Review Article

Changing Landscape of Nursing Homes in Singapore: Challenges in the 21st Century

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Abstract

The ageing population is posing new challenges to Singapore's healthcare system. The rise of dual income and the decline of extended families, as well as an increase in age-related degenerative disorders due to increased longevity render it difficult for the family to remain the primary social safety net to care for our elderly in their own homes. Consequently, nursing homes may become increasingly relevant for resource and expertise-challenged families to cope with the burden of caring for a frail and dependent elderly. However, as the recent Nightingale Nursing Home elderly mistreatment incident attests, the standards of some have been found wanting. This paper will trace the history of nursing homes in Singapore and the evolution of government policies towards them, discuss the challenges and trade-offs of nursing home regulation, and provide suggestions for better care and governance.

Ann Acad Med Singapore 2014;43:44-50

Key words: Elderly, Humanistic, Long-term care, Person-centred

Introduction: Nursing Home's Evolution

Nursing homes trace their evolution to American alms-houses in the 1930s where retired nurses welcomed the elderly and ill into their homes.[1] In Singapore, community-based charitable organisations pioneered the earliest sheltered accommodations for homeless and destitute elderly immigrants. For instance, the local chapter of the Little Sisters of the Poor founded St Theresa's Home in 1935 to provide accommodation, food, clothing and other services to the elderly.[2] Well known social worker, Teresa Hsu, also founded one of the earliest nursing homes, the Home for the Aged Sick at Jalan Payoh Lai, in 1965.[3]

Concerted social welfare programmes began after the Japanese Occupation to cater to the large swathes of displaced population. As the population resettled, welfare services grew to provide palliative, remedial and protective functions. While initially it was juvenile delinquents and commercial sex workers who were placed in welfare homes, they eventually evolved to encompass the sick and elderly. In 1959, the City Council and Rural Board passed the Nursing Homes and Maternity Homes Registration Ordinance to govern such homes.[4] Post-independence, 1966 Parliamentary Records document Minister of Health, Yong Nyuk Lin, citing the Trafalgar Home for Lepers as a means to "relieve congestion" for the adjacent Woodbridge Hospital. This marked welfare homes' incorporation into national healthcare considerations. Thereafter, psychiatric rehabilitation homes provided residential care for patients who no longer required active treatment but needed training to readjust to society. Construction of the earliest psychiatric halfway home in Sembawang began in the 1970s and channelled recovering patients from Woodbridge Hospital.[5]

During this period, the practice was applied to eldercare with the formation of homes for the aged, although they were limited in number.[6] Such nursing homes included the Singapore Christian Home, set up in the 1960s, and the Methodist Home for the Aged Sick in 1983.[7] The first government-directed nursing home initiative was the conversion of a disused school in Woodlands into Woodlands Home for the Aged. Conditions of these early homes were spartan; they were built dormitory-style and only had toilets at the end of each block.

In 1983, Woodbridge Hospital established the Chronic Sick Unit for the chronically ill to free acute care beds

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and centralise chronic care.[8] As homes for the aged lacked expertise and resources to care for elderly with chronic illnesses, many were sent to the Chronic Sick Unit for treatment. Ironically, when the patients recovered, families were reluctant to discharge them given the low ward charges at the unit.[8] It thus became a long-term care facility for some patients.

Despite all the activity, government policy towards homes for the aged was minimal. In 1976, Dr Tan Eng Liang, the Minister of National Development, broached the renting of Housing and Development Board (HDB) flats to homes for the aged to house the elderly as "old family traditions (were) breaking down".[9] The idea, however, received little traction. Instead, the government focused on a code of conduct for nursing homes. The Ministry of Health's 1981 Guideline recommended nursing homes set out standards for care to be reported to the Director annually and mandating they should have written policies, guidelines for hygiene. Besides stringent regulation on advertising, most guidelines were discretionary and aimed towards proper book-keeping and reporting.

