

Community care at scale: Singapore's Active Ageing Centres 2.0 as a model for healthy ageing

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ABSTRACT

Introduction: Singapore's Active Ageing Centres (AACs) are central to the national strategy to enable older adults to age in place through preventive, community-based services. Under the Healthier SG and Age Well SG reforms, AACs are being transformed from targeted social support points for vulnerable seniors into population-wide health-social hubs, with a goal of reaching 80% of seniors by 2025.

Methods: This policy commentary draws on national policy documents, programme reports and practitioner insights to examine the evolution and implementation of AAC 2.0, and to identify emerging opportunities and system-level challenges.

Results: We highlight governance shifts, regional coordination mechanisms and health-social integration strategies. Innovations such as thematic centres, peer-led programmes and extended operating hours aim to engage diverse senior populations. Key challenges include centralised policy design, limited community voice, workforce constraints and fragmented coordination. Promising pilots, such as integrated wellness hubs, are underway but require greater alignment, relationship-building and local adaptation to scale.

Conclusion: We propose strategies to strengthen community partnerships, invest in trust-based engagement and embed robust evaluation frameworks informed by implementation science. Singapore's experience offers actionable insights for health systems seeking to design scalable, community-rooted models for healthy ageing that integrate social and healthcare services.

Keywords: Active Ageing Centres, community-based care, health policy, integrated health and social care, population health, public health

CLINICAL IMPACT

What is New

- Singapore's Active Ageing Centres (AACs) are transitioning from social care nodes to integrated health-social hubs under Healthier SG and Age Well SG.
- AAC 2.0 introduces thematic centres, peer-led programmes and extended hours to better engage diverse senior populations.
- Building trust, community partnerships and implementation science are key enablers of successful scale-up.

Clinical Implications

- Scalable, community-based ageing models must balance standardisation with ground-level adaptability and relational trust.
- Multisector collaboration, decentralised planning and robust evaluation frameworks are critical for integrated, person-centred care.
- Lessons from Singapore's AAC 2.0 may inform global efforts to build sustainable healthy ageing systems in rapidly ageing societies.

INTRODUCTION

Populations are rapidly ageing, with 1 in 6 people projected to be 60 years or older by 2030 worldwide.¹ This has profound implications for health systems already strained by chronic diseases and escalating costs.² To address these pressures, countries must

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urgently transition from reactive, hospital-centric models to proactive, preventive, community-based approaches.^{3,4} In line with the World Health Organization (WHO)'s vision for healthy ageing, countries must strengthen community systems that enable older adults to live healthily, independently and meaningfully within their communities.⁵ This demographic transition calls for a fundamental and anticipatory reimagining of how health systems engage older adults by shifting from hospital-based responses after illness and complications set in, to community-rooted and preventive approaches.

Active Ageing Centre (AAC) models

Community-based AACs have emerged globally as a key strategy to support the well-being, independence and social inclusion of older adults. A 2020 review found that similar models exist in countries such as Australia (Day Clubs), Bahrain (Day Care Centres), Canada (Senior Centres, Adult Day Services), Czech Republic (Senior Centres) and Israel (Day Centres), and these have achieved commendable results in terms of enabling the elderly to age well in place.⁶ These centres typically serve 4 main purposes: to provide social and preventive services, support seniors' continued independence, meet health and daily living needs, and offer respite to caregivers. Consequently, older adults are more socially connected, are more engaged in structured daily activities that give them a sense of purpose after retirement or bereavement, receive and participate in preventive care, and therefore have better physical and mental health.⁷⁻¹³

In Singapore, the earliest model—Senior Activity Centres (SACs)—was introduced to address social isolation, frailty and gaps in community-based eldercare among low-income seniors.¹⁴ These centres offered basic daily activities such as group exercises and board games, alongside befriending services, wellness check-ins and referrals to other services when needed. SACs also played an informal role in monitoring at-risk seniors to support ageing-in-place. Typically small in capacity and co-located within public rental housing blocks, these centres received input-based funding by the Ministry of Social and Family Development, and were operated by voluntary welfare organisations or social service agencies.¹⁴ The SAC model laid the foundation for more comprehensive, population-based approaches to community ageing services in Singapore.

Singapore's national response to an ageing population: Healthier SG and Age Well SG

As of 2023, approximately 19% of Singapore's population is aged 65 and above, and the country is on track to become a super-aged society by 2030.¹⁵ These demographic shifts have contributed to

increasing chronic disease prevalence, more complex patient profiles and greater demands on both health and social care systems.¹⁶ In response, Singapore has adopted 2 complementary national strategies: Healthier SG and Age Well SG.

