



Hospice
Foundation of
Taiwan

HFT Newsletter

Forever Love, Endless Care

July 2017



2017 JKT Research Project TAIWAN

Geriatric Palliative Care



Current Status
Palliative Medicine
in Japan:
Geriatric palliative care,
an important issue

[READ](#)



Geriatric Palliative Care
in South Korea:
Issue and Trends

[READ](#)



Geriatric Palliative Care
in Taiwan:
From the perspective of
public health

[READ](#)



Current Status Palliative Medicine in Japan

~ Geriatric palliative care, an important issue ~

Speaker: **Dr. Seiji Hattori** by **HFT secretariat**



Dr. Seiji Hattori is the Director of Palliative Care & Pain Management Department and also Director of Cancer Pain Service Department for the Japanese Foundation for Cancer Research (JFCR).

His topic was on geriatric palliative care, which included a global understanding and the situation in Japan based on history and current events. He elaborated on the importance and lack of geriatric palliative care in Japan, pointing out that those beyond 60 years old continue to increase in the 21st century.

In Japan, the death rate of patients beyond 75 years old is decreasing. In 1970, the population of those over 65 years old was only 7%. By 2006, the same elderly population rose up to 20.8%, which makes it the highest ratio in the world. Thus, one can easily anticipate the need for long-term elderly service, which was already a critical social problem in Japan even prior to 2006.

As the population ages, the pattern of diseases also changes. For example, many elderly suffer from multiple diseases that might contribute to death, known as the Geriatric Syndrome. Thus, palliative care for elderly people, often phrased as geriatric palliative care, is an acute global agenda that cannot be delayed.

Dr. Hattori pointed out the following five factors that contribute to the lack of geriatric palliative care in Japan.

Lack of research data: Elderly people have multiple comorbidities, especially cognitive impairment, which makes it difficult to collect data for randomized, controlled trial. Most studies focus on patients with cancer or AIDS, but do not include the elderly population or associated comorbidity. Also, an objective examination of symptoms requires skill and experience, which typical observers do not possess. Studies of nonrandomized controlled or uncontrolled trials are necessary for evidence-based practice in geriatric palliative care.



Education to caregiver and medical professions: The majority of health care professionals receive insufficient specialized training in the care of terminally ill patients. For example, Japanese postgraduate training programs in palliative care is a two-day course focused only on cancer symptom management and communication skills, but not geriatric palliative care or end-of-life care.

Education for family caregivers is also important. The family members, and in fact, everyone in the country, need to know how and where to seek care. Government oversight and public announcements are needed for people to know how and where they can consult for care.

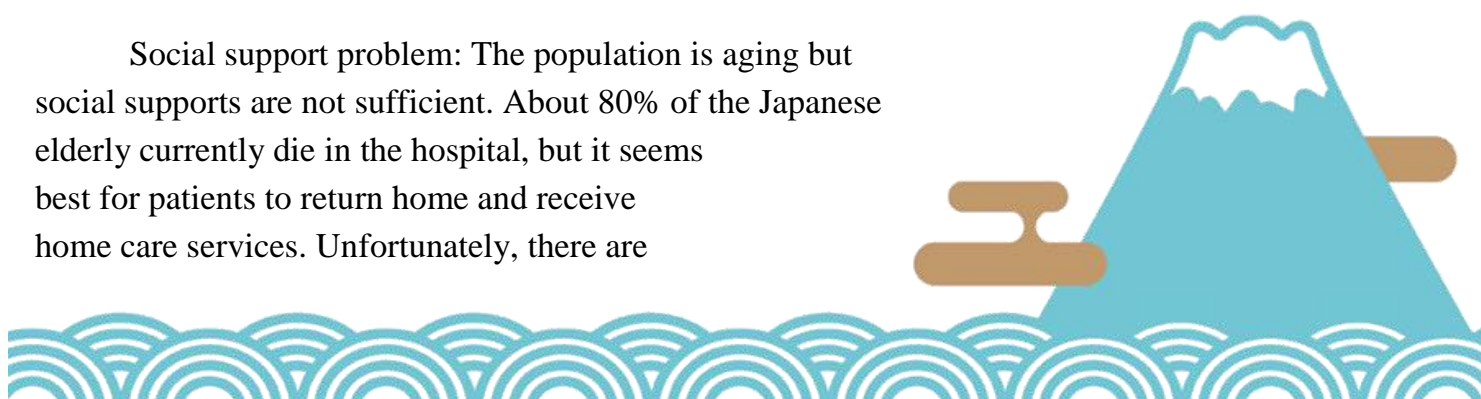
Underassessment resulting in under-treatment: Elderly people tend to underreport their symptoms, leading to under-treatment. Especially in Japan, the elderly try to bear the pain with patience instead of informing their family about their symptoms. Cognitive impairment can also contribute to poor symptom reporting and management. In addition, even when assessment is appropriately done, physicians tend not to give pain medications, such as opioids, to the elderly for fear of side effects (with the exception of cancer patients).

