St Andrew's Community Hospital: Leading Through Times of Change

By 2026, Singapore will be a "super-aged society", where individuals aged 65 years and older account for at least 21% of the population.[1] By 2030, one in four citizens will be aged 65 and over.[2] With an ageing population, a shrinking local workforce and the heavy burden of chronic diseases, there is now a greater demand for community-based healthcare services for the elderly population. In response to this shift in healthcare needs, the Ministry of Health (MOH) has implemented various policy experiments, particularly in the following areas: provision and funding of healthcare services; integration of health and social services; active ageing; disease prevention; health promotion; and enrolment in primary care panels.

The Singapore government has made policy experimentation a key part of its approach to managing both the national economy and society as a whole.[3] It is common practice for the government to try different policy combinations, or to roll out a specific policy by stages. This means that managers within the organisations that provide public services, whether public or privately owned, must necessarily be change managers – finding ways to carry their staff and service users with them as the government implements, trials and potentially cancels new policies. The present case study focuses on the means employed by the leadership of one such organisation: St. Andrew's Community Hospital (SACH).

This case study explores the organisational response of SACH to changes implemented by MOH in four policy areas, namely: expansion of means testing; clustering and re-clustering health services in search of optimal organisational sizing; changes in funding and awarding of services; and changes in domain responsibilities. In each policy area, the case study looks at how the SACH management led their organisation, as well as the sector. From a similar perspective, the case study analyses the motivations and responses of other actors, and how these affected the choices of the SACH leadership in steering their staff and the organisation as a whole.

Community Hospitals in Singapore

Community hospitals like SACH serve as intermediate care facilities that provide medical services for patients who need a brief period of continuation of care – typically those discharged from acute hospitals. The basic inpatient services offered by community hospitals include rehabilitation care and sub-acute care. In community hospitals with more advanced capacities, the following services are also available: palliative care, dementia care, dialysis and complex wound care. Indeed, community hospitals are crucial to Singapore's pivot towards a community-centric care model, especially amidst a rapidly ageing population.[4,5]

[1] Abhijit Visaria and Rahul Malhotra, "Live long and prosper? A super-aged Singapore society does not have to be a sad one," Duke-NUS Medical School, August 26, 2023, https://www.duke-nus.edu.sg/allnews/super-aged-singapore-society
[2] Joyce Teo, "Initiatives in place to tackle ageing issues as S'pore hits 'super-aged' status in 2026: Health Minister," *The Straits Times*, April 20, 2023, https://www.straitstimes.com/singapore/initiatives-in-place-to-help-tackle-ageing-as-s-pore-nears-super-aged-status-in-2026-ong-ye-kung
[3] Celia Lee et al., "The changing dynamics of policy experiment in Singapore: Does the 2011 general election make a difference," *Asian Journal of Political Science* 25, no. 3 (2017): 287-306.
[4] Ministry of Health, "Community hospital care: Handbook for patients," August 2018, https://www.moh.gov.sg/docs/librariesprovider5/default-document-library/handbook-for-ch-care-for-patients-2nd-edition-200918-for-printing.pdf
[5] Sean Kia Ann Phang et al, "Community hospitals of the future—challenges and opportunities," *Frontiers in Health Services* 3 (2023): 1-12, 10.3389/frhs.2023.1168429

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Patients receiving rehabilitation care are generally recovering from a stroke, orthopaedic surgery or elective joint replacement. They undergo intensive inpatient physiotherapy, occupational therapy or other types of therapy. Acute hospital patients who have become debilitated from prolonged inpatient stay may also be referred to community hospitals for rehabilitation treatments to improve their physical functioning.

Subacute care refers to the care for patients who are continuing their treatments that began in acute hospital wards. On the average, patients stay for two to three weeks in community hospitals, which are designed to provide targeted and more cost-effective care than acute hospital wards. Most of them are discharged into a home care environment, sometimes with continued care support or centre-based care support, while a few are discharged into nursing homes when their families are unable to care for them at home.

To provide acute care, Singapore's public healthcare clusters (ie, public hospitals and national specialty centres) are funded by a system known as the "S+3Ms": a combination of subsidies, along with MediShield Life, MediSave and MediFund.[6] Medishield Life is a national universal catastrophic healthcare insurance, while MediSave is a compulsory medical savings scheme that "helps individuals set aside part of their income to pay for their personal or approved dependants' hospitalisation, day surgery and certain outpatient expenses, as well as their healthcare needs in old age."[7] Meanwhile, MediFund is a safety net of last resort for those who cannot afford their healthcare expenses.[8]

In the case of the intermediate and long-term care (ILTC) sector (ie, community hospitals, nursing homes, day centres), means-tested subsidies are available as well as Medisave and Medifund. To pay for long-term care, a national long-term insurance scheme called CareShield Life exists. This insurance is mandatory for citizens aged 30 and above. It pays out when at least three out of six specific "activities of daily living" cannot be performed by the patient.[9]

Out of the ten community hospitals operating as of July 2024, the original four are operated by Non-Governmental Organisations – registered charities which supplement government funding with donations from the public. While obliged to meet key performance indicators set by MOH, they must also balance their books via independent fundraising efforts. Government subsidies are predicated upon the assumption that patients will co-pay for services, but most charity-backed ILTC providers tend to undercharge in this respect. Likewise, they strive to provide additional free services such as art and music therapy, as well as pastoral care.