The lack of alternative community-based care options such as day care, rehabilitation and therapy services left nursing homes as the most viable option for care of the chronically-sick elderly. Families who wanted to care for their elderly at home received limited practical help, medical or financial support, and the much-lauded Central Provident Fund (CPF) was created only after 1983. As noted by the 1991 Health Review Committee on National Health Policy, health for the elderly was one of the 5 inadequately supported aspects of Singapore healthcare which necessitated the "channelling of more resources".[10]

In the 1984 Report of the Committee on the Problems of the Aged, homes for the aged were broadly classified into 2 categories: for the destitute elderly; and the sickly elderly.[11] The government would be responsible for the former, under the then Ministry of Community Youth and Sports (MCYS), while voluntary welfare organisations were encouraged to set up and manage homes for the latter with assistance from the Ministry of Health (MOH) to ensure they were "adequately and efficiently managed". In 1989, Parliament enacted the Homes for the Aged Act to govern nursing homes. It grants power to the Director to issue, transfer or to terminate nursing homes' licenses and demand that nursing homes furnish him with relevant information. Refusal would be subject to a $2000 fine.[12]

Society's ethos emphasising filial piety persuaded government policy to prioritise familial support over nursing homes for care of the elderly. When the 1999 Inter-Ministerial Committee on Health Care for the Elderly noted the undersupply of facilities, the government continued to hold back nursing home numbers as it believed families would be "affected negatively" if nursing homes were readily available as they discouraged families from caring for the elderly themselves.[13]

Nursing homes gradually faded from legislative and public consciousness, albeit with occasional mention. For example, in a parliamentary debate about means testing, the issue of "disparity" in standards between nursing homes and community hospitals was raised.[14] However, without the necessary impetus, there was no concerted effort to re-examine policy towards nursing homes. Eventually, an ageing population and hospital overcrowding revived nursing homes' importance. Declining birth rates and increased life expectancy increased the burden on a dwindling supply of caregivers, while a shortage of facilities for the chronically ill threatened a "bed crisis". In response, the government, increased grants and subsidies for voluntary welfare organisations to construct and maintain nursing homes; and released 17 tender sites for private companies to set up nursing homes.[13]

In the 1990s, to encourage the growth of nursing homes, the government provided generous subsidies to voluntary welfare organisations (VWOs) to run nursing homes of up to 90% of capital costs for construction and continuing subsidy of 50% of operating costs. The government also emulated Australia in introducing categorisation for elderly patients into 4 classes based on time-motion studies of the resources needed to perform care procedures, and gave strong financial and subsidy incentives to encourage nursing homes to take on patients with higher medical needs and increased dependency (Category III and Category IV), thereby introducing the medical facet to nursing home care.

To further expand the residential eldercare sector, the government demolished the Woodlands Home for the Aged and constructed 3 homes in its place under the purview of MCYS: Christalite Methodist Home for the Aged, Bukit Batok Home for the Aged, and Jamiyah Home for the Aged. Compared to their predecessor, these new homes had upgraded amenities and improved care capabilities with communal areas for socialisation, gathering points for volunteers and social programmes for residents. Being primarily homes for the destitute elderly, this heralded a paradigm shift towards a more holistic and well-rounded living environment in long-term care for the elderly. Gradually, more support came from the community whereby companies would sponsor red packets for residents and doctors volunteered their time at the facilities.

However, not all efforts were smooth sailing. Attempts to introduce audits in the 1990s, with a view to improve clinical care, were met with some resistance from nursing home operators who felt it threatened their established modes of operation. As a result, such efforts never really took root. Workforce shortages also meant nursing homes

were increasingly reliant on foreign workers, which in 2011, constituted 25% of the total healthcare workforce,[15] with a larger proportion of foreigners in long-term care settings. Meanwhile, nursing home jobs remained unattractive to locals due to long working hours and modest remuneration. The foreign worker levy for nursing homes was waived in an attempt to address the problem, allowing homes to bring in foreign labour at cheaper costs.[16]

However, recent events brought to light the lack of quality care at some nursing homes. The Nightingale Nursing Home incident, where employees were filmed mistreating an elderly patient,[17] highlighted nursing homes' dubious employment practices and the difficulties in monitoring and regulation. In 2012, there were, in total, 9 reported complaints of abuse by nursing home staff mainly pertaining to rough handling, particularly, during patient transfers.[18] Intuitively, the possibility of under-reporting is high.

