making available multiple entry points into the care-giving system, other than hospitalisation
18. Though AIC is currently meeting some of the functions outlined above, it does not meet the entire spectrum of a care receiver's needs, as its services are currently only limited to the role of an intermediary between care-giving bodies and care receivers.
19. Currently, assessment of the care receiver's needs is not holistic, with evaluation of care needs limited to the Activities of Daily Living (ADLs). We recommend that assessment should holistically include the following items:
- a. Chronic illnesses and other health conditions of the patient
  - b. Assistance required by the patient at the home and outside:
    - i. Activities of Daily Living (ADLs): bathing, dressing, grooming, mouth care, toileting, transferring bed/chair, walking, climbing stairs, eating
    - ii. Instrumental Activities of Daily Living (IADLs): shopping, cooking, managing medications, using the phone, doing housework, doing laundry, driving or using public transport, managing finances (currently, only ADLs are included in the assessment of a care receiver's needs)

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<sup>8</sup> Even though the FLPR has been rising (60.4% in 2015), it is still low when compared to the male LFPR (76.7% in 2015) and to the FLPR of other developed countries, such as the UK (70.2%), Canada (74.3%), and Germany (72.9%). Singapore does only slightly better than Japan (60.1%). (See *MOM Report: Labour Force in Singapore, 2015* and OECD Stat.)

- iii. Medical attention at home
  - iv. Mobility equipment, home retrofitting
  - v. Physiotherapy
  - vi. Travel to care services provided outside the home
  - vii. Specialist support for patients with particular conditions e.g. dementia or stroke patients
- c. Availability of family member(s) at home, able and willing to provide care-giving
  - d. Patient's ability to finance care services

***Why are we making this recommendation?***

20. Care provision is currently service-centric, not person-centric (Loke 2013). Services and infrastructure are available only as piecemeal responses to requests made, without integration of the various types of care provided to ensure that an individual's full range of needs are adequately met. Elderly persons have complex needs that require a variety of different service providers, including home carers, social workers, doctors, nurses, or physiotherapists, and so on. The landscape of services is fragmented and piecemeal, and the extent of care provided depends on arbitrary factors such as the location of one's residence or whether the care receiver first found a supportive social worker in a VWO, who can help in the referral process. Without proper coordination, patients can receive inefficient, expensive and frustrating treatment.
21. Apart from an assessment of the care receiver's ADLs, the other issues that significantly affect elderly wellbeing, as described above, are currently omitted. A care receiver with chronic illnesses and other health conditions is often being treated by different specialists focusing on different parts of the body. This fragmentation means there is usually no overall assessment of the care needs entailed by all the different conditions.
22. We also recommend the inclusion of IADLs in the holistic assessment of the care receiver's needs. Using only the ADLs, which is currently the case, underestimates the degree of care needed and makes care-giving labour invisible. For example, only assessing the ADL of feeding assumes that someone else will perform the IADLs of food shopping and cooking. Including the IADLs gives a more accurate assessment of the care-giving work involved, instead of making it invisible (and therefore unsupported) as stereotyped women's work. It is also assumed that there are family members available and able to provide care to the care receiver and that they can either provide or pay for care services that are needed.
23. The landscape of care-giving services is fragmented and piecemeal, where the extent of care provided depends on arbitrary factors such as the location of one's residence or whether the care receiver first found a supportive social worker who helped in the referral process. Some VWOs, such as the Asian Women's Welfare Association (AWWA), attempt to meet the need for coordinated care. However, their efforts do not cover the full

range of different services. Care receivers or caregivers often need to spend significant time navigating service offerings to obtain the specific services required. As a result, the process of finding care-giving services to meet the needs of a care receiver is haphazard and inefficient.

24. Coordination usually falls on the family caregiver – typically a woman. This task greatly adds to the care burden, as it requires time, communication skills, in-depth knowledge of the services and subsidies available, access to telecommunications, with linguistic ability in English a definite plus, as the caregiver frequently accompanies the care receiver to various sources of care, and organises home visits by care providers. This coordination work can hinder a family caregiver’s ability to combine care-giving and paid work, especially if she is unable to make multiple phone calls of long duration, to find out about the services and subsidies available, has no access to a personal handphone number on which she can be called back, and/or is unable to take sufficient leave to accompany the care receiver to various sources of care or to be at home when care providers make home visits. She is also severely disadvantaged if she is less educated.

**B. Provide free health screening and primary healthcare for chronic illnesses to ensure early intervention so that the overall care burden is reduced for caregivers.**

25. We recommend that primary health screening be made free to encourage more early intervention, thereby reducing the need for acute care. This will tremendously reduce the care burden, as it will help to prevent catastrophic outcomes from illnesses, such as amputation from diabetes, which cause a much greater level of round-the-clock care to become necessary.

**Preventive services covered by insurance under the Affordable Care Act (2012) with no further out-of-pocket costs: USA**

After the enactment of the Affordable Care Act in 2012, preventive services with no further out-of-pocket costs were made available to all insured US citizens. Preventive care benefits available include those applicable to all adults, women, and children. These include health screenings for abdominal aortic aneurysms, alcohol misuse, blood pressure, cholesterol, colorectal cancer, depression, diabetes (Type 2), hepatitis, HIV, lung cancer, and obesity. In addition, a range of other services such as diet counselling, immunisation vaccines, and STI prevention, are also available with no out of pocket costs. Specific care benefits for women and children are available, including screening and counselling for reproductive health issues, and developmental screening for infants.

