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2008

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Citation

Akhileswaran, R and Mee, Seet Ai. Resuscitating a Healthcare Charity. (2008). *Social Space*. 54-59.
Available at: https://ink.library.smu.edu.sg/lien_research/6

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RESUSCITATING A HEALTHCARE CHARITY

When government funding policies change, voluntary welfare organisations that depend largely on subsidies to run their services can find their survival at stake. Dr R Akhileswaran and Dr Seet Ai Mee present the case study of HCA Hospice Care.



All photos courtesy of HCA Hospice Care.

HCA Hospice Care, a voluntary welfare organisation (VWO) that provides hospice home care to patients with a life-limiting illness (defined as a life expectancy of one year or less), was registered as an independent organisation in Singapore in 1989.

Since its inception, HCA (it was called Hospice Care Association till 2005) has been the largest hospice home care service provider in Singapore. As the first hospice organisation formed in Singapore, it has always served 75 percent or more of all hospice patients across the island. The number of new patients with life-limiting illnesses registered in one year and cared for in their own homes increased from 224 in 1991 to 2,759 in 2002. In fact, in 2002, HCA looked after about 350 to 375 patients on a single day. The total number of patients registered in 2007 was 3,302 and the number of patients cared for during a single day was between 750 to 800.

For the first 10 years, although the number of HCA's patients grew exponentially, the staff of nurses and doctors did not increase proportionately. In 1990, HCA had one full-time doctor and two full-time nurses, which increased to two and 13 respectively by 2000. Locum doctors helped look after the patients during this period. In 2007, the number of full-time doctors had increased to five and full-time nurses to 24. These low recruitment numbers are explained by the fact that hospice palliative care is not an attractive medical or nursing career choice.

HCA's home care programme is funded partly by the Ministry of Health (MOH) and the National Council for Social Service (NCSS). Between 1990 and 1996, the Ministry gave HCA a fixed grant. From 1997, the funding was based on the number of patients cared for per year, but as we shall see, the Ministry's mode of funding changed radically in 2002.

The years 2000 to 2002 were difficult ones for HCA. Financial constraints created high staff turnover and a drop in the quality of care.

Financial Turnaround

Between 1990 and 2004, the NCSS funded HCA's programmes using a deficit-funding model.¹ In 2000, the Council adjusted its funding policy and reduced the amounts it paid out. In 2005, HCA opted to be funded by the NCSS' 25 percent Grant Funding model: in other words, HCA had to raise funds to cover any shortfall

in its budget after the Ministry and NCSS had dispersed funds. Any excess funds could be retained by HCA.²

In 2001, HCA's operating expenditure was S\$2.4 million. But the change in funding policy cut this back to S\$650,000. Coupled with a sharp drop of S\$450,000 in unsolicited and designated donations, HCA ended up with a net deficit of S\$690,000. This contrasted with the S\$1.06 million surplus the previous year.

The operating results for 2002 showed a further deficit of S\$20,000, while 2003 saw a shortfall of S\$71,000. If the negative cash flow had continued, HCA's financial reserves would have reached zero within 18 to 24 months. HCA's then Honorary Treasurer recommended a review of its entire funding policy.

At the same time, the MOH also changed its funding basis from per patient per year to one based on per doctor or nurse home visit. These changes increased HCA's financial problems and put additional strain on the staff who were forced to do the means test on the patients on top of their regular duties.

From 1 January 2002, the MOH implemented patient means testing as the basis for funding. The test was calculated based on the total annual income of the patient and his family divided by the number of dependants.

In 2002, HCA conducted a survey to gauge the impact of means testing on its funding. Due to the increasing reluctance and resistance in the staff to implement it, the survey results showed that less than 30 percent of patients were successfully means-tested. This resulted in an almost 50 percent reduction in funding from the MOH. On the basis of the survey results, HCA wrote to the Ministry to postpone the implementation of means testing but the request was turned down.

HCA decided early on that it would continue to provide its hospice home care service free of charge to patients as it did not want patients and caregivers to refuse or delay needed service due to a patient's financial constraints. Patients or their caregivers who refuse to do the means test will continue to receive the service. The idea is not to impose any additional burden on the families during the emotionally challenging final phase of the patient's life. Grateful family members have always donated voluntarily to HCA for the services they received. HCA's calculations have



HCA's Student Education Programme participants at HCA's Day Care Centre.

shown that the sum of the voluntary donations are equal to or more than the sum that would have been received through charging for the home visits.

Amidst these funding and staff issues, there was a perceived slide in the quality of patient care. It was time for a change: a classic 'do or die' situation.

In the healthcare 'business', the first step in the successful management of a patient is an accurate diagnosis. A common consensus was that unless HCA achieved a quick turnaround within two years, it would not survive. A good 'clinician' who could not only diagnose the problem but also conduct the necessary investigations and initiate appropriate treatment was urgently required. Fortunately, the correct person was identified and persuaded to take on the case.