SACH: Serving through Intermediate Care and Community Care

SACH is one of several community services offered by St Andrew's Mission Hospital (SAMH), a faith-based charity founded in 1913. SAMH is a statutory body governed by the St Andrew's Mission Hospital Act. Founded in 1992 as Singapore's first community hospital, SACH was later relocated to Simei in 2005, where it would share premises with Changi General Hospital (CGH), an institution focusing on acute care.

Hitherto, all previous community hospitals had been run as stand-alone facilities in the community, and the co-location strategy was implemented to study whether a co-located acute hospital and community hospital model would result in tighter integration of services and more effective combined care. From the beginning, the leadership of SACH and CGH worked together to establish shared clinical governance structures.

SACH offers subsidised intermediate care for patients after the acute phase of their treatment at a general hospital. The inpatient care services available at SACH include rehabilitation care, sub-acute care, dementia care, palliative care and paediatric care. Aside from intermediate care, SACH also provides community case

[6] Ministry of Health, "Healthcare schemes and subsidies," June 20, 2024, https://www.moh.gov.sg/healthcare-schemes-subsidies
[7] Ministry of Health, "Medisave," October 2, 2023, https://www.moh.gov.sg/healthcare-schemes-subsidies/medisave
[8] Rob Taylor and Simon Blair, "Financing health care: Singapore's innovative approach," World Bank, 2003.
[9] Feeding oneself, dressing, going to the toilet, washing, walking or moving around and moving from a bed to a chair or vice-versa.

management service and community care (ie outpatient clinics at Simei and Elliot Road, day rehabilitation centre, community therapy services and home healthcare services).[10] In 2023, the community hospital saw 3,225 inpatient admissions, 8,819 outpatient appointments and 9,146 home care visits.[11]

SACH's service provision takes place in the context of a wider suite of services offered by the parent organisation, SAMH. As such, it also serves as a hub providing medical and related manpower to the seven nursing homes within the St Andrew's group. In addition, SACH has partnerships with all three public regional health clusters via various local centres and home-based care services across the country.

Steering through the Waves of Policy Change

Reconciling SACH's state-mandated obligations with its duties to patients and donors can be challenging, and the SACH senior management has had to navigate carefully. In this journey, SACH's Chief Executive Officer, Dr Loh Yik Hin, found that the leadership theories of Dean Williams were of particular help.

Williams' theories emphasise that the role of a leader is to convince people to face reality and understand that external changes must be accommodated or even transformed into opportunities. Such a leader seeks to cross the boundaries both within and beyond his or her organisation, building bridges across internal gaps as well as with external organisations. By doing this, the leader is able to turn changes that may otherwise be seen as threats into opportunities.[12]

Following these principles, the SACH leadership team has steered through continuous waves of policy change, notably in the following areas: expansion of means testing in the healthcare sector; clustering and re-clustering of healthcare services; changes in funding and awarding of services; and changes in domain responsibilities.

The Expansion of Means Testing in Healthcare

In 1993, the MOH published a landmark White Paper entitled "Affordable Health Care". This became the blueprint for the subsequent development of the Singapore healthcare system. The paper listed five objectives that would become the foundation of Singapore's healthcare philosophy:

1. Become a healthy nation by promoting good health;
2. Promote individual responsibility for one's own health and avoid overreliance on state welfare or third-party medical insurance;
3. Ensure good and affordable basic medical services for all Singaporeans;
4. Engage competition and market forces to improve service and raise efficiency; and
5. Intervene directly in the healthcare sector, when the market fails to keep healthcare costs down.

Accordingly, MOH established a system under which subsidies would be contingent upon patients' chosen ward classes when receiving inpatient care in a public acute hospital. Inpatients in C-class and B2 wards (ie 6-8 bedder, non-airconditioned wards with no choice of consultant specialist in charge) would be given a flat subsidy rate of 65-80%, whereas patients in single, air-conditioned rooms with their choice of consultant specialists (A-class type) would not receive any subsidy. A similar system was implemented in community hospitals, under which all admissions to a shared room would receive a flat 50% subsidy of total hospital bill.[13]

[10] St. Andrew's Mission Hospital, "St. Andrew's Community Hospital: Services," no date, https://www.samh.org.sg/st-andrews-community-hospital/
[11] Titus Chung et al., "Love Never Fails: 2023 Annual Report," St. Andrews Mission Hospital, January 2024, https://www.samh.org.sg/wp-content/uploads/2024/04/Online-Review-18-AR-2023-SAM-1.pdf
[12] Dean Williams, *Leadership for a fractured world: How to cross boundaries, build bridges, and lead change* (Berrett-Koehler Publishers, 2015).
[13] Habibullah Khan, "Social policy in Singapore: A Confucian model?," World Bank, January 2001, http://documents.worldbank.org/curated/en/193101468758956946/Social-policy-in-Singapore-a-Confucian-model