### *Why are we making this recommendation?*

26. Investing in free primary health screenings and primary healthcare for chronic illnesses, rather than in acute care, provides better returns for Singapore's health expenditure. Preventive healthcare ensures intervention before the eventuation of common health risks, lowering rates of stroke, heart attack, kidney failure, and blindness (Lim 2015). A study on the Singapore primary care system (Khoo, Lim et al 2014) based on 85 health experts comparing it with internationally adopted health system characteristics categorised Singapore as a "low" primary care country. It is well recognised that chronic illnesses, left unchecked, can lead to not only to hospitalisation but to permanent disabilities. Once such disabilities occur, the increased costs include not only clinical healthcare costs, but also the cost of managing everyday life, often requiring a full-time carer, plus opportunity costs borne by both care receiver and carer, such as employment and education options. Caring for a diabetic patient requires fewer resources than caring for an amputee or someone with kidney failure, who needs regular dialysis. The costs arising from lack of prevention are real and calculable.
27. As noted by Lim (2015), while steps are being taken by MOH to transform primary health care in Singapore, particularly in service delivery, it is nevertheless necessary "to strengthen financing to drive the right behaviour." Lim (2015) suggests that when patients have to make co-payments and pay GPs for every visit, they have no incentive to seek preventive care, and doctors will have no incentive to offer it.<sup>9</sup>
28. A medical doctor running a hospice has told us through personal communication that even subsidy schemes, such as the Community Health Assist Scheme (CHAS) and the Pioneer Generation Package (PGP), are insufficient to cover health screening and primary healthcare for chronic disease management, with the patients' CHAS or PGP accounts running dry even before the calendar year is over, particularly when multiple drugs are needed. In contrast, the generous subsidies for hospital services currently provided for Singaporeans may skew incentives, encouraging them "to forgo early primary care – which is cheaper for the system as a whole – and opt for late expensive hospital care because of greater subsidies there" (Lim 2015). According to the World Health Organization (WHO), having primary healthcare as the core is "the most efficient, fair and cost-effective way to organise a health system". As stated by Dr Margaret Chan (2008), WHO's director-general: "Decades of experience tell us that primary healthcare produces better outcomes, at lower costs, and with higher user satisfaction." The care burden for caregivers would also be reduced.

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<sup>9</sup> His view is supported by a study done by Okeke, Adepiti and Ajenifuja (2013). Another ongoing study of relevance -- "Impact of subsidies for preventive health screenings in Detroit" -- is being conducted by the University of Michigan, Population Studies Center, Institute for Social Research: <http://www.psc.isr.umich.edu/events/archive/feature-detail/1761> [accessed on 26 February 2016]

29. Free health screenings would motivate patients to visit GPs and polyclinics as their first port-of-call, rather than entering the healthcare system via hospitals. Some may argue that Medisave can be used for preventive health screening. However, Medisave is derived from the CPF contributions of employed persons. Unemployed and low-waged persons may not have much Medisave available for health screening, especially if their priority is to save Medisave for treatment, rather than for screening.

***What's happening now?***

30. Government healthcare spending is expected to increase from more than S\$9 billion in 2015 to more than S\$13 billion in 2020. However, most of this expenditure will not be directed towards preventive or primary healthcare (Lim 2015).

31. MOH provides Medisave to individuals, as a medical savings scheme to meet their own or immediate family's hospitalisation, surgery and certain outpatient expenses. This is not a subsidy by the government as individuals must put aside their own income into their Medisave accounts, which can then be withdrawn to pay for medical expenses. As individuals have to make contributions, it is not 'free healthcare'. However, one earns interest on this amount.

32. Singapore does poorly with diseases that can be managed with early intervention: more than 25,000 Singaporeans suffer visual impairment because of poorly controlled diabetes. Singapore also has the fourth-highest incidence of kidney failure in the world (Lim 2015). Besides needlessly curbing the productivity of workers, such illnesses also result in an avoidable burden of care being placed on the shoulders of the healthy.

33. The Government presently subsidises GP and polyclinic visits for Singapore Citizens and Permanent Residents. While the following schemes meet certain needs, they nevertheless have various limitations.

a. Subsidised health screenings by the Health Promotion Board (HPB) are available, but residents do not seem to be sufficiently aware of these. Called "Screen for Life", this is "a new branding which consolidates HPB's existing screening programmes, previously known as Integrated Screening Programme, BreastScreen Singapore, CervicalScreen Singapore and National Colorectal Cancer Screening Programme" and which offers "eligible Singaporeans and Permanent Residents subsidised screenings, recommended based on their age and gender."

b. The Pioneer Generation Package (PGP) provides increased medical subsidies to elderly persons born before 1950. However, the PGP is unavailable to persons born after 1950, even though they are an increasing proportion of the population.

c. The Community Health Assist Scheme (CHAS) provides medical and dental subsidies only to households where the household monthly income per person is

\$1,800 and below or where there is no income,<sup>10</sup> an income cap which excludes many households, given that median income from work per household member was SGD 2,380 in 2014 (Department of Statistic Singapore 2014: 4). Furthermore, CHAS is available only at participating GPs and dental clinics, of which there are only 1500 (Community Health Assist Scheme no date/a). According to MOH (2015b), there are 8840 non-specialist doctors and dentists in Singapore, indicating that only 16.9% of GPs and dentists are on the CHAS scheme.