The new president of HCA, Dr Seet Ai Mee, who took over its reins in 2003, was a visionary who wasted no time in diagnosing and tackling the problem. A team of new Board members and herself scrutinised HCA's organisational structure, the roles and functions of the clinical and administrative staff, the funding policies and accounts. Negotiations with various funding agencies followed, and staff changes and re-

alignment of various functions were quickly instituted.

The Board's Monitoring Role

Jill Mordaunt and Chris Cornforth have shown that in cases of successful turnarounds of non-profit organisations, the boards in question have, in fact, run counter to the conventional wisdom that the board's role is mainly strategic, or concerned merely with 'policy governance'.³ At least for short periods of time, these boards have had to take a very hands-on approach, sometimes even taking over aspects of the organisation's management. Apart from skills, such as leadership and team working, those leading the turnaround process also need time, commitment and emotional resilience. The case studies showed that successful turnarounds demanded a lot of time from board members and could be very stressful as conflicts had to be dealt with and difficult decisions made that affected people's jobs, values and lives. The work done by HCA's council members virtually mirrored the conclusions of that research.

Various HCA council members with a variety of expertise chaired newly formed committees for HR, medical and professional audit, public relations and fundraising and they helped in closely monitoring the different departments of

In the healthcare ‘business’, the first step in the successful management of a patient is an accurate diagnosis.

HCA. Senior council members and management staff met personnel in the MOH and NCSS to discuss the changes needed to achieve a turnaround within two years. The funding agencies agreed to give HCA a free hand in implementing the changes. This was an important concession as the support of the funding bodies and their confidence in the organisation was essential for going ahead.

External consultants conducted a change management seminar on a pro-bono basis for HCA staff. This provided a platform for staff to air their concerns about means testing, lack of manpower, scarce funding, poor internal communication and the quality of care of the patients. The interaction in the forum with the staff enabled the council to identify the strategic thrust of its work for the coming years.

More Cost-effective Organisation

As the MOH's funding policy was based on patient visits, the total number of home visits by doctors and nurses was a key component for HCA's financial sustainability. Compared to the average of four home visits per day in 2002, HCA's clinical staff was encouraged to increase the visits to an average of 5.5 home visits per day by each nurse and six home visits per day by each doctor. This was a major mindset change that had to be carefully implemented. The staff had to be shown that they would be able to achieve the same or better quality of patient care by planning their time and visits carefully.

To help the doctors and nurses plan their home visits, patient categorisation into stable and unstable patients and further sub-categorisation was implemented. This helped clinical staff to prioritise their home visits, and also helped in following up the more symptomatic and sick patients in a systematic way. This not only helped improve patient care but also enabled the clinical staff to achieve the minimum number of visits that was needed per day.

As the HCA turnaround was being planned, a review of all its work processes threw up areas which could be made more cost-efficient. For instance, as HCA's patients are spread all over Singapore, its clinical staff spent a lot of time and money travelling to and from its headquarters to the patients' homes. It was also evident that despite doing hospice work in the community for more than a decade, HCA was not a well-known name. In response, HCA launched its 'Hospice into the Community programme' in 2003. The programme had five objectives:

- Create an office space for each HCA clinical team in the community so that the travel time for the staff is decreased and more time is spent with the patients.
- Have a presence in the community heartlands so that caregivers can identify HCA and have an easier access to its staff when required.
- Be the centre for training hospice caregivers in the community.
- Liaise with the other non-governmental organisations in the community so that the patients could benefit more easily from the required services and to avoid duplication of services.
- Connect with doctors and healthcare providers in the community.

With its financial constraints, HCA could not have launched this programme on its own. Fortunately, the Lien Foundation agreed to fund the first four satellite centres as well as the administrative costs. We are pleased to report that the programme was successfully implemented within the planned time frame of four years.

Staff Turnaround

In August 2000, HCA's then medical director resigned and a suitable replacement could be made only in May 2001. During the interim period, part-time clinical leadership for the medical and nursing staff was provided by HCA's council members who were palliative



HCA Home Care doctor and nurse in patient's home.

medicine specialists. The administrative area of the organisation lacked experienced staff. A rift between the general administrative staff and the clinical staff resulted in the deterioration of internal communication between them. This also led to a large number of staff being ignorant of the actual state of affairs in the organisation. Staff morale headed south.

The interim HCA president who took over the reins of the organisation's governance in 2000 was busy in his clinical practice and could not devote enough time to set directions for the staff. In 2001, pay rises were put on hold due to funding issues, and this continued for another year. Predictably, this led to a predictable further drop in staff morale that, in turn, led to a high staff turnover.