To compound matters, the construction of nursing homes near property also aroused public displeasure. One, at Bishan Street 13, stirred nationwide conversations when residents in the vicinity petitioned the government to have it situated elsewhere, claiming decreased ventilation would raise utility charges and they would have elderly "groaning" into their homes.[19] This has been termed the not-in-my-backyard (NIMBY) syndrome, and highlights the lack of societal support and acceptance for nursing homes.

Current Policy Towards Nursing Homes

Nursing homes are part of the wider eldercare initiatives that include ElderShield, services that encompass befriending, home help and respite care, and public education campaigns like the active ageing initiative. "Ageing in place" are buzz words today as more initiatives are rolled out to facilitate senior citizens in maintaining wellness and independence, and supporting those with disabilities with services in the community so as to enable them to continue living in the comfort of their own homes instead of the nursing home. Community-based services also have the advantage of reduced cost compared to institutional care. Information on the different types of eldercare services and their respective locations around the island can be conveniently found on the Eldercare Locator of the Silver Pages of the Agency for Integrated Care (AIC).[20]

Nonetheless, despite efforts to help seniors age in place, it is projected that Singapore will need up to 15,600 nursing home beds by 2020 from the present 9300 thereabouts[21] to cater to the frail elderly with high care needs. The government employs a "many helping hands" approach towards nursing homes, engaging a diversity of external partners, ranging from VWOs to private operators to construct and operate nursing homes. The diversity allows different nursing homes to cater to different niche segments of the elderly population.

To aid in allocation, elderly patients are classified into 4 categories by the Resident Assessment Form: Category I patients are physically and mentally independent; Category II patients are semi-ambulant; Category III patients are wheelchair or bedbound; and Category IV patients are highly dependent. Category I and II patients are primarily admitted to sheltered homes, while the limited nursing home places are mainly reserved for Category III and IV patients. Category II patients may be admitted to nursing homes, but intake is highly restricted and capped.[22]

The Private Hospitals and Medical Clinics (PHMC) Act and Regulations, and Specific Guidelines for Nursing Homes, enacted in 1981 and 1990[23] allow nursing homes to determine the standard and system of care, with regular reporting to the Ministry. It, however, maintains strict restrictions on advertising and promotions, restricting "testimonials by…patients", "any mention…of personal skills of doctors", "comparisons…between one nursing home and another" and generally "any sales promotions".[23] Such restrictions are meant to limit nursing homes' appeal to Singaporeans. Instead, the government encourages co-residence between children and ageing parents as a financial arrangement and moral obligation.[24]

To operate, nursing homes must receive 2-yearly licences from the Ministry, subject to yearly formal inspections. In the light of the Nightingale Home incident, Minister of State for Health, Dr Amy Khor, proposed a "Visitors Programme" where volunteers would visit nursing homes and interview patients and family members, before submitting a report back to the Ministry.[18]

To help reduce the government's financial burden of running nursing homes and ensure "shared responsibility", in line with the 1981 National Healthcare Plan, patients' families have to pay part of the costs of their stay and treatment. Patients from households with under $2200 per capital monthly income would have a subsidy range from 10% to 75%. These patients may be further covered under ElderShield, helping defray costs of long-term costs.[24] For financially able households, they would have to pay the full fee estimated at $2000 monthly. However, there has been criticism that the subsidies are inadequate and the monthly income cap is inflexible and insufficient, given inflation.

Recently, the government has attempted to remake nursing homes to be more liveable through incorporation of greenery and communal spaces into the design, and greater emphasis on attending to the social needs of residents. New standards for nursing homes are expected by 2015 and homes are also encouraged to "expand their services" to offer day care and rehabilitation services to the wider elderly community.[25] In the future, the government plans to aggressively expand nursing home numbers and bed

space, building 10 new nursing homes and complementary day care, dementia day care, day rehabilitation services by 2016.[26] Such facilities will be well connected to the areas in the vicinity to involve the community in eldercare and create elderly-friendly neighbourhoods.