34. Health screening is heavily subsidised for citizens and permanent residents. While individuals aged 50 and above who possess a Health Assist card (under CHAS) are entitled to free cancer screening tests, most screenings require co-payments (HPB n.d.). HPB advises those who continue to find it difficult to “speak to the medical social worker at the polyclinics”. This process friction combined with limited and uncertain subsidies may discourage people from seeking health screenings, as suggested by Lim (2015).
35. Medishield Life insurance can only be claimed when a patient suffers from catastrophic illnesses requiring hospitalisation. It is not available for primary healthcare, particularly preventive health screenings, which is an area of need that should receive higher prioritisation.

**C. Based on holistic assessment, provide adequate care-giving services so that women do not have to drop out of the workforce to provide care.**

**a. Provide comprehensive long-term care that meets the entire spectrum of the care receivers’ needs**

36. Care needs can be met significantly by developing permanent care provision that draws on successful programmes that are being carried out on a limited scale. Notable examples of such programmes are the Singapore Programme for Integrated Care for the Elderly (SPICE) programme of the Agency for Integrated Care (AIC) and AWWA’s holistic care-giving services. This would provide comprehensive care to elderly persons in Singapore so that the primary responsibility of care provision does not fall on the female caregiver in the care receiver’s family.
37. The AWWA and SPICE programmes are mentioned specifically as they are person-centric rather than service-centric. SPICE uniquely assesses the holistic needs of elderly persons and matches them with corresponding services to enable them to recover and age within the community, as opposed to institutionalising them in nursing homes, or transferring non-medical care to the female caregiver in the family. It aims to provide comprehensive, integrated centre and home-based services to the elderly.

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<sup>10</sup> “A further criterion of eligibility for households with no income is that the Annual Value of the home must be \$21,000 and below.” (Community Health Assist Scheme [CHAS] *Who is eligible?*)



38. AWWA similarly provides a comprehensive basket of services for the elderly. The organisation meets the entire spectrum of non-clinical elderly care in a way that is people-centric, drawing up a care plan that is based on in-depth assessment of the client's needs. AWWA has social workers who conduct regular evaluations to see if a client's care needs are changing. Specifically, they have a Community Home, a Senior Activity Centre, a Rehabilitation centre, A Dementia Daycare Centre, as well as extensive support for family caregivers, ranging from training, befriending programmes, respite care to community networks.

***Why are we making this recommendation?***

39. AIC's SPICE programme is commendable, but capacity is extremely limited. There is little current information available. The most recent press release, dated 2013, indicated that "more than 100 frail elderly" had benefited from SPICE since its inception in 2010 (AIC 2013). Given the estimated 60,325 elderly persons who needed some form of care in 2015, the last reported scale of SPICE does not provide anything close to what is needed. Assuming that the programme is still in existence, we would recommend that it be scaled up dramatically to meet the level of care needed.

40. Likewise, AWWA's services also have very limited capacity: they serve 148 people in their Community Home, 300 people in their Senior Activity Centre, and 200 people in the Daycare Centre. Using the Ministry of Health's "functional categorisation of residents" in nursing homes, AWWA accepts only elderly people in Categories 1 and 2. Once their care needs increase to Categories 3 or 4, AWWA no longer caters to them and refers them for transfer to nursing homes.<sup>11</sup>

41. Interviews with AWWA and AIC indicate interest in, and some potential for, scalability. In an interview with AWWA CEO Tim Oei, he stated that AWWA had been in discussions with the Government to replicate the model across Singapore. Similarly, interviews with AIC representatives suggested that the SPICE Programme is still in existence and has expanded since 2013, but no concrete information was given.

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<sup>11</sup> [MOH \(2002\) classifies](#) residents in nursing homes into 4 functional categories:

- Category I  
Physically and mentally independent; may or may not use walking aids; do not need or need minimal assistance in activities of daily living (ADL).
- Category II  
Semi-ambulant; require some physical assistance and supervision in activities of daily living; may have mild dementia, psychiatric/behavioural problems.
- Category III  
Wheelchair/bed bound; may have dementia or psychiatric/behavioural problems; need help in activities of daily living and supervision most of the time.
- Category IV  
Highly dependent; may have dementia, psychiatric and behavioural problems; require total assistance and supervision for every aspect of activities of daily living.

42. The availability of comprehensive long-term care programmes that meet the entire spectrum of need, the lack of capacity of such programmes, and the government's interest in scaling up suggest that current long-term care needs are not being fulfilled across the board although there are already smaller-scale examples of how to do so.

**b. Subsidise more adequately home care provision by private care companies and VWOs**

43. The Government should increase the level of subsidies to home care provided by private care companies and VWOs, so that elderly people can age in place without their younger female relatives having to leave the workforce to care for them.

***Why are we making this recommendation?***

44. Home care provision allows elderly people to “age in place”, adding significantly to care receivers’ quality of life and the efficacy of care (MOH 2015c). Relocating elderly persons to a nursing home can result in stress and poorer quality of life. At nursing homes, in addition to care, families and the Government pay for bed space and food, both of which are likely easier and cheaper to provide at home. Yet from our research with different care providers, it seems that there are currently more subsidies available for institutional care at nursing homes, than care at home.

45. In the US, a study by Kaye et al (2010) has found that home-based care can save states money in the long-term. While new social service programs providing home care cost money to create, they are more cost-effective in the long-term because it is cheaper to care for people at home. Additionally, Addley and Gentleman (2016) reported in February 2016 that a hospital in the UK saved £500,000 by providing rapid specialist assistance to people referred by GPs or social workers, preventing them from being admitted to the hospital and allowing them to continue treatment at home.