Palliative care society focusing mainly in cancer: In 2006, the Cancer Control Act was approved after a politician shared his cancer treatment experience and demanded better treatment including for palliative care. It was a good advertisement for cancer palliative care. One of the overall goals as stated in the Act was “reduction of burden among all cancer patients and their families and improvement of quality of life.” One of the three priorities, surprisingly, is to “initiate palliative care from the beginning of the therapy.” This is not yet satisfactorily done in actual clinical practice because it would be hard for patients to accept treatment and palliative care at the same time.

Many people became aware of palliative care but only as it concerned cancer. It even became mandatory for cancer hospitals to include palliative care teams. Unfortunately, Japanese Palliative Society does not yet address geriatrics or chronic diseases, and for the government, cancer palliative care is much easier to provide compared to geriatric palliative care since cancer is shorter term and more predictable.

Dr. Hattori shared his thought that the Geriatrics Society is doing a very good job. In 2001, they released a position statement regarding palliative care for the elderly. It consists of thirteen statements to provide the elderly and their families the support they need for optimal care at the end of their lives, with respect to their value, philosophy, and faith. The society equates “palliative care” as synonymous to “end of life care” or “terminal care,” which is much more realistic.

Social support problem: The population is aging but social supports are not sufficient. About 80% of the Japanese elderly currently die in the hospital, but it seems best for patients to return home and receive home care services. Unfortunately, there are



not enough workers or home caregivers, which is a big problem in Japan.

Many caregivers have emotional, physical, and financial stress. From 2010-2016, 183 people were killed by their caregivers in Japan due to lack of love and hope. If they had more social or psychological support, or had placements in long-term care facilities, tragedy could have been avoided. Thus, social services need to provide support to the elderly patients and their families, which would require a combination of government act, financial support, insurance, construction, public service, and law enforcement.

[<<PREV](#)

[HOME](#)

[NEXT>>](#)





Geriatric Palliative Care in South Korea: Issue and Trends

Speaker: A/Prof. So-Hi-Kwon by HFT secretariat

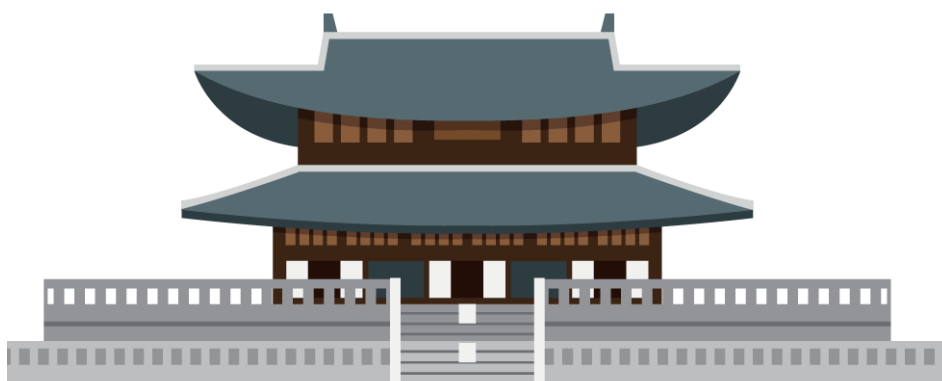
Associate Professor So-Hi Kwon is an expert in Hospice & Palliative Care (HPC) at the College of Nursing at Kyungpook National University. She elaborated on the issues and trends of geriatric palliative care in Korea.

Kwon briefly introduced the health system and HPC in Korea, which adopted the universal health care system from Germany in 1989. As a result, health care is now very affordable, covering 97% of the total population. However, it has been over-utilized, especially in the acute care setting. For example, only 8.2% of the healthcare expenditure is for long-term care. In 2008, the government adopted the social insurance for long-term care from Japan to encourage long-term care for chronic illnesses, but this insurance does not cover HPC.



Like many developed countries, Korea has a rapidly aging population. It will become a super aging society in 2026. Kwon noted a growth of patients and expenditure with chronic diseases such that patients with chronic diseases increased by 10.9% from 2011 to 2015, as total healthcare expenditure increased by 36.7%. Furthermore, a challenge that Korea faces is end-of-life care in hospitals. Death has been institutionalized (81% death in hospitals), and only 3% of death was served by HPC in 2015. Another big social issue in geriatrics is poverty, especially with the high growth household expenditure before death.