Challenges of Legislating Nursing Homes in Singapore

In regulating nursing homes, the government faces several quandaries. Firstly, it must balance the risks of under-regulation and over-regulation. While the risks of the former are clearly manifest in the Nightingale Home incident, the latter risks raising costs for both operators and consumers, and even driving some below par nursing homes out of business, compounding the already severe shortage of bed space for the chronically ill.[27]

Secondly, it must weigh the risks of an increasing reliance on nursing homes undermining traditional values of filial piety. Fan et al argues that a "promotion of filial piety values" could be a "solution" to an ageing population[28] which includes caring for one's elderly parents. Nursing homes could potentially encourage children to abrogate this responsibility. However, they are also essential for the chronically or terminally ill, as families often lack the resources and expertise to care for them, and ill-equipped caregiving risks decreasing patient's quality of life and adds stress to caregivers. It is becoming increasingly clear that with smaller and dual income families, relying only on families as the social safety net may no longer be tenable. There is a need to enhance safety nets within the community and nursing homes play a pivotal role in this respect.

Lastly, the government must also consider the implications of further privatisation of the nursing home industry. The current system is a tenuous balancing act between voluntary and commercial operators, with 4979 patients in the former, and 3039 in the latter,[29] although tight advertising regulations restricts the ability of commercial nursing homes to differentiate services and build consumer awareness. However, further privatisation provides distinct advantages in allowing market forces to influence operators to enhance industry efficiency in lieu of supply and demand. It would also accord greater flexibility and allow the development of niche areas to cater to dynamic changes in consumer demand. As Wunderlich and Kohler observed, current long-term care recipients often lack a "choice" of providers or services, limiting the efficaciousness of market forces in upholding standards.[30]

However, as the availability and quality of nursing homes is a public good, with externalities on the wider healthcare system, unfettered market forces alone should not govern its supply. The lack of effective regulation to deter errant behaviour and ensure minimal standards further increases the risks of moral hazards and poor quality care. It is also morally dubious to create a system where only the well-off have access to nursing homes. Furthermore, expansion of the nursing home sector by the private sector may risk diluting standards and increase the complexity of auditing and regulation.

Recommendations

To tackle these problems, firstly, a calibrated approach to increasing regulatory oversight and standards of care could be introduced. A basic evidence-based education outreach programme to impart and reinforce vital caregiving skills could be conducted for nursing home staff where "oral and visual information" are disseminated via PowerPoint presentations and brochures to medical professionals, which Bernal-Delgado et al suggests is "incrementally more effective" than conventional outreach.[31] Lectures via video conferencing as part of an overall telemedicine initiative can serve this purpose well. In conditions that require specialised care such as dementia, there often lies the issue of providing specialised dementia homes versus up-skilling all nursing homes to care for residents with dementia. Both approaches can be adopted, whereby all nursing homes should have staff with skills to manage dementia but at the same time, there should also be homes specialising in dementia care to care those with higher needs such as difficult to manage behaviours.

To increase accountability and incentivise good care, end-of-life elements could be introduced into nursing home's clinical audit as recommended by the National Strategies for Palliative Care Workgroup,[32] and surveying families upon patient demise on care quality, as modelled after the Toolkit of Instruments to Measure End-of-life care (TIME) from Brown University.[33] Such measures strengthen the feedback mechanism and increase nursing home accountability to patients' families and the wider community. The current practice of displaying results of key performance indicators of various hospitals[34] in the public domain could be extended to nursing homes to spur competition amongst homes to upgrade standards and give families of prospective patients a more informed choice.

Secondly, improved coordination and communication between nursing homes and hospitals, and instilling a culture of continuous quality improvement could raise standards of medical care. Currently, nursing homes lack input from hospital specialists on matters of clinical care. Local studies have highlighted issues of concern such as poly-pharmacy and inappropriate medication prescriptions in 58.6% to 70% of nursing homes surveyed.[35,36] Diminished quality of life as suggested by a significant prevalence of malnutrition, urinary incontinence, falls, functional decline and impaired vision have also been described.[37] Improved medical support could ameliorate the situation and this

can be realised through periodic visits by physicians and geriatric specialists or telemedicine.[38] Some noteworthy recent initiatives to improve long-term care quality include recommendations from the Nursing Home Expert Panel at MOH[39] and quality initiatives by AIC.[40]