***What's happening now?***

46. Even if institutional care is being prioritised over care at home, there is a shortage of nursing homes. In 2010, *The Straits Times* reported that Singapore had about 60 nursing homes with 9,236 beds. In 2011, *The Straits Times* reported that “the average waiting time for a bed in these homes rose from about 50 days in 2008 to about 60 days early last year. It is slightly easier to get a bed in a privately run home – provided you can afford it.” In 2015, MOH (2015d) announced the award of two Build-Own-Lease nursing homes to NTUC Health Co-operative Ltd as part of its plan (announced in 2014) to build 9 nursing homes in 2020.

47. It is commendable that MOH is expanding nursing home capacity,<sup>12</sup> and that previous years have seen subsidy increases (subject to means-testing) for patients and MOH-funded nursing homes. Additionally, MOH has also introduced “greater subsidy rates for home and community-based care” to “enable elderly Singaporeans who do not need institutionalised nursing home care to age comfortably at home and in the community” (MOH 2012). However, nursing home providers can set their fees autonomously and future fee increases may be unavoidable, due to increased operating costs. Many families therefore still face difficulties in paying institutional charges. However, current provisions arguably do not adequately address the difficulties faced by families in paying nursing home fees, given the stringent and, arguably, inappropriate method of means-testing, as we will show below.
48. There is a much lower level of government support for home care. AIC does not subsidise home care services by private companies, even though it subsidises nursing homes. The MOH subsidises some Intermediate and Long-Term Care services provided at home, such as medical, nursing, palliative services, meals on wheels, and other *en suite* services, but apart from the limited information available on MOH’s website on the level of subsidies available (MOH 2015), anecdotal evidence from family caregivers suggests that the subsidy is only for a limited number of hours of home care each week, based on assessment of income level. In one case reported to us, care at home for a disabled childless person was subsidised for only three hours per week.
49. By contrast, an interview with Orange Valley Nursing Home revealed that nursing home charges were subsidised by the Agency for Integrated Care (AIC), with a fixed co-payment due to be paid every month. Average co-payments ranged between SGD 550-750, with a maximum of SGD 1,100. Co-payments are determined by how much the client can afford, rather than the total cost of the care that is needed.
50. Few VWOs provide home care. There are some specialised services like YWCA who provide Meals-On-Wheels but do not provide any other services. We learnt from our interview with them that even this limited service provides meals to only 300 clients per month – a far smaller number than the 60,325 community-dwelling (that is, non-institutionalised) adults aged 60 years and above require human assistance in at least one of six Activities of Daily Living (ADL).
51. Domestic worker levy subsidies are available for families with elderly or disabled care receivers, but this provides support only for those who can afford to hire domestic workers in the first place.

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<sup>12</sup> MOH lists the range of subsidies available for nursing home charges as well as residential services at [https://www.moh.gov.sg/content/moh\\_web/home/costs\\_and\\_financing/schemes\\_subsidies/subsidies\\_for\\_government\\_funded\\_ILTC\\_services.html](https://www.moh.gov.sg/content/moh_web/home/costs_and_financing/schemes_subsidies/subsidies_for_government_funded_ILTC_services.html)

## **D. Support care provided at home by family carers**

### **a. Compensate family home carers**

52. Family carers who spend at least 20 hours each week caring for elderly or disabled family members who have been certified, by a needs assessment, to require assistance with a certain number of IADLs or ADLs (effectively a half-time job) should be compensated for their caring work. This compensation could take the form of CPF credits or an allowance for carers. Only one caregiver per care receiver would qualify to receive this compensation at any one time.
53. Some may be concerned that such compensation for women care-givers would further encourage women to stay at home, without making up for the resulting loss of income, social capital and self-esteem. We recognise that compensation for their care-giving work would not fully replace what women could earn in the labour force. However, the reality is that women are already dropping out of the workforce to provide care to families and relatives, without there being any compensation whatsoever. Our concern is that these women should not be penalised for being caregivers or impoverished when they are older. The long-term solution to disproportionate care-giving by women is to develop the systematic provision of care to elderly persons. Women, who are care-givers, can return to the workplace, only if there are care services provided for those who need care. As it will take time to develop these alternative care services, we are making this recommendation in the context of a transition from inadequate support for care to adequate care provision for all.

#### **Financial assistance for carers: Australia**

The Australian Government explicitly acknowledges that “caring daily for someone with a disability, illness or medical condition is an important responsibility.” In addition to supportive services, the Government provides payments for carers: Carer Payment, Carer Allowance, and Carer Supplement.

- Carer Payment: This is for carers who personally provide constant care at home for a care receiver who is severely disabled, has a medical condition, or is frail aged. The payment is a basic rate of AUD 867 per fortnight. An income and assets test of the carer affects the amount received.
- Carer Allowance: This is a supplementary allowance for people who provide additional daily care and attention to a care receiver, who is severely disabled, has a medical condition, is frail aged, or is under 16 years old. Payment: AUD 123.50 per fortnight. Carer Allowance is not income and assets tested, and can be paid in addition to wages or other income support payments such as Carer Payment or Age Pension.

- Carer Supplement: This is an annual lump-sum payment to assist carers with the costs of caring for a person with a disability or medical condition. All Carer Allowance recipients receive a supplement up to \$600 for each eligible person in their care.