HPC was first introduced in Korea in 1965 in Mary's Calvary Clinic. The Ministry of Health and Welfare started fostering HPC programs in 2003, and in 2009, the National Health insurance started a pilot project for case payment of palliative care unit (PCU). Since then other payment programs were introduced under the Cancer Control Act in 2011 to include inpatient HPC, home hospice, and convalescent hospice. As a result, Korea's world ranking for end-of-life care has



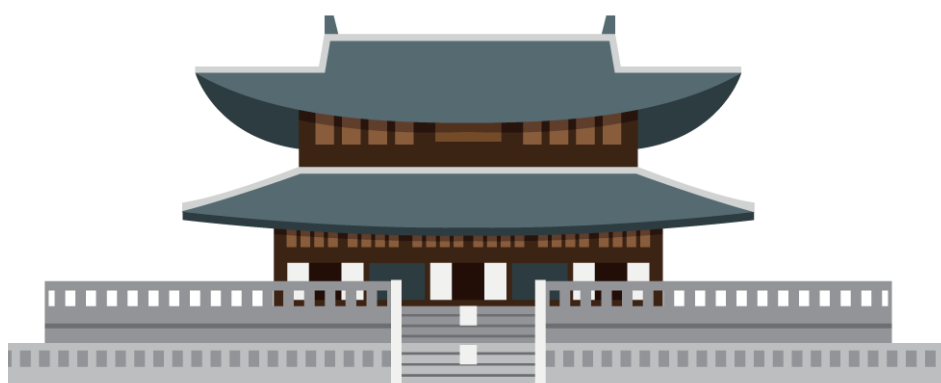
improved from 32nd in 2010 to 18th in 2015. Among HPC health care professionals, nurses received the most training, which includes advanced and specialized HPC training. In contrast, most physicians and social workers have only basic level HPC training.

In 2016, Hospice & Palliative Care and Self-Determination Life Sustain Treatment Act was passed to expand HPC from only cancer patients to all patients with terminal illnesses and to allow long-term care for HPC patients. Since the implementation of the social insurance in 2008 and the act in 2016, long-term and HPC in convalescent hospitals have dramatically expanded by 7 times in Korea. These convalescent hospitals admitted about 230,000 patients in 2015 alone. The benefits of this expansion are easy accessibility, efficient use of medical resources, and cost effectiveness of convalescent hospitals.

However, there are also a few concerns, including patients' anxiety, lack of educated staff, and quality control. Many patients prefer famous hospitals in big cities to convalescent hospitals in communities. The families are afraid and think of convalescent hospitals as a modern version of Goryeojang, a place for sick people left to die. Also, only 20.9% of convalescent hospital staffs have received appropriate education. For example, research shows that 50% of nurses hesitate to give pain medication and 80% of them administer placebo to patients that complain about pain often. Additionally, there has been a dramatic increase in opioid use in acute care setting since 2008. These are all important issues that require attention and education.

In order to address these concerns, public health policy approaches for HPC in convalescent hospitals are needed at various levels. Level 1 includes palliative care approach from all staff and community. Level 2 is advanced general palliative care by additional HPC training and expertise. Level 3 is specialist palliative care in PCU and home hospice. It is unclear where convalescent hospitals fall in these approaches, but the Korean government is currently planning new models with pilot studies for this issue, and results may be published at the end of this year.

For cultural considerations, Kwon's research shows that the Korean value of "not burdening others" is the most important factor of death with dignity over "free of pain" or "being at home." Other cultural considerations in geriatric palliative care include filial duty, lack of patient involvement in decision-making, and the taboo against death. Family members feel guilty and not filial for institutionalizing their parents. Ironically, there are no caregivers available at home, and only 21.7% of patients are fully involved in decision-making. Patients and their families often



lack and fear experience with death and dying.