Thirdly, there could be reconsideration on the current stringent classification of elderly patients which determine the care they can receive. The current classification of patients according to the Resident Assessment Form with the attendant categorisation of homes by level of nursing capability opens up a "service gap" for some Category II patients transiting into Category III.[22] As Category II patients suffer cognitive and physical decline, they need to be uprooted from assisted living facilities run by MCYS and transferred to nursing homes operating under MOH's purview, a process that can be disruptive and distressing to the patient. Instead, eldercare facilities should ideally allow the elderly to "age-in-place".[22] Increasing the capabilities of all homes and implementing a more flexible classification system would provide more patient-centric treatment that upholds the dignity and autonomy of our elderly. It would also facilitate market creativity and potentially spawn integrated centres where patients can traverse the ageing continuum with greater comfort and security.

Additionally, in the long run, reliance on foreign nursing home staff can be gradually reduced. This can be implemented through MOH's efforts in increasing local intake at healthcare training programmes, encouraging mid-career switches and drawing back healthcare professionals working overseas.[15] There is a need to afford greater recognition to nursing home medicine as a unique discipline, enrich the academic curriculum, delineate attractive career paths, and enhance work benefits and remunerations to draw local employees. This is critical as foreign staff could experience cultural and linguistic barriers communicating with local patients, and a small minority may have inappropriate qualifications or are ill-equipped to perform their role. Hence, a core pool of local staff in nursing homes is essential to adequately meet the emotional, social and cultural needs of the elderly.

In tandem with financial incentives to support home-based care of the elderly, for instance, the Enhancement for Active Seniors Scheme which grants subsidies up to 90% for Singaporeans to make elderly-friendly modifications to their homes like grab bars and non-slip tiles,[41] foreign domestic helpers can help to provide home-based care to frail elderly and serve as an alternative to foreign nursing staff. There are more than 200,000 foreign domestic workers in Singapore[42] and recent initiatives such as a $120 monthly grant for families to hire foreign domestic helpers to care for elderly with dementia[41] are incentives to support care for the elderly at home. To increase the proficiency of domestic helpers, the recently set up Foreign Domestic Workers Association for Skills Training[43] is a laudable effort.

Lastly, nursing homes could move towards humanistic and holistic care to meet increasing expectations for more privacy and higher quality of resident-centric care from better educated and more affluent generations. This is in line with the need for nursing homes to evolve alongside changing expectations of the elderly and families and would entail a shift away from current institutional-based care modelled after hospitals where the highly structured environment and centralised decision-making process may undermine patient autonomy and lead to depersonalisation, isolation and loneliness of the residents.[44]

The care could be modelled after the Green House Project in the United States, which seeks to create a homely and communal residence for residents[45] with an emphasis on quality of life beyond safety and risk management. Homes could be redesigned to be more aesthetically appealing and with more recreational spaces for residents. Locally, such ideas are beginning to take root. For instance, the Hope Resident Living Area at Peace Haven Nursing Home seeks to maximise independence and autonomy for persons with early dementia.[46] It is a stellar example of what nursing home care in the future can be like. Such care would improve resident welfare by according them with more dignity, agency and respect, and merge the medical and social facets of long-term care. It would also allow nursing homes to evolve beyond its current custodial roles, towards more holistic and person centred care.

Conclusion

With nursing homes playing a central role in the future make-up of our healthcare landscape, the policies that affect and govern it will have widespread repercussions on society. While legislation was initially restrictive on nursing homes due to filial piety ethos and modest to evolve with families' changing dynamics, population pressures have forced a policy re-think. In moving forward, Singapore must appreciate the complexity in nursing home history and the evolution of its policies, and be cognisant of the dilemma the country faces in amending policy. A clear understanding of these trade-offs would not just inform policymakers, but assist families, healthcare professionals and caregivers in making optimal choices for their ageing elderly. Hopefully, in the future, stronger regulation, improved medical care through firmer tie-ups with hospitals and physicians, and an emphasis on humanistic person centred care will make nursing homes a more attractive place to spend one's twilight years.

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