For the carer to be eligible for these services, the care receiver must:

- Achieve a qualifying score as determined by the Adult Disability Assessment Determination 1999 (ADAT Determination), which includes a questionnaire to be completed by the carer and a questionnaire to be completed by the Treating Health Professional.
- Be likely to suffer from the condition or disability permanently or for an extended period of 6 months unless the care receiver has a terminal illness
- Require care in their home or in hospital, and meet an income and assets test.

#### ***Why are we making this recommendation?***

54. The Australian example of compensating carers should be seriously considered to forestall the risk of unpaid female caregivers facing impoverishment. Payments to carers will demonstrate public recognition of the value of care work. This may encourage families to accord higher value to the provision of care.
55. Policymakers increasingly recognise the negative financial impact on women who become full-time family carers, resulting in “lower CPF accounts because they took time off to look after ... families”, to quote Minister Tan Chuan-Jin (2015). For example, in 2015, the Government introduced more incentives for topping up the Central Provident Fund (CPF) accounts of stay-at-home wives and mothers. However, it is not known whether the incentive of gaining an extra 1 percentage point of interest for the first \$30,000 of their CPF accounts would achieve the aim of “encouraging CPF members to top up low balances in their family members’ accounts” (IRA 2016). There is also an assumption that family members with jobs are financially able to top up the CPF accounts of family carers. However, this may not be so. Minister Tan Chuan-Jin said on 8 July 2014 that “about 50 per cent of active members who turned 55 in 2013 achieved their Minimum Sum in cash plus property” (Yong 2014), implying that the remaining 50 per cent of CPF members were not able to meet the Minimum Sum (SGD 148,000 in 2013) (CPF 2016). Since CPF members must have the Minimum Sum in their accounts at the age of 55 before they are allowed to withdraw any money, this may deter them from making transfers to other accounts.
56. MP Foo Mee Har has suggested that there should be automatic transfers to the CPF accounts of stay-at-home wives and mothers, rather than relying on the voluntary actions of family members with more CPF savings. But her suggestion has not yet been taken up.

57. It is possible to do both: (i) encourage family members with more CPF savings to make transfers to family carers with inadequate savings; and (ii) make state payments to carers. Many families across society are facing similar difficulties in trying to solve the problem of care, family by family. It is becoming unavoidable for a more holistic (social) approach to be taken, so that female family carers are not penalised by having to take up (and privatise) the burden of care at great personal cost.
58. Social transfers to the care sector will produce benefits for the economy as a whole. At the very least, increased demand for healthcare, care services and other related services will be stimulated. As discussed by Pang and Lim (2015a):

Domestic demand can ... be increased through more social transfers, which in Singapore is ... very low compared with other rich countries. Public spending as a proportion of GDP in Singapore is half that of many developed countries - 20% versus over 40% - and lower than it was in our first three decades. Recent budgets have increased government subsidies for health care (Medishield Life), training (SkillsFuture) and the elderly (Pioneer Generation and Silver Support). But these are narrowly tied to specific expenditures, many occurring primarily in the public sector, and so do not promote spending by a broader base of consumers ... that could create demand for a wider range of goods and services to be provided by private entrepreneurs.

Besides directly improving citizen welfare, social transfers reduce inequality and increase domestic demand as net recipients are mostly lower-income earners who have a higher marginal propensity to consume than the wealthy. More transfers are affordable given Singapore's large accumulated public sector surpluses—which represent decades of transfers from households to the government chiefly via CPF mandatory contributions, annual budget surpluses, and off-budget user charges by statutory boards and GLCs.

The Singapore government has already introduced social expenditures in the form of PGP, Medishield Life etc, with the expectation that it will increase domestic expenditure. But it needs to do more, and widen its ambit.

### ***What's happening now?***

59. Currently, measures to address the low female LFPR have focused on encouraging women to rejoin the workforce through retraining programmes. However, this will not succeed without adequate care provision or employment conditions that enable individuals to combine paid work with home care.
60. A multi-year ongoing research project by Ng, Mehta, Rowlands and Takiko (commenced since 2007) is studying the pressures that cause adult children or children-in-law to give up their jobs to care for ailing parents throughout the day. Often, care-giving activities, such as preparing meals and accompanying elderly parents for medical appointments, cannot be blended smoothly into working hours, especially when working hours in

Singapore among the longest in the world (Ng, Mehta et al n.d.). Respondents interviewed in this research said, for example (Mehta n.d.):

I think the most stressful part is if there is no understanding from the employer. As the elder parent's medical condition changes, definitely it will change, and the day draws near when she becomes more dependent on you. So, anytime, the situation collapses and you need to go, you need leave. If the employer can understand sometimes, under these special circumstances, then it would help a lot. Bonus is affected sometimes, if you are under-performing or often late. Aside from certain agencies, it is quite standard. You just give your soul away!

## **b. Introduce eldercare leave and flexible work arrangements**

61. Introduce and pay for seven days of eldercare leave as part of family care each year.
62. Incentivise employers to introduce shorter working hours and shifts, more flexible hours with work-life balance, and job-sharing.

### ***Why are we making this recommendation?***

63. An NTUC survey of more than 3,600 respondents found that while 60% (2,050) had multiple dependents and even more (77%) had no eldercare leave.<sup>13</sup> Working caregivers have to apply for annual or sick leave, or arrive at work late and leave early (Goy 2013). Many Singaporeans do not have enough support with balancing work and taking care of their dependents. This has been recognised by Speaker of Parliament, Halimah Yacob, who said: “(Caregivers) struggle daily to balance their work and their family needs.” She called for legislation of eldercare leave to help especially those who are “sandwiched between looking after young children and frail elderly parents”. She pointed out this would send a strong signal to employers about the need to support workers with caregiving responsibilities (Hoe 2013).
64. To support family care and increase the female LFPR, employees must be supported in combining work and care. Shorter working hours and shifts, and flexible hours should be a norm so that family carers who want to work full-time experience less conflict between work and care responsibilities. Increasing job-sharing arrangements will ensure that family carers with a heavy care burden will be able to combine work and care, even if they cannot work full-time.