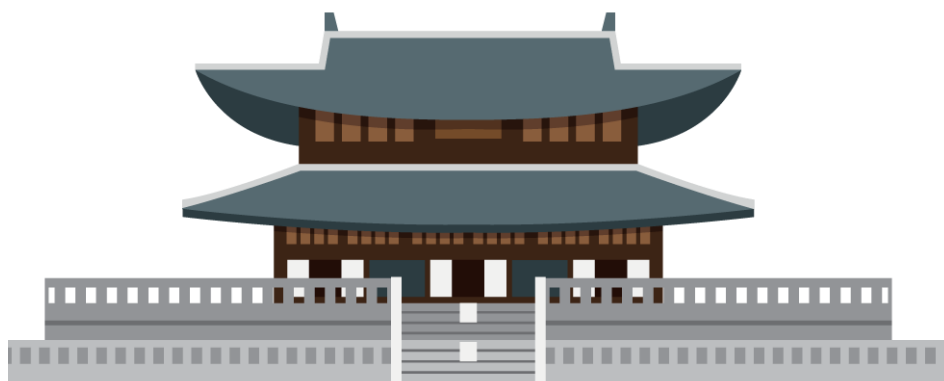
Lastly, Kwon pointed out the urgent tasks to ensure quality HPC in convalescent hospitals in Korea. Education and training for staff are needed as well as construction of culturally sensitive standards and guidelines, organizational policy and regulation, integration of HPC into long-term care insurance system, and strategies for quality control.



[<<PREV](#)

[HOME](#)

[NEXT>>](#)





Geriatric Palliative Care in Taiwan:

From the perspective of public health

Speaker: **Director-General Ying-Wei Wang** by **HFT secretariat**

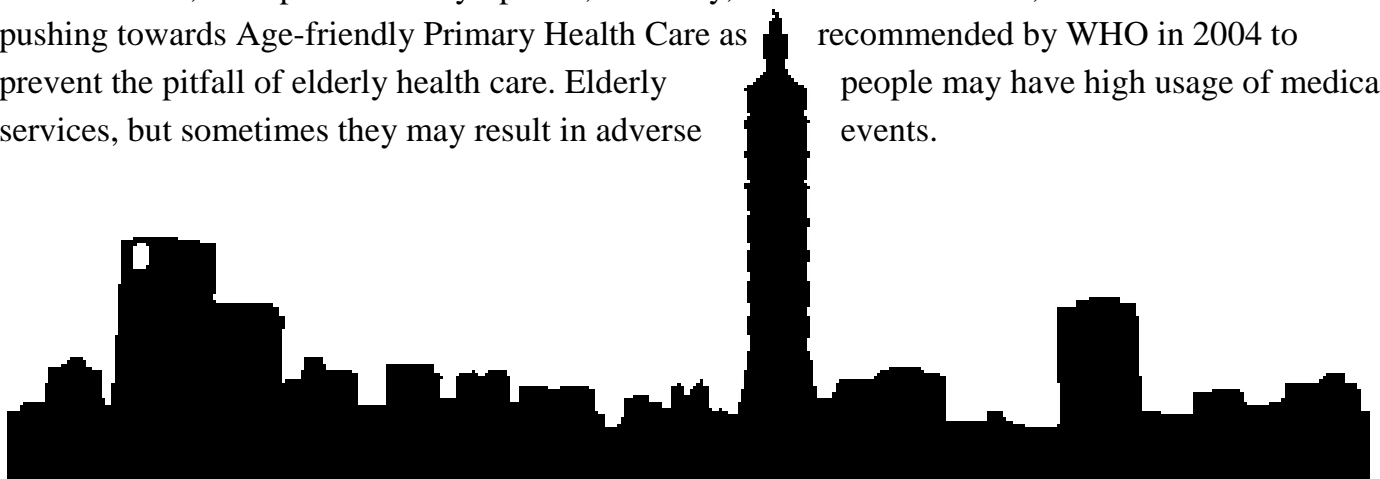


Dr. Ying-Wei Wang is the Director General of the Health Promotion Administration at the Ministry of Health and Welfare in Taiwan. His talk focused on the public health perspective of geriatric palliative care.

Like many other developed countries, Taiwan has an aging population. Taiwanese elderly population is predicted to increase to 41% in 2061. Although cancer is the leading cause of death at 28.6%, more than half of the deaths are still non-cancer related. Thus, the care for the elderly will continue to focus on non-cancer illnesses. The unhealthy year (i.e., average age - healthy age) in Taiwan is similar to most developed countries at around 9-10 years, but Taiwanese healthy age (71) is lower than Japan (75) or Korea (73), so there is still more that can be done to improve health and decrease unhealthy years.

According to the WHO Aging and Health Report in 2015, the ideal trajectory of life consists of high intrinsic capacity until the end of life (活得老死得快). To achieve this trajectory, the public health framework for Healthy Aging requires prevention, early detection, and control of chronic conditions when capacity is high and stable. However, when capacity is declining, those can reverse or slow down. Lastly, when capacity is significantly lost, it is crucial to manage and support chronic conditions while ensuring dignity. During this whole aging process, capacity-enhancing behaviors should be promoted, barriers to participation should be removed, and loss of capacity should be compensated. With this public health framework, unhealthy years will decrease, which is also known as the compression of morbidity.