By the 2000s, the government was leaning towards a more progressive payment system. Under this system, subsidies would not be based simply on the patient's choice of ward, but also on the ability of the patient (or their family) to pay, making subsidies available only when the "family as the first line of support" approach fails to provide – when individuals have no family, for example.[14] Cognisant that rolling out this policy across the board would be a significant change, MOH piloted the scheme in community hospitals and other ILTC institutions beginning in 2001.[15]

The Roll-Out of Means Testing in Community Hospitals

Prior to the 2000s, the only means testing in the Singapore healthcare system was in the form of the Medifund scheme. Created in the 1990s, Medifund is an endowment fund set up by the Singapore government to provide safety net for patients "who face financial difficulties with their remaining bills after receiving government subsidies and drawing on other means of payment including MediShield Life, MediSave and cash."[16] In the late 1990s, MOH extended this to other areas of the healthcare system, beginning with a pilot programme focusing on step-down services for elderly clients: community hospitals, nursing homes, day rehabilitation services, hospices and home care services.

Where previously all patients had been subsidised at the same rate, MOH announced that henceforth the aim would be to "focus limited resources for needy Singaporeans, by channelling it to those who need it most."[17] Initially, means testing was applied in four bands, with patients being subsidised to the tune of 75%, 50%, 25% or 0% depending on their monthly household income (Table 1).[18]

Table 1. Means testing in community hospitals: Subsidy rates for Singapore citizens (2008-09)

Monthly per capita family income	**Subsidy rate for citizens**
≤ $330	75%
$331 - $800	50%
$801 - $1,300	25%
> $1,300	0%

With the implementation of this policy, the situation went from one where all non-single room inpatients received 50% subsidies, to one in which only around 50% of SACH's inpatients had any subsidy at all. Defining "family income" as comprising the income of all children, whether residing at the patient's home or not, meant that many families failed the means test.[19] As Dr Loh put it: "In the community hospital, the floor used to be zero and they increased the floor to 20, but it was still per capita family income – if you had children living with you, their incomes would make your per capita levels higher and you would get much less subsidy."[20]

Some, who were moved from acute to step-down care before being informed that their care would no longer be subsidised at the same rate as previously, were surprised by the news. A larger proportion of patients whose incomes were above a given subsidy threshold realised that moving to a community hospital or similar

[14] Youyenn Teo, "Interrogating the limits of welfare reforms in Singapore," *Development and Change* 46, no. 1 (2015): 95-120.
[15] Ministry of Finance, "Budget Statement 2004: Building a Future of Opportunity," February 27, 2004, https://www.nas.gov.sg/archivesonline/data/pdfdoc/2004022703/FY2004_Budget_Statement.pdf
[16] Ministry of Health, "Medifund," accessed January 31, 2024, https://www.moh.gov.sg/healthcare-schemes-subsidies/medifund
[17] Ministry of Health, "Subsidy (Means Testing at Restructured Hospitals)," 2007, https://web.archive.org/web/20090218232830/http://www.pqms.moh.gov.sg/apps/fcd_faqmain.aspx?qst=2fN7e274RAp%2BbUzLdEL%2FmJu3ZDKARR3p5Nl92FNtJifw8iBZoOww9Gf8%2FdLi7cbTadpIw2tF7Fdn5I9r5Y9UM9XPY37bcAtM7ZvDLVsTJgDSks74Ew7gnY0O7OPO5%2FzDG7VL1ugrF%2Fa3wpwYm%2FLw8EgQTEN2HpITreQmMf2L2f0BUIH5nRwNLV5fvxTy5jHxoEd75Hgf8LI%3D
[18] Abel Chen et al., "Post community hospital discharge rehabilitation attendance: Self-perceived barriers and participation over time," *Ann Acad Med Singapore* 43, no. 3 (March 2014): 136-44.
[19] Loh Yik Hin, interview by Jennifer Dodgson, January 26, 2024.
[20] Loh, interview.

would cost them more per day than remaining in acute care, and thus, tried to remain in general hospitals for as long as possible.[21] In Dr Loh's words: "Very often we would have patients in acute hospital telling us, 'I don't want to come to you, because after financial counselling (…) I just realised that I'm losing a lot of the benefits of acute hospital subsidy.'"[22]

This change was particularly difficult for SACH, as it had always placed a great emphasis on the affordability of its services and its role in ensuring accessible care, especially for the poorest and most disadvantaged in society. Noting patient and provider reactions to the change and fully cognisant of their obligations as a faith-based charitable organisation, the SACH management rapidly stepped in to increase donation-funded support for patients. Additionally, the inpatient fees were deliberately capped to reduce the financial burden on those who failed the means test.