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<sup>13</sup> The sample size of 3600 respondents constitutes 0.17% of the total resident labour force of 2,138,800 in 2013 (<http://stats.mom.gov.sg/Pages/Labour-Force-Summary-Table.aspx>). The sample size is just short of the desired sample size for the population at 4089, with confidence level at 80% and a margin of error at 1.0. The desired sample size was calculated using the tool provided by Survey Monkey (n.d.) While a larger sample size would yield greater statistical significance (at a higher confidence level and a reduced margin of error), this survey is nevertheless indicative, even if not wholly representative, as it seems to be the only such survey in existence.

65. Singapore has some of the longest working hours in the world (Ng, Mehta et al n.d.). According to MOM (2001), only 3.0% of private sector employees enjoy flexible working arrangements.
66. Some may object that the introduction of eldercare leave and flexible work arrangements will reduce the employability and progression of women, as it will still primarily be women who take these up. Similar arguments have been made regarding maternity leave (Sanghani 2015). Yet, as a society, it is still important for parents, including women, to take time off when they have children. The problem is not with eldercare leave or flexible work arrangements but rather with an organisational and society-wide culture that stigmatises this and that treats the unmarried non-parental male as the social norm at the workplace (Budig, Misra et al 2013). Women should not be penalised for taking eldercare leave or availing themselves of flexible work arrangements, and attitudes towards eldercare leave and flexible work arrangements must shift rather than denying family caregivers these options altogether.

**E. Make eligibility for care more inclusive by means-testing only individual applicants, not their households, and simplify the procedure for receiving social assistance.**

67. Administer the means test only to the individual receiving care. The Legal Aid Bureau of MinLaw already uses a more inclusive method of means testing, which acknowledges the individual's right to disposable income and disposable capital. This method more accurately estimates the need for assistance and a higher level of transparency, thereby making it easier to cross check.
68. Care provision should be automatically administered, and information about eligibility should be easily found online. Means testing should be conducted automatically and efficiently at the assessment stage, so that the care receiver and their family members are not burdened by a large amount of paperwork required. The maximum possible financial support should be provided to all care receivers.

***Why are we making this recommendation?***

69. Losing subsidies and benefits as income increases amounts to a disincentive for working. In Singapore, a rise in income can mean losing benefits, including HDB rental eligibility, childcare subsidies, and/or ComCare assistance, effectively penalising that person several times over for earning more money, without any certainty that the additional income earned is enough to pay for these services in the open market. This has been borne out by AWARE's interviews with single parents who rent flats from the HDB:

For your income, you're already earning a low income. \$1600, \$1700 is not a big amount! But the way they calculate the rental, it just gets higher and higher! If our salary gets higher, the rental gets higher and higher. But they never think that we're single.



A second single parent reported:

This flat now, I am not working and they are still charging me \$120 for this [in rent]. If I got a job now, they would probably up it to \$250.”

70. The inappropriate method of means testing is a major cause of such exclusion, borne out by AWARE’s 2014 Research Study on Women Ageing into Impoverishment and Singapore Management University’s Lien Centre for Social Innovation’s study on “Elderly Population in Singapore: Understanding Social, Physical and Financial Needs” (Donaldson, Smith et al 2015). Household or family-based means testing excluded respondents from both studies from receiving social assistance (AWARE 2015):

A respondent from the AWARE study reported that she was not eligible for medical subsidies at her polyclinic, because it was assumed that her children would be able to provide for her: “They say I cannot help you, all because I have two sons.” Another respondent (Case 44) from the Lien Centre study reported being disqualified from social assistance for the same reasons. However, while her children did support her, her sister, who lived with her in a rental flat, was not supported by her children: “My sister’s sons, don’t talk to her anymore, how to punish them? She can’t even hear.” Together, the respondent and her sister lived on SGD 200 a month from the respondent’s children.

71. Although we recommend that free health screenings and primary health care for chronic diseases be available to all, we acknowledge that there are limited resources and a need to prioritise care spending, since intermediate and long-term care must be provided over a certain period of time. Thus, means-testing is necessary for expenditure control, but we reiterate that this should be applied on an individual rather than household basis.

### ***What’s happening now?***

72. Although some social assistance is available, many families are excluded through overly stringent means-testing. The current method of means-testing the whole family does not account for the particular expenditure incurred for the care of a family member who needs support for such care to be provided. There is no assurance that financially better off family members are paying for this expenditure. Nor can the person in need of care access the financial resources of other family members (Ministry of Social and Family Development 2014).
73. Means-testing the gross income of the applicant’s household or Annual Value of the residence is inaccurate and unfair, because it derives from an unfounded assumption or a moral injunction that richer relatives presently support (or should support) their poorer relative. While the Government does want to make children (or other relatives) support their elderly parents or relatives, household means-testing does not actually provide any incentive to the wealthier relative to support their poorer relatives financially. In the meantime, this penalises the poorer relative who requires assistance. The child may also not have the ability to financially support their parent. This has been borne out by AWARE’s interviews with elderly low-income women, which found that adult children

are not always able or willing to provide financial support, perhaps due to limited income. For example, a 71-year-old respondent said:

I asked my younger sons for help but after a while, they got tired of using their Medisave to help me, and complained about not being able to save the money for their children instead.