Healthier SG, launched in 2023, is a major health reform initiative that anchors residents with a primary care provider and strengthens partnerships between healthcare and community actors to deliver preventive, person-centred care.¹⁷ Singapore's healthcare landscape was reorganised geographically into 3 healthcare clusters, which now serve as Regional Health Managers under Healthier SG, each accountable for the health outcomes of their assigned populations.¹⁷ These clusters oversee acute hospitals, community hospitals and polyclinics, and work closely with private healthcare providers and Community Care Organisations (CCOs) within their geographical boundaries.¹⁸ Funded on a per capita basis, healthcare clusters are incentivised to promote preventive care, appropriate care delivery and integration across the care continuum.¹⁹ CCOs deliver much of the community-based social care in this model.²⁰ Strengthening these linkages between health and social as well as hospital, primary care and community assets is essential to realise the full potential of Healthier SG's person-centred, preventive approach. Under Healthier SG, AACs support seniors in following up on their health plans through an ABC + 2S framework: Active ageing (A) programmes promote wellness and learning; Befriending and buddying (B) reduce social isolation; information and referral to Care services (C) links seniors to needed services; and Social connector for social and lifestyle interventions and community Screening (2S) facilitates early identification and follow-up for health and social risks.²¹ In Singapore, seniors are generally defined as individuals aged 60 years and above, in alignment with national ageing policies and eligibility criteria for programmes such as the AACs and public transport concessions.²²⁻²⁴ Entry into AACs is age-based, reflecting Singapore's universal approach to community ageing services. This expansion aligns with WHO's model of healthy ageing,⁴ where AACs enhance seniors' intrinsic capacity through targeted physical and cognitive health interventions, while supporting functional ability by creating an enabling environment.

The Age Well SG initiative was also launched in 2023, with fresh government funding of SGD800 million.²⁵ This initiative aims to expand the number of AACs from 119 in 2023 to 220 by 2025, with the goal of reaching 80% of Singapore's senior population,^{26,27} beyond low-income groups. As of April 2025, Singapore's AAC network has expanded to 223 centres, enabling 8 in 10 seniors to access a centre near their home.²⁸ The average daily attendance has also more than doubled, from 17 seniors in 2021 to 42 in

2023.²⁷ However, comprehensive data on population penetration and utilisation rates remain limited. Central is also the transformation of AACs into accessible, one-stop community hubs for health promotion, social engagement and care navigation.^{27,29} Singapore's AAC model has evolved over the past decade—from the original SACs, which primarily served low-income seniors in rental housing, to a population-wide AAC 2.0 model. AACs are thus expected to go beyond their original scope of services, to deliver a structured and evidence-based range of activities that span 5 key domains: social engagement, physical health, cognitive stimulation, lifelong learning and volunteerism.²⁶ This reflects a strategic shift from targeted social welfare to an integrated, preventive health-social approach that empowers all seniors to age meaningfully in the community.

Age Well SG reflects the government's recognition that ageing is a multidimensional issue requiring a multi-sectoral, whole-of-government response. Jointly led by Singapore's Ministry of Health (MOH), Ministry of National Development and Ministry of Transport, Age Well SG implements coordinated reforms across housing, transport, active ageing and care services to enable seniors to age confidently within their communities.^{21,25} Funding is now managed by the Agency for Integrated Care (AIC) rather than the Ministry of Social and Family Development through a mix of output and outcome-based targets with a small quantum allocated for ground-up pilot innovation.^{25,30} AAC services are delivered by a range of CCOs.²⁵ The Health Promotion Board, a statutory board under MOH, now supplements AAC programming with national wellness campaigns and resources.²⁵ Healthcare clusters, as Regional Health Managers under Healthier SG, also play a new, critical role in supporting AACs to integrate community social services into regional preventive health strategies. This transition of governance structures underpins a national understanding of the influence of social determinants on health. Concurrent efforts are also underway to enhance and fund the information technology infrastructure supporting AACs, to enable better client tracking, streamline health-social referrals, and improve data management and sharing between stakeholders.^{31,32}

Beyond AACs, Age Well SG also encompasses broader interventions to build age-friendly neighbourhoods and communities. These include the development of Community Care Apartments and assisted living facilities to provide integrated housing-care options, senior-friendly home retrofitting through the Enhancement for Active Seniors 2.0 programme, and estate-level upgrades under the Neighbourhood Renewal Programme and Estate Upgrading Programme.²⁵ Urban planning initiatives such as wayfinding projects and Singapore's Silver Zones

(residential areas with high senior populations that feature reduced road speed limits, etc.) also aim to create safer, more accessible environments for seniors in public spaces.²⁵

This commentary examines the early adaptation and implementation of AACs in light of recent policy reforms, explores the challenges and opportunities in strengthening community-based health-social models, and offers lessons for health and social system leaders seeking to scale integrated ageing strategies.

Challenges in implementation and opportunities to future-proof AAC 2.0

While AAC 2.0 holds strong promise as a scalable, community-based model for healthy ageing, its implementation presents several real-world challenges that must be addressed to ensure long-term sustainability and impact.