Policy Evaluation and Adjustments

MOH responded quickly to the changes in patient behaviours and feedback from service providers. In 2009, the subsidy tiers were modified to introduce a gentler sliding scale (Table 2):[23]

Table 2. Means testing in community hospitals: Adjusted subsidy framework for citizens (2009-12)

Per capita family income per month	Subsidy rate for citizens*
⩽ $360	75%
$361-$550	70%
$551-$750	60%
$751-$950	50%
$951-$1,150	40%
$1,151-$1,300	30%
$1,301-$1,350	20%
$1,351-$1,400	10%
> $1,400	0%

The authorities later moved towards a position under which means-tested subsidies would be tied to household rather than family income, as well as providing additional funds via other channel.[24,25] Nevertheless, while policy adjustment was ongoing, means testing was extended to cover acute hospital stays in 2009.[26]

Even after the expansion of means testing, the government continued to seek feedback which led to additional moves to mitigate the effect of means testing across the board.[27] Notably, the sliding scale of subsidies was further softened, and the number of bands increased from four to nine (Tables 1 and 2), with additional band modulation taking place from 2012 (Table 3). At the same time, the practice of basing subsidy levels on family income was entirely phased out, being replaced with assessments based on household (ie the members of a family actually living with the claimant) income for ILTC providers.[28]

[21] See also: Abel Chen et al., "Post community hospital discharge rehabilitation attendance".
[22] Loh, interview.
[23] Tan Chorh Chuan et al., "A Guidebook on Nursing Homes," Ministry of Health, 2002.
[24] Loh, interview.
[25] Jeremy Lim and Veena Dhanajay Joshi, "Public perceptions of healthcare in Singapore," *Annals of the Academy of Medicine Singapore* 37, no. 2 (2008): 91.
[26] William Haseltine, *Affordable excellence: the Singapore healthcare story: how to create and manage sustainable healthcare systems* (Brookings Institution Press, 2013).
[27] Ijlal Naqvi et al., "Grievance Politics and Technocracy in a Developmental State: Healthcare Policy Reforms in Singapore," *Development and Change* 55, no. 2 (2024): 244-275.
[28] Loh, interview.

Table 3. Means testing in community hospitals: Adjusted subsidy framework for citizens (2012-14)

Per capita household income per month	Subsidy rate for citizens*
Less than $600	75%
$601 - $900	60%
$901 - $1,300	50%
$1,301 - $1,500	50%
$1,501 - $2,200	45%
$2,201 - $2,700	40%
More than $2,700	20%

Leading the Switch to Means Testing: The Maintenance Challenge

When faced with a cut in patient subsidies, SACH chose to focus on its non-profit, faith-based mission, stepping in to provide support from donor income to patients who fell outside the initial means-testing thresholds but who nevertheless struggled to pay for care. It also capped inpatient ward charges and fees in the first instance.

In this situation, the SACH leadership chose to take an approach inspired by Dean Williams' vision of the "maintenance leadership challenge", under which the leaders of an organisation must strive in adverse circumstances to maintain the organisational mission and core values, be strategically defensive and weather the storm.[29] The aim under such circumstances is to enable the organisation to survive the immediate difficulties without losing sight of the larger goals, and arrive at a point at which it will be better equipped to deal with challenges more proactively.

Eventually, a tactical step was undertaken by SACH management to implement a two-tier charging system where patients who had taken up Medishield insurance (which was not mandatory before 2015) would be charged an amount closer to the full cost of care. In the case of patients who did not have Medishield coverage, SACH would use donations and reserves to make the patient-payable portion more affordable. This was described as "right pricing" services for patients with Medishield coverage, where previously they had been "over-subsidised" by SACH's flat inpatient charges. Following the introduction of this two-tiered system, other community hospitals began to follow suit.

While the SACH leadership had never seen its role as being that of a lobbying organisation, they nevertheless provided feedback to MOH via various channels. This is known in Dean William's work as "perturbing the system" and not letting the natural "drift" of circumstances carry one along. By maintaining service while also providing appropriate feedback on the means-testing policies as they were rolled out, SACH contributed to the shift towards a means-testing scheme that would be acceptable for everyone.

Given the nature of this "maintenance leadership challenge", the SACH management had to ensure that the morale and spirits of the staff did not wane, despite the challenging financial circumstances. Doubling down on their vision and mission was critical. This required support from the SAMH Board and a commitment to "staying the course". Experimentation to stay afloat financially and communications to keep all staff on the same page were equally important components of the collective response to the change.

Clustering and Re-Clustering Health Services

Organisations tend to swing periodically between centralising and decentralising tendencies, and this is particularly true of public healthcare services, thanks to the inherently conflicting and hard-to-measure

[29] Dean Williams, *Real leadership: Helping people and organizations face their toughest challenges* (Berrett-Koehler Publishers, 2005).

objectives they pursue.[30] In Singapore's case, the state has experimented extensively with different forms of organisation, requiring health system managers to be adaptable and communicate these changes effectively.

