



Hospice Foundation of Taiwan

HFT Newsletter

Forever Love, Endless Care

February 2019

2018 International Conference on Palliative Care in Long-Term Care Settings

TAIWAN-JAPAN-KOREA TRILATERAL ACADEMIC EXCHANGE

(continued from the previous newsletter)

Combined with the conference theme of 2018 International Conference on Palliative Care in Long-Term Care Settings - Integration of Palliative and Long-Term Care, we had the privilege to invite palliative experts from Taiwan, Japan and Korea to talk about the current status and how palliative care is being implemented in each country.

By sharing these valuable experiences, we learn from each other by celebrating what has been achieved and forecasting what challenges may lie ahead of us.

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The Current Status of Palliative Care in Long-term and Home Care Settings in Japan

Written by the **HFT Secretariat**

Based on Assistant Professor Jun Hamano's presentation in the 2018 International Conference on Palliative Care in Long-term Care Settings - Integration of Palliative and Long-Term Care.

Assistant Prof. Jun Hamano served as a family physician in a GP clinic for six years as its director. With his special interest in palliative care, especially for the community, he now practices at Tsubaku University Hospital while still serving at the GP clinic one day a week.



While he serves at the GP clinic, Assist. Prof. Hamano has noticed many dying patients needing home care and long-term care resources; these needs have driven him to do more research on the issue. Palliative care in Japan was developed based on cancer patients' needs, as the Japanese government passed the Cancer Control Act in 2007. As a result, palliative care was encouraged to develop due to financial, educational, and public aspects; but it hasn't fully engaged with long-term care services. Assist. Prof. Hamano expresses his concern about this, and believes this should be the next goal of the academic community.



Overview of End-of-life ("EOL") Care in Japan

In his presentation, Assist. Prof. Hamano defines end-of-life as a period of deteriorated health not limited to only dying patients. He especially points out that Japan is a super-aged society with high population growth of people over 75 years old—life expectancy in Japan is 82 years old for males and 90 years old for females—and the rapid decline of the labor force has made the Japanese government extend retirement age from 65 to 70 years old.

According to the population dynamic forecast in Assist. Prof. Hamano's speech, there were 15% elderly over 75 years old in



2015, and it will increase to 20% in 2040. However, the population will decrease from 1.3 billion in 2015 to 1 billion in 2040. With a growing percentage of elders over 75 years old in a declining total population, the number of yearly deaths is expected to increase 0.36 million on top of the original yearly deaths in 2040. Considering this changed population, Assist. Prof. Hamano expressed his concern on man power shortage asking: “Do we have enough professionals to cope with such a large patient demand?” He noted there is already a lack of doctors and nurses in the current healthcare system.

Over the last six decades, the percentage of dying at home has dropped from 82.5% in 1951 to 13% in 2016, and risen from 9.1% to 74.6% in hospitals. Furthermore, over the years the location of death has diversified beyond homes and hospitals as 2.3% of deaths occurred in long-term care facilities and 6.3% occurred in nursing homes.

Assist. Prof. Hamano presents a national survey regarding people’s preferred place of death. In it respondents were asked what they would do in certain scenarios, such as for advanced cancer patients with anorexia and dyspnea, or for dementia patients with anorexia and disorientation who require toilet assistance. For most advanced cancer patients, more than half of the respondents chose to be cared for and die at home. For dementia patients, most chose to be cared for in long-term care facilities. However, when asked where they preferred to die, half of the respondents who chose to be cared in facilities would rather die at their own homes.



Long-term Care Facilities in Japan

In Japan, care facilities are categorized in three types: nursing homes, long-term care facilities, and sanatorium medical facilities. Nursing homes are for the elderly who need long-term care and whose ultimate purpose is not returning home. The average stay for nursing homes is 1,405 days and a doctor’s presence is not required by law. This is the most common type and serves the most patients. Long-term care facilities, however, are for the elderly whose ultimate purpose is to return home and need rehabilitation. It takes on average almost a year for these elderly to be ready to return to their homes. In addition, a full-time doctor is required to be in these facilities. The last type is the sanatorium medical facilities that provide medical care to the elderly, and their average stay is about 15 months.

Assist. Prof. Hamano further shows how the percentages of dying patients compare among these facilities. More than 60% of nursing home patients stay until death, while the figure drops to 3.8% for long-term care facilities and 33% for sanatoriums. Nursing homes do not require the presence of doctors by law yet has the largest percentage of death. This



sends a message of how important and urgent it is for these nursing homes to be capable of providing end-of-life care and tackle the staff shortage issue.

Looking at the causes of death for these facilities, one can notice that both nursing homes and long-term care facilities' main causes of death is old age (frailty), severe pneumonia, and heart failure.