(A) The scale, frequency and speed of change needs ecosystem support

A key challenge is the increasing complexity of care models that strain the operational capacity of AACs. With the shift of care from healthcare institutions to the community setting, the responsibilities placed on AACs have been growing and are becoming increasingly complex. With Healthier SG, AACs are expected to deliver ABC + 2S, support residents in following up with their Healthier SG health plans and improve communications with primary care providers. A few months later, with the launch of Age Well SG, AACs were required to provide a suite of programmes across 5 standardised domains. This is especially challenging as many CCOs are manpower-lean organisations and may not have the ability to make frequent adjustments to their care models. As voiced by some AACs, frequent change has contributed to staff morale issues and operational misalignment. Another facet of change is the new roles and relationships between MOH, AIC, Health Promotion Board (HPB), healthcare clusters and AACs in Healthier SG and Age Well SG. These stakeholders must now align on shared system goals and delivery approaches.

A more participatory approach is needed, one that meaningfully involves AAC providers and ground staff in shaping service standards and performance frameworks, allows adaptation to local contexts, incorporates qualitative metrics to reflect care quality and community relevance, and moderates the pace of change. Such strategies are essential for keeping the model grounded, person-centred and sustainable. Existing platforms that bring stakeholders together include annual community partner appreciation events hosted by healthcare clusters, as well as AIC-led engagements on quality assurance and operational

standards. However, more can be done at both formal and informal platforms across various levels of cooperation to build the trust required to sustain such changes. For example, the Healthy, Empowered, Active Living (HEAL) Labs approach by the SingHealth healthcare cluster (a group of healthcare institutions in Singapore) exemplifies this ethos by embedding researchers in the community, engaging service providers as co-creators of locally grounded, culturally resonant interventions.³³ The Community Ageing in Place programme in eastern Singapore is one application of the HEAL Labs approach where SingHealth, AACs and government agencies come together to support older adults to age in place with interventions in the 3 pillars of built environment, health-social integration and technology.³⁴

(B) Care should integrate around the person

With the many stakeholders brought together under Healthier SG and Age Well SG, there is potential for care to be fragmented, with overlaps or gaps. Fragmented implementation where providers execute initiatives in isolation risks deepening systemic inequities in service quality and reach. This can manifest in heterogeneous referral pathways, limited visibility of services and unclear coordination roles. In parallel, MOH and AIC are also working with AACs and other stakeholders to streamline the care journey for seniors and provide more coordinated care. Within each geographical region, providers will come together to form an Integrated Community Care Provider to oversee care coordination for seniors in that region. However, it remains to be seen whether CCOs can perform this role effectively, as it will be contingent not only on capability, but also on relationships across the ecosystem. Pilot initiatives such as the Integrated Senior Health and Wellness Hubs aim to bring together stakeholders to co-create and align roles and expectations, so as to develop common referral and share care protocols between community nurses under the healthcare clusters and AAC partners. Underpinning these efforts is a trust and relationship-building process. These could be scaled up, although the current process is labour-intensive and time-consuming. Evidence from collaborative learning health systems suggests that trust and coordination can be deliberately strengthened through structured mechanisms.³⁵ Key strategies include establishing shared goals and transparent performance dashboards to promote accountability, developing enabling infrastructure such as shared data platforms and liaison roles to support daily coordination, and institutionalising cross-organisational learning forums for joint evaluation and problem-solving. Fostering reciprocity and distributed leadership where partners co-create resources and share recognition, can further build

psychological safety and sustain collaboration over time. These approaches, reflected in Singapore models such as the Integrated Senior Health and Wellness Hubs, offer feasible pathways to enhance collaboration for integrated community care. Finally, there are opportunities for HPB to play a bigger role in AAC programming. Currently, HPB programmes are hosted in AACs and may draw in participants to join other AAC activities. These include Health and Active Programme for the Young-Old,³⁶ which focuses on physical activity and healthy lifestyle habits, and Seniors Taking Extra Active Steps Daily (STEADY) Lah,³⁷ which emphasises fall prevention and balance training for older adults. Looking ahead, there could be potential for HPB to support evidence-based programme development and implementation resources for AACs to test evaluated innovative programmes that can enhance residents' well-being.

(C) Enrolment targets must leverage new strategies

While AACs are operated by non-government agencies, a substantial amount of funds for AACs originate from MOH, with AIC acting as a fund administrator to disburse funding to service providers. Tagged to AIC funding is the need to adhere to certain quality standards and policies that originate from both AIC and MOH, as well as pay-for-performance targets related to enrolment of seniors. Unlike the earlier SAC model, which focused on lower-income seniors, AAC 2.0 seeks to engage 80% of Singapore's senior population by 2025. Accordingly, the number of AACs have been scaled up. To mitigate the pressure placed on AACs, MOH has focused on building new AACs in areas where there is no existing service coverage. Additionally, the targets have been set as a proportion of the population within the AACs assigned catchment area.