Health sector clustering and the policy experimentation feedback loop

In the 1980s, Singapore, like many countries, began a shift towards a more efficiency-oriented public sector, taking inspiration from private sector management methods, and particularly the theories of Michael Porter, who saw organisational strategy as being driven by competition.[31] The Singapore government implemented policy reforms in the healthcare system to incorporate more private-sector mechanisms and entities. This involved the corporatisation of hospitals (thereafter called "restructured hospitals") and the promotion of competition between them, based around four guiding principles: free choice; cost sharing for service users; market competition; and government-funded services for those who could not afford to cover their own care.

Public hospitals were encouraged to compete in attracting Class A and B1 patients – those for which they could earn the highest profit margins.[32] While this resulted in increased performance, it also led to a rise in costs as hospitals competed on comfort and niche services to attract high margin patients. They were also encouraged to attract overseas patients (ie people visiting Singapore for the purpose of medical tourism).

In an attempt to get the best of both worlds – embracing both centralisation and decentralisation – MOH split restructured hospitals into two clusters in 2000: Singapore Health Services and National Healthcare Group. Each cluster included hospitals, ambulatory services and specialist centres, and was constituted as a not-for-profit organisation. The results were broadly positive: the clusters realised significant aggregate savings and unified record systems enabled better vertical integration between local services. However, the large size of the clusters also made governance more complex and rendered decision-making less efficient. Hence, the MOH later increased the original two clusters to six, each with a more formalised set of frameworks covering its relationship with MOH and stipulating the types and levels of care to be provided.[33]

However, as the population aged and specialist services proliferated, it eventually became clear that the six clusters were too small to be able to offer all services independently and efficiently, or to tackle new health strategies focused on ageing-in-place and community-based health initiatives. As a result, the six clusters were reduced to three in 2017: the Central (National Healthcare Group); Eastern and Southern (Singapore Health Services); and Western Clusters (National University Health System). While each of the three public healthcare clusters comprises hospitals, national specialty centres and government primary care clinics, they have also been tasked by MOH to become the "health managers" of all residents who live within their catchment areas. To this end, the clusters received funds to support community healthcare initiatives such as community nursing,[34] Healthier SG[35] and Age Well SG.[36]

Reconciling Diverse Hierarchies: Creative Developmental Challenges

Though the problem of finding the correct organisational structure at any given time can only be solved through experimentation, there is often a tendency among staff and service users alike to see continual change

[30] Chandrashekhar Sreeramareddy and Tamysetty Sathyanarayana, "Decentralised versus centralised governance of health services," *The Cochrane Database of Systematic Reviews* 2019, no. 9 (2019).
[31] Michael Porter, *How competitive forces shape strategy* (Macmillan Education UK, 1989).
[32] Kandiah Satkunanantham and Chien Lee, *Singapore's health care system: What 50 years have achieved* (World Scientific, 2015).
[33] Kandiah Satkunanantham et al, "State of Health: 2003-2012," Ministry of Health, 2012.
[34] Community Nursing is a national programme wherein public sector nurses are deployed by the clusters to various day care and active ageing centres in the community in order to deliver free basic nursing aid and personalised health and lifestyle advice.
[35] Healthier SG is a national initiative that aims to help all Singaporeans take steps towards better health and quality of life.
[36] Age Well SG is a national programme led by the Ministries of Health, National Development and Transport to support seniors to age well in their homes and communities by promoting physical activity, social connections and care within their communities.

as an admission of repeated failure or a sign of confusion within the leadership – rather than a process of incremental improvement. Communication, therefore, is vital to avoid losing their buy-in and commitment.

A major challenge faced by SACH during the repeated clustering exercises was the emergence of dual hierarchies as a result of the creation of new clusters. Unlike the other clusters based around government-owned public sector entities (eg restructured hospitals, national specialty centres, polyclinics, etc), the Eastern Health Alliance (EHA) included SACH and The Salvation Army Peacehaven Nursing Home as founding members.

In this new arrangement, SACH had to adapt. From reporting only to the SAMH board as required by its incorporating ordinance, SACH also had to maintain ties with the MOH-constituted board of the EHA and formal organisational linkages with the EHA management. Once a link in a single chain, Dr Loh became a point of contact between his own board and the EHA management, providing information and feedback to both about the other's priorities. Over time, this feedback and feedforward mechanism became pivotal in the EHA's pioneering role in many community care and age-in-place initiatives, such as GPFirst,[37] Neighbours Programme[38] and CareLine,[39] that would later be replicated by the other clusters.

Leadership Through Challenges

The SACH leadership worked out how best to communicate the implications of the sector restructuring to its board members, staff and stakeholders such as donors, the Anglican churches, and long-term clients and patients. They found that being a charity and a private organisation worked to their advantage in this case, as they could respond quickly and pivot as necessary. As Dr Loh explained: "One thing that works in our favour is that our teams are smaller. We don't have large complex structures nor layers of administration. It's very flat here out of necessity. It means we often have to multitask but that also makes us more agile."[40]

Over time, the team began looking into ways to carve out a new niche for SACH within the restructured health system. Notably, they leveraged their ties with the growing stable of services within SAMH (ie the addition of several St Andrew's Nursing Homes, St Andrew's Senior Care Centres and St Andrew's Autism School and Day Centres) and with the psychiatric rehabilitation services within SAMH's sister organisation, Singapore Anglican Community Services. This helped SACH to establish a stronger place in the government's wider strategy of integrating healthcare policy more deeply with social, employment and community policies, as well as develop pathways for vertical integration and become more holistic in the care provision.

