



Beyond Hospitals to Communities. Beyond Healthcare to Health.

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Our shared reality

Health needs are shifting and the pace of change is accelerating.

Ageing

Comorbidities
Complexities

Chronic
Diseases

Our
Populations

Our shared reality

Health needs are shifting and the pace of change is accelerating.

**Acute
Centric**

**Hospital
Based**

**Our Health
Systems**

**Illness
Focused**



SINGAPORE GENERAL HOSPITAL

This is not simply a capacity problem.
Design and alignment matter.

Designing care around population needs.

Population Health & Integrated Care

- Life-course approach linking hospital care with primary care and community/social resources.
- Place-based multidisciplinary teams (e.g. Community Health Posts, Urgent Response Teams) coordinating care closer to home.
- Trigen initiatives with >3,500 youth volunteer placements and 20,000 patients supported in next 3 years. Pilot study reduced LOS by 2.87 days.
- Proactive management of high utilisers, reducing hospital long-stayers by 15% over a year.



Hospitals should not be the default.

SGH@Home

- A hospital-at-home model that delivers acute inpatient-level care at home through multidisciplinary teams, telemedicine, and remote monitoring.
- Will expand to 60 beds in 2026.

Apr'24 to Sep'25:

\$17.7M

Cost avoided arising from

8,772

bed-days saved

=

+1,350 patients

FY26 Projected:

\$23.7M

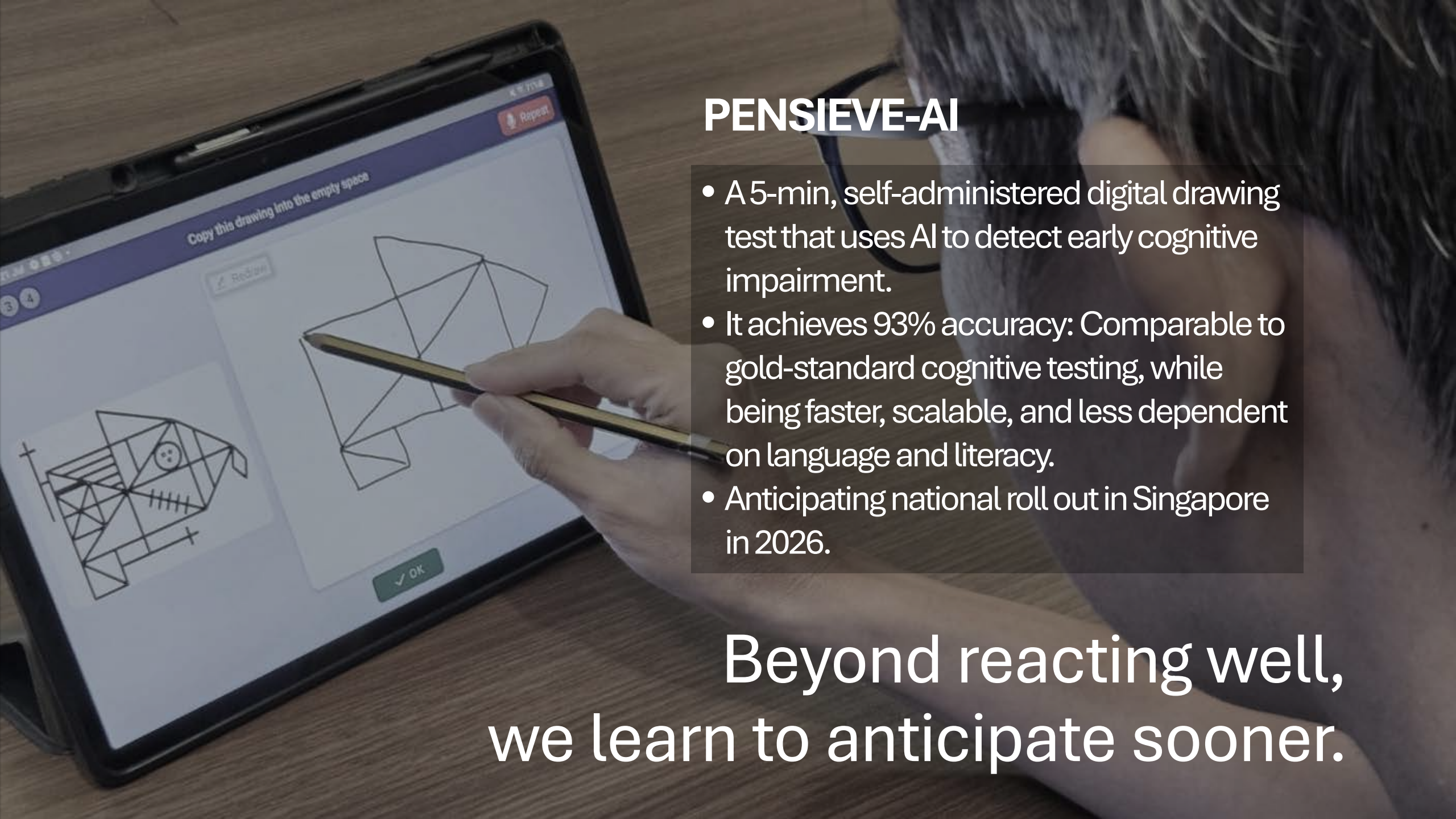
Cost avoided arising from

11,745

bed-days saved

=

+1,806 patients



PENSIEVE-AI

- A 5-min, self-administered digital drawing test that uses AI to detect early cognitive impairment.
- It achieves 93% accuracy: Comparable to gold-standard cognitive testing, while being faster, scalable, and less dependent on language and literacy.
- Anticipating national roll out in Singapore in 2026.

Beyond reacting well,
we learn to anticipate sooner.

Aligning incentives with our goals

Healthier SG

- Healthcare clusters as population health managers taking care of 1.1 – 1.6 m population.
- Providers receive per-resident funding to manage care over time than per visit.
- Aligns financing with continuity and prevention.



A Different Approach to a Familiar Patient

Elderly with Chest infection + Heart Failure + Diabetes + Mild Cognitive Impairment

Identify risks earlier
with pop health
stratification and
anticipatory tools

+

Recovery at home
through SGH@Home
with medical and
nursing support

+

Social prescription
through collaboration
with community
partners

Better functional recovery, confidence, fewer readmissions

From reacting to illness
to sustaining health.