74. Under the Maintenance of Parents Act, any Singapore resident who is 60 years old and above who is unable to maintain himself/herself adequately, is entitled to claim maintenance from their children. Since its first year of inception, 1,411 applications for maintenance have been filed and 1,047 maintenance orders made (National Library Board 2009). This is a drop in the bucket compared to the 60,325 elderly adults who needed some form of care in 2015. It has also been suggested that many parents are reluctant to take their children to court even if they themselves are experiencing financial hardship (Goransson 2009). This is therefore not an effective alternative to more inclusive social assistance.
75. There is some recognition of the difficulties faced by “the sandwiched class”. As MP Lim Biow Chuan noted, “The challenge is the middle income. They do feel the pinch because they’re not yet entitled to the benefits and yet they feel the full blow of increases in the cost of living.” As a result, the Government is now “tweaking ... certain financial schemes to allow a greater pool of people to qualify” (Koh 2015).
76. The fact that the PGP and GST voucher are subsidies that are provided automatically without needing applications indicates a potential for flexibility with regards to means testing. It should not be too much to ask for more inclusive methods of means-testing, given that we already have subsidies that do not require any means testing whatsoever.

## **F. Invest in the care sector so it delivers quality care efficiently.**

### **a. Finance care support by introducing Long-Term Care Insurance, not just health insurance.**

77. Improve Eldershield and extend Medishield Life coverage so that it pays for:
  - a. Non-catastrophic illnesses
  - b. Rehabilitative services and medication diagnosed after hospital discharge
  - c. Long-term care for all who need it, with the level of care provision depending on the care receiver’s needs. The range of care services can be provided by home carers who are not necessarily related to the care receiver.
78. Long-Term Care Insurance can be financed by premiums, government subsidies and copayments. Japan’s financing model can be studied as there is a co-payment of 0-30% of the total cost depending on income level, with remaining costs being financed half by premiums and half by government subsidies.

### **Long-term care insurance: Japan**

Japan's long-term care insurance (LTCI) was introduced in 2000. All persons aged 40 years and above must subscribe to the scheme regardless of their care needs (Hayashi 2011). For persons aged between 40-64 years, the premium is levied as an add-on to public health insurance. For persons aged 65 and over, the premium is deducted from their pension payments. Overall, the cost incurred by LTCI is financed by premiums, government subsidies and copayments. Apart from the co-payment, which is 0-30% according to income level, the remaining cost is financed 50% by premiums and 50% by government subsidies.

Subscribers receive care services at a reduced price if they are aged 65 years and above, and after their care needs have been assessed by the municipality. The care services provided include home services such as home help, bathing, nursing, rehabilitation, outpatient rehabilitation, medical care management counselling, day service, short-stay service, group home for elderly with dementia, long-term care at private homes for the elderly, provision or subsidy for care equipment, subsidy for home alteration to meet care needs. There are also institution-based services such as special nursing homes for the elderly, long-term care at health facilities for the elderly, long-term care at medical care facilities at a sanatorium.

Long-term care insurance was actually introduced in order to reduce the costs of providing care to the Japanese state:

- Before LTCI a significant number of elderly persons were occupying hospital beds even though they did not need day-to-day medical services because they could not be taken care of outside the hospital by their family. The hospital bed crunch situation in Singapore, which has been directly related to a lack of care support at home (Khalik 2014), suggests that a similar cost saving would take place were LTCI to be introduced here.
- Moreover, hidden costs are reduced: as early as 2002, there was found to be a statistically significant decrease in the number of hours spent by female family carers on elderly care after LTCI was introduced. This reduced burden was welcome, given a 1994 national survey that claimed one in two family carers had subjected frail older relatives to some form of abuse, with one in three acknowledging feelings of 'hatred', attributable to the heavy care burdens placed on care-givers (Hayashi 2011).

### ***Why are we making this recommendation?***

79. In Japan, costs to the state decreased after the introduction of LTCI, while coverage expanded (Abe 2010).

80. There are serious limitations to Medishield Life’s “universal coverage”:
- a. It is only available for illnesses which are catastrophic or require hospitalisation.
  - b. It does not cover rehabilitative services and medication diagnosed after hospital discharge.
  - c. Most importantly, it does not provide long-term care.
81. Long-term care insurance should be adequate, accessible and long-term. As private insurers generally do not offer policies for long-term care, the Government must step in.
82. Eldershield insurance payouts for severely disabled elderly adults are too small. At \$400, they cannot cover the full cost of care. They are limited to a maximum of 72 months, when payouts should last for as long as the elderly person needs it. While it is compulsory to pay the premiums (which are allocated from CPF and decreases the amount available for Medisave), beneficiaries must apply to get payouts. AGC’s website states that “If you are eligible to claim Eldershield payouts, you can use the money to pay for our services”. However, when asked about their experience with Eldershield, its representative of AGC reported that to the best of their knowledge no client had ever enquired about claiming Eldershield payouts or used it to pay for care services. While it may be the case that patients are receiving cash payouts from Eldershield without informing AGC, we also found that none of our respondents mentioned Eldershield, which suggests lack of awareness of this insurance scheme among Singaporeans.