With many eyes on SACH in the context of the EHA experiment, SACH management believed that it was essential to make the CGH-SACH partnership the centrepiece of the EHA cluster. To this end, SACH worked with CGH on several groundbreaking projects:

1. Establishing the Integrated Building: a shared hospital block in which both hospitals operate wards cooperatively, integrating acute hospital and community hospital care;
2. Creating sub-acute care and inpatient palliative care wards for the first time in a community hospital;
3. Pioneering direct admissions from an acute hospital's emergency department into a community hospital, bypassing acute hospital admissions; and
4. Being the first community hospital to provide palliative home-based care and operate active ageing centres.

[37] The GPFirst programme encourages people with mild to moderate medical conditions to visit their general practitioners first, rather than going directly to the Emergency Department.
[38] The Neighbours for Active Living (Neighbours) programme encourages volunteers, friends and neighbours to help with the health care and social needs of high-risk residents within their neighbourhoods.
[39] CareLine is a 24/7 personal care telephone service providing health and social support to seniors.
[40] Loh Yik Hin, interview.

SACH's goal as a community hospital was to provide a "safe harbour" to enable staff to come up with novel ideas that would propel SACH forward. Much time and resources were set aside for this. Simultaneously, the EHA helped to provide the right combination of incentives and support for the development of these new capabilities. Thus, as an EHA member, SACH staff felt they had a stake in the provision of good healthcare services to the whole of the eastern region.

Declustering: The Transition Challenge (ie Moving from One System of Value to Another)

When the clusters were later downsized to three, the challenge was how to continue to reap the benefits that had emerged from the EHA experiment as well as to communicate MOH's reasons for the re-clustering to the board, the staff and stakeholders. To achieve this, CGH and SACH decided to build on many of the programmes and services established during the EHA days while helping stakeholders understand the healthcare shifts for which MOH was preparing.[41] If this had not been done thoughtfully, the staff would easily have become disoriented and might have lost faith in the future of the organisation and its leadership.

Funding Changes and Build-Own-Lease

Healthcare is particularly susceptible to Goodhart's law: "When a measure becomes a target, it ceases to be a good measure." As soon as a target is set, organisations within the sector begin optimising towards it, rather than to produce the benefits it was originally intended to measure.[42]

Consequently, it can often be useful for governments to change healthcare financing systems periodically, not necessarily because any given system is "better" than the others, but simply because the effectiveness of any reward system will decay over time as those subject to it invent reward hacks to maximise their gains.[43]

Singapore is no different. In recent years, the state regularly tweaked healthcare financing policies to maximise efficiency and minimise costs. This means that provider organisations must always be prepared to deal with changes to their funding and be flexible in financing and providing care.

Spurs to Reform: Shortcomings in the Charity Sector

Certain key events spurred the funding reform. Firstly, a succession of revelations surrounding the financing of the National Kidney Foundation in the early 2000s. In 2004, the local press published a series of articles alleging that the organisation sold patients' personal data to the insurance company Aviva, paid management above-market salaries and installed extravagant facilities in their offices. Moreover, the management was accused of engaging in business practices with conflicts of interest and allegedly lied about their conduct when discovered. In response, the Inter-Ministry Committee on the Regulation of Charities and Institutions of Public Character was formed and the regulations governing charitable organisations were revised.[44]

In 2009, the Chief Executive Officer of Ren Ci Hospital was found guilty of misappropriating the hospital's funds by approving illicit loans, falsifying accounts and giving false information to the Commissioner of Charities.[45] Finally, in 2011, the Bright Vision Community Hospital was transferred to SingHealth ownership, following

[41] Ivy Ng, "Reorganisation of Healthcare System into Three Integrated Clusters to better Meet Future Healthcare Needs," Ministry of Health, January 18, 2017, https://www.moh.gov.sg/news-highlights/details/reorganisation-of-healthcare-system-into-three-integrated-clusters-to-better-meet-future-healthcare-needs

[42] Christopher Hood and Barbara Piotrowska, "Goodhart's law and the gaming of UK public spending numbers," *Public Performance & Management Review* 44, no. 2 (2021): 250-271.

[43] Michael Crawford, "Goodhart's law: When waiting times became a target, they stopped being a good measure," *BMJ* 359 (2017).