Challenges and Future Prospects



Assist. Prof. Hamano concludes with two main challenges that will affect Japanese society in the near future: one is the increasing number of dying elderly patients who live alone; the other is the decreasing workforce population. He foresees that there will be fewer health care providers to address the former challenge, and so, the care system for elderly who live alone needs to build up as soon as possible, not only in offering health care services, but also in initiating the ACP dialogue.

As already mentioned, over 60% of nursing home residents die in the same facilities, and this statistic suggests that demand for palliative care and EOL life care are of crucial importance. Therefore, how best to implement Advance Care Planning in long-term care facilities and to equip staff with adequate knowledge and EOL care skills need to be examined carefully.

Many questions remain as little research has been done on long-term care facilities thus far. For example, it is unclear what kind of primary care approach and what level of EOL care quality are appropriate. It is also unclear how much reimbursement for care services is insufficient whether for nursing homes or for home care. Additional challenges include staff shortage and lack of financial support.

Though palliative care is still being introduced to the facilities, relevant surveys on the current status will need to be done in order to understand a bigger picture of the facilities' demand. Thus, key issues include clarifying facilities' need for palliative care, offering education and training for the staff, and raising the public's awareness about ACP. It may also be helpful to include experiences from other professionals in the field.

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The Current Status of Korea's Palliative Care in Long-term Care

Written by the **HFT Secretariat**

Based on Dr. Jeanno Park's presentation in the 2018 International Conference on Palliative Care in Long-term Care Settings - Integration of Palliative and Long-term Care.

Dr. Jeanno Park is the Director General of Bobath Memorial Hospital and was the Director of the Insurance Department (2006-2016) and Auditor since 2014 in the Korean Society for Hospice and Palliative Care (“KSHPC”).



In Korea, palliative care was focused on cancer patients because the Korean government was worried about the financial burden that non-cancer patients would have if they received long-term care. Palliative care usage rate had also been low due to the public's lack of awareness and the shortage of palliative care institutions that were able to provide services. However, according to a statistical report published by the National Cancer Center in Korea, the percentage of advanced cancer patients who received palliative care has grown from 9.1% in 2009 to 17.5% in 2016.



Background

There are currently three types of palliative care services in Korea: hospital admission, home visits, and consultation. Only cancer patients are allowed to receive palliative care in hospital wards. Non-cancer patients are not eligible for palliative care ward coverage, but are eligible for other forms of palliative care services like consultation.

The Ministry of Health and Welfare of Korea (“MHWK”) had officially allowed public insurance coverage for the KSHPC administration type in July 2015 and started a test-run program in geriatric hospitals in September 2016. In 2018, there were 81 hospitals providing palliative care with a total of 1,346 beds available, 25 home visit units, 20 consulting services, and 16 geriatric hospitals. The KSHPC usage rate is expected to increase 20% until 2020, while the number of KSHPC beds occupied is expected to increase from 1,318 beds in

2018 to between 1,520-1,810 beds in 2020. Similarly, MHWK expects the coverage rate will increase 20% and be between 1,528-1,810 beds.

Korea's cancer incidence rate has increased rapidly from 214.2 to 427.6 out of every 100,000 people in 1999. The mortality rate in 2016 is 76,611 people (27.8% of total deaths in Korea) which roughly represent 71.8% of 65 years old in 2017. This is also why the Korean government previously focused palliative care on cancer patients.

To understand the development of palliative care in Korea, one needs to look at its legislative branch of government. In 2002, the Korean government established the HPC as part of a comprehensive plan to work with geriatric diseases, and passed the Cancer Control Act in 2003. It also started to support hospice care designated institutions in 2008, and included terminal cancer patients under the public insurance service coverage in 2015. In 2016, the Korean government passed the Hospice and Palliative Act and Decisions of Life-sustaining Treatment for Patients at the End-of-Life and expanded from only cancer patients to include patients who had AIDS, chronic obstructive respiratory diseases, chronic liver cirrhosis, and any other diseases prescribed by the Ordinance of the Ministry of Health and Welfare.

According to a statistics report published by the Korean government, geriatric hospitals have also increased during the last 7 years from 867 in 2000 to 1,529 in 2017.



National Policy: On-going Test-run Programs

The Geriatric Hospital Test-run Program lasted from September 2016 to January 2018. The purpose of this test-run program is to (1) increase KSHPC institutions and beds; (2) check compatibility of KSHPC in geriatric hospitals; (3) extend extra-large general hospitals and general hospitals to hospitals and clinics; and (4) distribute city-centered services network more evenly. It is important to note that the insurance cost for this program is the same as the KSHPC administration type.