**b. Ensure higher pay, better working conditions and accreditation for predominantly female carers working in public and private sectors**

83. The Government should set the market rate for caregivers by paying public sector home carers, nurses, and other care workers better wages and providing better conditions of work, so as to compete with other developed countries with ageing populations, who are also seeking foreign caregivers.
84. Allow non-nationals to work as accredited nurses in the private sector.

***Why are we making this recommendation?***

85. Singapore is competing for care workers with other developed countries with ageing populations, such as Germany or Japan. Unless they are offered adequate pay and working conditions, care workers may go elsewhere, exacerbating Singapore’s caregiver crunch, again burdening the unpaid female carer.
86. One private caregiver organisation (Comfort Keepers) that we interviewed pays its employees \$10/hour, and \$13/hour for shifts that take place after office hours and weekends. Another (Active Global Care-givers) pays its live-in care-givers \$600-\$1000 per month, depending on qualifications. This is low compared to several other developed countries which offer home carers higher wages, with Canada offering home care

workers CAD 16.1 (about SGD 16.44) / hour (Colombo et al 2011) and New Zealand offering average monthly salaries of NZD 2900 – 3300 (about SGD 2714 – 3088) (Careers NZ 2016).

87. Under Singapore Nursing Board rules, non-national nurses can only be accredited to practice nursing in Singapore if they are employed by Singapore hospitals. If they leave their employment their accreditation is revoked. This means that non-nationals cannot work as private nurses in Singapore.
88. Most employees in eldercare jobs are foreign nationals. A private home care company (Active Global Caregiver) has 220 foreign nurses and 40 Singaporean nurses. Most are from India, Sri Lanka, Myanmar, Philippines and Indonesia. Regardless of their qualifications or abilities, foreign caregivers typically work on foreign domestic worker (FDW) visas, preventing them from being recognised as nurses. This wastes time and resources, as it means that live-in caregivers qualified to provide basic medical support, such as administering injections, are unable to do so. This requires female family carers once again to coordinate and pay for additional services by accredited nurses at home, when there are already home carers able to do the job.
89. When a nurse is downgraded to a FDW, her pay may also be reduced (Seow 2015). FDWs receive some of the lowest salaries in Singapore, earning an average of \$500 per month. They also work unlimited hours and there is poor enforcement of their weekly days off – employers may compensate domestic workers for days off not taken, with no guarantee of the voluntariness of this arrangement (HOME 2015). They do not receive paid vacation or sick days.

### **c. Develop quality training and upgrade existing training for family and non-family carers**

90. Provide accredited, comprehensive care training for both family and non-family carers so that quality care can be provided at home, including training for daily medical needs and for emergencies.
91. Provide training in the ethics of care for all carers, including training to recognise and address symptoms of abuse.

#### ***Why are we making this recommendation?***

92. Often the training provided to caregivers by private care companies is very limited – usually over 5 days with no follow-up. Inexperienced caregivers often learn on the job, resulting in a steep learning curve and mistakes, such as dropping the care receiver, which can be dangerous for the elderly.
93. Training of even shorter duration is given in the courses supported by Caregiver Training Grants (CTG), many of which are only one day long, with no post-training monitoring

(MSF 2011). While the grants are welcome, more support is needed for ensure higher quality of care training of longer duration.

94. If such a system were to be set up, ensuring that carers undergo training can enable the state to provide female family carers with formal recognition by the Government, especially for providing compensation for care work.

#### **IV. Conclusion: why implementing these recommendations will benefit Singapore**

95. Investing in the care of elderly persons as a social good will enable female family carers to combine work and care. Such investment should include:

- a. Strong coordination for integrating care services
  - b. National upscaling of successful pilot programmes
  - c. Free primary healthcare for early intervention
  - d. Long-Term Care Insurance, not just health insurance
  - e. Upgrading the availability and quality of care for all so that care receivers are not at the mercy of resources available to family members
  - f. Financial support for care at home by family or non-family carers
  - g. Higher pay and better conditions of work and accreditation for non-national care-givers in public and private sectors
  - h. Development of training for quality care
  - i. Eldercare leave and flexible job arrangements as a norm
  - j. Expanded access to subsidies by means-testing only individual applicants
96. This will greatly improve the current situation. Instead of the current reliance on inefficient individualised solutions to eldercare, investing in more efficient collective solutions will result in many macroeconomic benefits, including the following:
- a. The care industry in Singapore will grow due to increased demand for more professionalised healthcare, care services and other related services.
  - b. Enabling more women to return to the workforce by providing adequate care services will help to alleviate Singapore's labour shortage. The opportunity cost sustained by caregivers and society at large, due to unpaid care-giving, will be reduced.
  - c. Family income will rise and families will have more resources at their disposal, including time, money and attention for children's development (reducing crime, delinquency and school non-completion rates) and family relations in general. There will be increased domestic consumption because of the larger disposable income available to the family. The low TFR may be reversed.

- d. Family carers will enjoy greater financial security, with reduced lifetime income and retirement savings gaps, thus contributing to the accumulation of adequate retirement savings of the next generation.
- e. Young families may be encouraged to consider having more children, especially because women will be less likely to perceive tension between work and care duties. An increased Total Fertility Rate will result in a more favourable old-age dependency ratio.<sup>14</sup>

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<sup>14</sup>The Total Fertility Rate in 2014 was 1.25, far below the replacement rate of 2.1. The TFR has been low for decades, since the 1970s. The combination of a low TFR with increasing life expectancy means that Singapore faces "the prospect of a shrinking and ageing citizen population and workforce", with ramifications for economic growth. (See *Issues Paper 2012*.)

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