[44] Terence Foo, "National Kidney Foundation Financial Scandal (2005)," National Library Board, April 11, 2024, https://www.nlb.gov.sg/main/article-detail?cmsuuid=3b84ddbc-c732-4e7b-9cfe-4000b098bb5a

[45] Elena Chong, "Singapore's Ming Yi goes on trial in April for fraud," *Straits Times*, January 6, 2009.

reports that the charity that originally managed the hospital had become unable to operate at full capacity. Bright Vision thus became Singapore's first government-owned community hospital.[46]

The Build-Own-Lease (BOL) Model

The state implemented a policy under which new ILTC healthcare facilities would be developed under a Build-Own-Lease (BOL) model. Under this system, the state would build and own healthcare facilities, then lease them to providers for 3+3+3-year terms. This contrasts with the previous model, under which the government would fund 90% of the cost of construction of an ILTC healthcare facility, with the charity providing the remaining 10%, based on a negotiated allocation (instead of competitive public tender) with no upfront restriction on the duration of the charity's right to operate.

Under the new policy, each lease would be based upon a tendering process, factoring in both costs and quality of care provision. This was intended to ensure service providers would maintain high quality care at reasonable costs throughout the duration of their lease. Under the BOL model, beyond the nine initial years, the state would release a new public tender and the incumbent provider would need to compete with other tenderers to win the right to operate for another nine years.

Not everyone within the system favoured the change. For instance, some pointed out that such a model could discourage capital investments in facilities, given the risk that the incumbent may lose the right to operate. Moreover, the uncertainty, while improving performance, also increased staff stress. Dr Loh shared:

> *Executive Directors of each nursing home are on their toes all the time, because they know that any black mark or any adverse situation will count towards that whole record of the nursing home. So, the model does achieve its intended purpose. The downside would be the uncertainty to the provider and possibly the added administration that goes into a major tendering out exercise*.[47]

SACH, however, decided to "make lemonade from its lemons" and gamely reconfigured itself to grow a portfolio of these BOL nursing homes. It planned to have a stable of eight such nursing homes by 2027. This will make SACH one of the largest providers of residential nursing home care – enabling it to have a significant impact in the community and on nationwide standards of care.

Financing and Tendering Reforms to Maximise Efficiency

In the early 2000s, the state subsidised hospitals based on the number of beds occupied per day over the course of a year. However, under this system, there was no incentive for hospitals to shorten the average length of patients' stay. Consequently, the government began experimenting with a block budgeting system, with hospitals receiving standard yearly funding amounts based on historical costs and nominal inflation.

This was later paired with a US/UK-style "bundling" system. Under this scheme, providers would be compensated on an episode-of-care basis for certain treatments (eg heart attacks or strokes). Over time, the block budget concept was expanded. The state provided block payments to each cluster, which in turn, distributed the block payments to the constituent facilities and services.

Where the BOL system had pushed ILTC providers into greater competition with one another, the planned expansion of block budgeting to community hospitals increased the need for cooperation, requiring careful adaptive leadership change. As Dr Loh put it:

[46] Salma Khalik, "SingHealth asked to take over Bright Vision Hospital," *Straits Times*, April 1, 2011.
[47] Loh, interview.

> *This change, from direct per diem funding by MOH, to block funding through the clusters, requires operational and financial data to be reviewed and parsed through carefully. Then there needs to be joint discussions on disbursement mechanisms, performance indicators and the like. Key to success is having a joint vision of what needs to be done collaboratively for the community and patients, a funding system that is fair and progressive and has a degree of give and take.*[48]

Organisational Responses: The Activist Challenge

While these changes were certainly challenging, the management team did not see them in negative terms. They understood that if the healthcare sector is to function efficiently, it was necessary to carefully balance incentive structures to maximise performance – the goal being to provide the best possible service to patients.

The SACH leadership strove to meet both the increased competitive pressure and the new obligation to cooperate with cluster organisations for fund distribution by evolving to become indispensable. As Dr Loh said:

> *We are always looking at our own performance and outcomes. We compare them with our compatriots and benchmarks, and we try to do better. On top of manpower shortages throughout the sector, the public sector has much better access to skills, staffing, facilities and equipment. On the other hand, we have social capital, the goodwill of the public and our constituents. Still, it is a huge challenge. Internally, we've had to do a major rethink about our own strategic plan. We have three main aims for the next four years: to be a provider of choice, a learning organisation and to be an employer of choice. These are all very lofty goals, but they give us a focus and they invigorate the staff. We feel that with our values, unique characteristics and strengths, we add [value] to the overall system and make a real difference.*[49]

While, as mentioned above, the SACH did not consider itself a lobbying organisation, it embraced its capacity to influence the future of the sector through networking and interactions with MOH and other organisations. It also harnessed synergies within its own SAMH and Singapore Anglican Community Services cluster and the wider social-health environment to best position itself and improve overall system performance.

Changes in Domain Responsibilities

As Singapore's demographics and public health demands changed, the government instituted policy changes to improve vertical integration in healthcare, while simultaneously redefining healthcare to include social and economic dimensions – rather than merely curing illnesses and healing injuries. This led to changes in the domains in which community hospitals were expected to provide services.

Vertical Integration

While the organisations involved in the clustering and block budgeting initiatives often chose to manage both exercises in a relatively egalitarian and horizontal manner, via dialogue rather than hierarchy, other policy changes created new channels of vertical integration, albeit not necessarily in strictly hierarchical forms.