Three key approaches have also been trialled to engage and enrol this new demographic, and these have allowed most AACs to hit their enrolment targets. First, some AACs have pivoted to new models to reach populations who do not traditionally attend AAC activities, particularly younger seniors, men, ethnic minorities and those residing in private housing, who may find conventional activities like arts and crafts or group exercises unappealing. CCOs such as Montfort Care have introduced thematic AACs offering interest-based programmes such as carpentry, theatre, podcasting and digital media.³⁸ Other CCOs like Brahm Centre complement these offerings with evidence-based mindfulness programmes that equip seniors with practical techniques for stress reduction and enhanced mental well-being.³⁹ These models appeal to niche but underserved populations, complementing traditional AAC models that cater to the wider population. AACs generally adopt a "no

wrong door” policy, allowing seniors to participate in programmes even if they reside outside the centre’s designated catchment area. This flexibility enables older adults to join centres offering activities that better match their interests or needs, reinforcing the inclusivity of the AAC network and its role as a community-wide, rather than geographically bounded platform for active ageing. The thematic AAC model also seeks to empower seniors as peer leaders and contributors within their communities, fostering ownership and social participation. This could serve to keep seniors engaged and participating in the AAC activities more frequently and for a longer time. Second, AACs empower seniors to take on active roles within the centres. For instance, able-bodied seniors are enlisted to assist with daily operations and provide peer support to more frail or socially isolated individuals. This extends out of the centre and into the neighbourhood. Several centres have implemented micro-job schemes that offer nominal compensation to seniors for ad hoc tasks, such as event support and outreach activities.⁴⁰ These initiatives not only help alleviate manpower constraints but also promote a sense of ownership, purpose and dignity among participating seniors, thereby contributing to the long-term sustainability of AAC operations. Finally, recognising the needs of working seniors, some AACs have introduced extended opening hours to improve accessibility for seniors.^{41,42} Together, these efforts reflect the utility of tailored, inclusive ground-up strategies to strengthen engagement and sustain participation across diverse senior population, which need to be evaluated to inform future scaling efforts.

(D) More evidence generation is needed to evaluate the impact of social determinants on health

Finally, the shift of governance and roles means that community development and capacity building in the social sector need to translate to better health and well-being among older adults. Robust evaluation rubrics must be embedded from the outset to assess the implementation fidelity, effectiveness and scalability of both the new AAC model, and novel strategies such as thematic programmes are needed.

To date, there is limited good quality, real-world evidence for models on health and social integration in community-based active ageing models. There is a need for such evaluations to inform future community health policies and iterations of the AAC model. Implementation science offers insights into the facilitators and barriers at the various system levels and throughout the designing, implementation and process phases, and should be systematically captured through quantitative and qualitative methods.⁴³ Both the health and social outcomes of seniors as well as studying the relationship between these metrics

would inform stakeholders on how to continue synergising efforts. Data availability and interoperability are key, so stakeholders can take evidence-based approaches to programme development and improvement. AIC has rolled out a list of approved management systems for AACs to enable limited bidirectional flow of information between healthcare clusters and AACs to support this. However, for information to flow, trust must be built first to avoid the alternative outcome of an unutilised platform. Gaps remain between stakeholders in terms of what data should be collected, how the data will be used and whether there is competency to interpret the data to guide programmatic improvement.

Co-creation approaches such as One Care Plan, a piloted technology-driven solution that integrates information across entities is progressively being rolled out across all healthcare settings, which may provide a useful foundation to align stakeholders.⁴⁴ Additionally, more can be done to integrate and make accessible HPB’s and MOH’s national level health, social and demographic data so stakeholders can evaluate and better develop services to meet the needs of residents. These insights should be shared through regular cross-learning platforms between agencies, healthcare clusters, researchers and AACs. This will enable a data-driven, iterative approach to the design, implementation and evaluation cycle, ensuring that the most effective programmes are continuously implemented and scaled to meet the evolving needs of seniors.

CONCLUSION

Lessons for the region

Singapore’s AAC 2.0 represents an ambitious, whole-of-government and whole-of-society approach to healthy ageing. While implementation challenges remain, this evolving model offers valuable insights for countries seeking to address similar challenges. Embedding community ageing services within national health strategies through strong governance, integrated care, inclusive engagement and rigorous evaluation can support seniors in ageing with dignity, purpose and support. As countries navigate demographic transitions, Singapore’s experience presents a compelling blueprint for designing community-rooted and prevention-focused systems to deliver healthy ageing at scale.

Ethics statement

Not applicable as no study participants are involved.

Declaration

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