HPC services in geriatric hospitals are growing step by step. The occupied bed rate has increased from 49.6% to 71.8%. The efforts of participating hospitals and the sustaining abilities of the National Health Insurance Corporation (NHIC) make HPC effective in geriatric hospitals. HPC in geriatric hospitals intends to start with this test-run program and to eventually achieve the permission and expansion of HPC in all geriatric hospitals. As there will be more geriatric hospitals providing HPC services, the general public will have more and easier access to palliative care services, which should also encourage the improvement of quality care. Nevertheless, it remains uncertain whether the manpower and facilities can fulfill all patients' needs.



Conclusion

Community based care service is still developing in 2018, and thus details are still unavailable to include in this article. However, it is important to note that palliative care is being included in the community based care as emphasized by the Korean Hospice and Palliative Care Association. Geriatric hospital based care has been developed over the past 20 years, but it still lacks a proper communication structure. For example, there is a general physicians' lack of interest to be involved with community based care and also the tendency for palliative physicians to not share key information with patients and communicate with the palliative team. These are just a few of the communication barriers to overcome.

The Korean government is considering community based care to constantly provide for non-cancer patients in the future, and for hospital based care to be provided for cancer patients under the test-run program. Though many administrators are inclined to offer end-of-life rather than palliative care in the hospitals, these barriers will need to be overcome as soon as possible in order to provide palliative care with easier access especially in the super-aging society in Korea.

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Community Hospice Care - The Significant Puzzle of Long-term Care

Written by the **HFT Secretariat**

Based on Associate Professor Huey-Tzy Chen's presentation in the 2018 International Conference on Palliative Care in Long-Term Care Settings - Integration of Palliative and Long-Term Care.

Assoc. Prof. Chen is currently teaching at the Nursing Department in Fu Jen Catholic University and serves as a consultant to Taiwan's Long-term Care Professional Association.



Assoc. Prof. Chen began her speech with a graph of the aging population, and pointed out that long-term care services were once targeted at a group of people in their prime, who needed to take care of their aging family members. However, as time rolls by, the same group has now grown old and in need of long-term care services for themselves.



Long-term Care 2.0 Program

Assoc. Prof. Chen explained the three tiers of long-term care services under the Long-term Care 2.0 Program: tier A is the community integrated service center, tier B is the combined service center, and tier C is LTC stations around the neighborhood blocks and the current long-term care management system. Those who are in need of long-term care services can receive access to the LTC system in two ways, either through using Discharge Planning or calling the 1966 hotline. Their needs will then be referred to Long-term Care Management Centers run by local governments for further assessment, care-planning and resources.

The Long-term Care Management Center will be responsible to control supply and demand and oversee the entire long-term care services, be it provided in homes, facilities or communities, so as to monitor and control the service quality and human resources. When LTC Management Centers receive applications, applicants will be assessed and screened by their level of disability and the care required. Only applicants who are being evaluated as CMS02 to 08 are qualified for receiving long-term care service. CMS01 is



defined as “frail” and will be referred to rehabilitation services. Furthermore, a questionnaire with 34 questions will be used to better identify what kind of care is needed.

According to the current Long-term Care 2.0 Program, the cost of service will be split between the government and the beneficiaries. The percentage of cost that needs to be paid by the beneficiaries will depend on their household income level. In order to better take

care of caregivers and encourage more young people to participate in this industry, the payment for caregivers has been revised to the current package deal from the original package deal of being paid per visit.

The revised package deal payment allows the caregivers to focus more on professional care; for instance, swallowing and feeding care, rehabilitation and nutrition care, rather than the usual daily routine care.



Hospice and Palliative Care

Hospice and Palliative Care service has been provided in Taiwan since 1990 and is covered by National Health Insurance. Assoc. Prof. Chen presented a demand forecast from a Taipei City Hospital research published by Dr. Chao-Ming Huang (2015), which shows that the demand for palliative care service for non-cancer patients will rise significantly in the years to come. According to this statistics, the coverage rate for cancer patients to receive palliative care is now 55-56% in 2016; however, it is relatively low for non-cancer patients. If palliative care can be provided in the long-term care setting, the beneficiaries will greatly expand.

The original palliative care system that focuses on the hospital setting will be unable to meet the demand, and thus it is vital to expand palliative care services to the community setting and institutional setting in order to include more elderly. The system flow for palliative care in community setting is now constructed and steadily functioning.



Looking Ahead: Connecting Long-term Care with Palliative Care

Assoc. Prof. Chen also shared two case studies of long-term care patients, who received palliative care at home at their own expenses.



These cases indicate that demand for palliative care existed among long-term care patients, but they did not have access to palliative care services.

In considering the integration of the two current systems, long-term care service and palliative care, Assoc. Prof. Chen pointed out the compatibility issue of each assessment tool as related to CMS and palliative needs assessment. She also proposed ways to integrate the financial aspects of a combined policy within the NHI coverage and payment. As the Patient Autonomy Act will be enforced in 2019, her speech is timely to reconsider the distribution of resources and ease of access to those in need.

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Happy Chinese New Year



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