Notably, the government launched the Healthier SG initiative, under which providers would focus more on preventive health, social prescribing and better chronic disease management.[50] Among other goals, the programme aims to strengthen primary care by integrating general practitioners more closely with the healthcare system.

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[48] Loh, interview.
[49] Loh, interview.
[50] Chuan De Foo et al., "Healthier SG: Singapore's multi-year strategy to transform primary healthcare," *The Lancet Regional Health–Western Pacific* 37 (2023).

Residents are encouraged to enrol with a family doctor who will provide continuous and comprehensive care, while – if necessary – working with local hospitals and other services to provide enhanced continuity of care. Residents would receive personalised health plan created by their primary care doctor, in cooperation with other services. This would require significantly improved vertical coordination between healthcare providers.

Community-Based Healthcare Services

While MOH was pushing for greater vertical integration of healthcare providers, it was also working to expand the definition of "healthcare" adopted by each organisation in the chain. The aim was to make sure that health problems were treated at the lowest possible level, and that healthcare providers take greater responsibility for non-medical factors in health and quality of life. This included initiatives such as social prescribing: "an intervention aimed at improving wellbeing by linking individuals to community assets with a view to optimising their social determinants of health."[51] Particular attention was paid to elderly people, given the known benefits of such approaches for "populations who experience loneliness, social isolation, suffer from multiple co-morbidities and frequently utilise healthcare services."[52]

In 2015, the National Action Plan for Successful Ageing began incorporating health promotion and healthcare initiatives with lifelong learning, employability, social inclusion and housing strategies, among others. The plan aimed to reinforce the social infrastructure to enable older adults to continue participating in society. This meant expanding healthcare into community settings – focusing not just on physical and mental health, but also on social activities and physical infrastructure elements that promote strong social networks.[53]

The growing importance of social factors in healthcare provision was both a challenge and an opportunity for SACH. The SACH management decided to take advantage of its unique position to become a change leader within the shift to greater community-based care. To this end, SACH's services have been woven into a strategic matrix and continuum for integration and coordination. As Dr Loh expounded:

> *We used to operate as two NGOs: St Andrew's Mission Hospital, and our sister organisation, Singapore Anglican Community Services, which was doing socially focused services as opposed to healthcare. But in reality, the work has always overlapped. Now that the social work [aspect] of ageing has been transferred to the MOH by the Ministry of Social and Family Development, we are looking at not just the medical aspects of ageing, but the social aspects as well. The coming together of the two charities has enabled [better] efficiency [through] sharing of resources, economies of scale and a singular direction.*[54]

In these great transitions, the pressure of working in collaboration and competition with public and private providers pushed staff to move quickly and innovate in order to maintain their niche within Singapore's healthcare landscape, particularly within the community care sector. The staff knew that the pace of change would likely be sustained, and that they too would have to evolve to continue providing the quality of care that Singaporeans had come to expect. As Dr Loh explained:

> *A social charity already has its work cut out for it and has to manage challenges; but here at the coalface of healthcare, we are forced to go at a very fast pace because of these rapid changes. And I think the Ministry [of Health] knows that time is not on our side, and hence, the timelines are short. If we want to have a place in community care, we follow that speed of change. It's all down to relevance.*[55]

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[51] Kheng Hock Lee et al., "Implementation of social prescribing: Lessons learnt from contextualising an intervention in a community hospital in Singapore," *The Lancet Regional Health–Western Pacific* 35 (2023).
[52] Kheng Hock Lee et al., "Implementation of social prescribing".
[53] Yeo Wen Qing, "Response to Questionnaire," Singapore Ministry of Health, no date, https://www.ohchr.org/sites/default/files/Documents/Issues/OlderPersons/Practices/States/Singapore.pdf
[54] Loh Yik Hin, interview.
[55] Loh Yik Hin, interview.

Conclusion

While keeping up with a fast-moving and ever-changing sector can often be a complex and uncertain business, Dr Loh believes that this is fully compatible with SACH's ethos: "Purely from a religious point of view, God is a God of order. Out of the void, he created order… So, it's not anathema to the faith." Dr Loh feels that SACH's ethos of seeking the welfare of the community has been key to the organisation's continued relevance.[56] The management made a conscious choice to embrace change and lead the way in driving the continuous innovation and high performance of Singapore's community care sector.

Discussion Questions

1. How did the various stakeholders react to the introduction of means testing? How did this affect SACH's response?
2. Describe SACH's leadership approach during the clustering and re-clustering exercises. What aspects are similar to your own leadership style? What are different?
3. If you were part of SACH's leadership team, how would you deal with each of the four sector changes (means testing, clustering and re-clustering, funding changes and build-own-lease)?
4. SACH Chief Executive Officer Dr Loh Yik Hin referred to Dean Williams' theories of leadership. This approach breaks down leadership into six types (see: https://platformc.org/sites/default/files/2019-08/Six%20adaptive%20challenges%20checklist.pdf). Can you think of specific occasions on which your organisation had to face one of these challenges and how you responded?

[56] Loh Yik Hin, interview.