A new human resources sub-committee reviewed many of the urgent staffing issues and implemented the necessary changes for all levels of staff. A salary review brought salaries up to par with market rates. HCA's Vice-President, who runs an international HR agency, volunteered her firm to provide

leadership coaching to the medical director, and the president volunteered to mentor him. This scheme proved very effective and it helped a good leader emerge from within the organisation.

As Stephen E Clapham et al have stressed, the CEO's role is critical in reversing a company's decline by "replacing denial with dialogue, blame with respect, isolation with collaboration, and helplessness with opportunities for initiative".⁴ They also indicated that the replacement of the CEO is a common but not essential element of an organisation's successful turnaround. After all, the existing CEO is already familiar with the organisation's culture and staff compared to a new manager or CEO.⁵ In HCA's case, its CEO, then called the medical director, had already been with the company for a year. The HCA Council decided not to replace him, opting instead to coach him for better leadership and enlarged tasks and responsibilities.

Financial support was also provided for training. Regular multi-disciplinary team meetings and

tests helped clinical staff upgrade their skills and knowledge. With good training opportunities in place, more local nurses and doctors, who previously were very reluctant to come into this field of work, started taking up jobs in HCA.

Appropriate recognition at HCA functions and nominations for national awards also increased staff morale. HCA nurses and doctors have been awarded the Healthcare Humanity Awards every year for the past four years since the awards were instituted by the National Healthcare Group. Special increments for staff obtaining additional relevant certificates, diplomas or degrees have also become the norm.

A part-time nursing director from a sister hospice organisation and a new nursing officer were recruited to give the necessary leadership for the nurses. A COO with a healthcare background and experience was also recruited to replace the executive manager and strengthen the administrative and financial management. This helped in addressing the poor internal communication issues and differences among the administrative and clinical staff at the time.

A new category of staff called Social Work Assistants was put in place to help implement the mandatory means test. As this was not budgeted for, the approval of the NCSS was obtained before recruitment was initiated. This was an important step as it transferred the burden of the unpopular means testing from the shoulders of the clinical staff to dedicated staff who were trained specifically to interview patients and their families.

Afternoon shifts and Saturday duties were introduced so that the nurses could meet some of the caregivers after office hours, and for administrative staff to be available when caregivers return equipment. Initially, these changes were not very popular with the staff and they were not easy to implement, but once the staff saw the rationale and usefulness of this, the majority accepted and followed them.

Turnaround Achieved

HCA's turnaround can be discussed in terms of its similarity or dissimilarity to corporate turnarounds. Companies that overcome their troubles and returned to match or exceed their pre-downturn performance are known as turnaround firms. HCA falls into that category of firms.

With the help of focused guidance from its senior management and strict implementation of the

recovery plan, HCA's turnaround was achieved by 2004. This period of 13 months was well within the projected time frame of 24 months. Indeed, 2004 saw HCA record a surplus of S\$263,183 compared to a deficit in the previous two years. Since then, HCA has been growing steadily and meeting its planned goals and objectives.

At the risk of generalisation, the lessons learnt from HCA's experience in turning around a struggling NPO were:

- Have good governance practices in place, with a strong and active council to monitor this constantly.
- Staff training and development are vital for staff motivation.
- Recognise and reward good work.
- Implement achievable targets and monitor them with regular assessments and reviews.
- Focus on the core competencies and build your growth around them.

HCA may have turned the corner in 2004 and continued to grow since then. But the challenge for the future is to keep the growth curve moving upwards. □

¹ The deficit funding model of the National Council for Social Service is based on the actual expenditure for a budget submitted earlier. The Council gives HCA more if the expenditure was more, and less if the expenditure was less. It would also fund the difference in the expenditure after deducting the Ministry of Health subsidy and donations.

² The National Council for Social Service's 25% Grant Funding Model gives HCA up to a maximum of 25% of the operating costs. Currently, HCA receives about 40-45% funding from the Ministry of Health. For the remaining 30-35%, HCA raises funds and retains excess funds raised as reserves. The excess could not be retained before HCA went into this mode of funding and had to be returned to the National Council. This explains why HCA only began fund raising after adopting this model.

³ Jill Mordaunt and Chris Cornforth, "The Role of Boards in the Failure and Turnaround of Non-Profit Organizations", *Public Money & Management*, (Aug 2004) Vol. 24 Issue 4, pp. 227-234

⁴ Stephen E. Clapham et al, "CEO Perceptions and Corporate Turnaround", *Journal of Change Management* Vol. 5, No. 4 (December 2005), pp. 407-428

⁵ Conor O'Kane, "Management Styles of a Newly Appointed Leader in a Turnaround Context", *The Irish Journal of Management* (2006) Vol. 27 Issue 1, pp. 111-144



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