The health care system is not familiar with how to take care of the elderly due to comorbidities, multiple unclear symptoms, and busy, untrained staff. Thus, Taiwan has been pushing towards Age-friendly Primary Health Care as recommended by WHO in 2004 to prevent the pitfall of elderly health care. Elderly people may have high usage of medical services, but sometimes they may result in adverse events.



These issues are addressed in The Religions of the World Charter, Palliative Care for Older People. It defines the clinical rights, patients' rights, families' rights, human rights, and also clarifies spiritual and religious perspectives of geriatric care. Clinically, elderly people have the right to early access to high quality palliative care, which includes workers with appropriate training and education and capacity building in communities. From patients' and families' perspectives, quality of life, individual cultural norms and beliefs, and the person's wishes and preferences should be respected. From human rights perspectives, palliative care is a human right that includes essential medicines and the elimination of ageism. The elderly have the right to freely consent to, refuse, or suspend medical treatment. Lastly, religious faiths can contribute to the support and training of religious leaders, spiritual care professionals, and other healthcare members.

Palliative care is necessary to live an enjoyable life, age slowly, and die with dignity. Palliative care embodies not only disease- and comfort-focused cares, but also psychosocial and spiritual support for patients and families before and after death. The new palliative care movement in Taiwan includes care for cancer, non-cancer, elderly people, and dementia in long-term care, ICU, and communities. Policies and promotion, like Advanced Care Planning (ACP) and Shared Decision Making (SDM), were implemented to help encourage culture shift and establish common language for palliative care.

Some challenges to providing end-of-life care for elderly people with frailty include different disease trajectories, multiple comorbidities, and issues with mental capacity. Based on disease stable years, prognosis, and needs, Dr. Wang noted the support matrices to provide tailored support for patients and family. There is also a frailty scale that can be used to assess patients' ability and capacity.

Besides health services, palliative care from a public health perspective also needs to include public policy, supportive environment, community action, and personal skill. In 2007, WHO introduced a guide for global age-friendly cities that include accessible urban environment and promote active aging. As of 2015, Taiwan has 22 cities that continue to promote development of elderly friendly cities.

As an application of the WHO global age-friendly cities and health promotion palliative care (HPPC), the Compassionate Cities (CC) model was developed. In the CC model, the ultimate

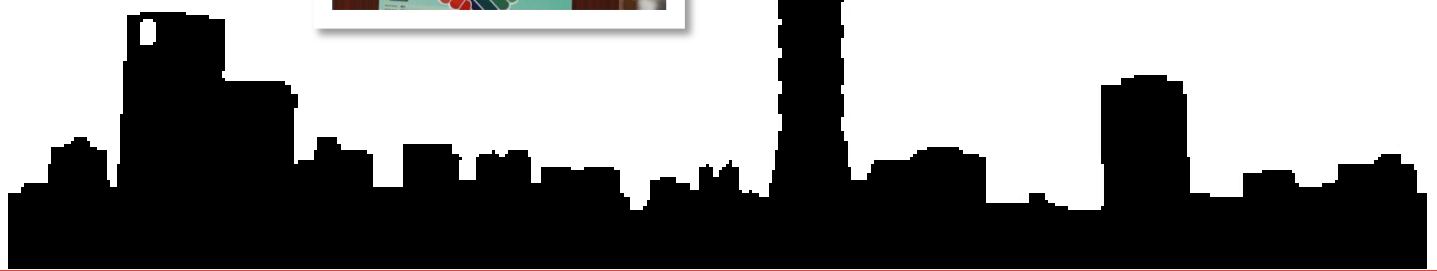


palliative care consists of caregivers, health professionals, volunteers, public health workers, and communities that normalize death, promote health, provide leadership, and SDM to empower patients and systems. Both the inner network of close family members and outer network of community work together to help patients and prevent caregiver exhaustion. Currently, the Taiwanese Department of Health and Welfare has multiple projects to implement the CC model.

The public health perspective of HPPC can help avoid social tragedies, like unnecessary deaths of sick elderly, because palliative care is “everybody’s business.” To achieve this, Dr. Wang recommended the 5 P’s: Promotion, Prevention, Protection, Participation, and Partnership.

[<<PREV](#)

[HOME](#)



Hospice Foundation of Taiwan www.hospice.org.tw Line@ ID: @tdt9241n

No. 45 MinSheng Road, Danshui District, New Taipei City 25160, Taiwan
Tel: +886-2-28081130 Fax: +886-2-28081137 E-mail: hospice@hospice.org.tw