Learning From Diversity:
Hospice and Palliative Care in Singapore & Hong Kong

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Fellow in Thanatology, Association for Death Counseling and Education.
Elected Member, International Work Group on Death, Dying and Bereavement.
Population Ageing in Singapore

- In Singapore, number of persons aged 65+ has surged more than 200% in the past 20 years, from 164,500 in 1991 to 352,600 in 2011.

Life expectancy at Birth

Women: 84.5 Years
Men: 79.9 Years

Population Ageing in Hong Kong

- In Hong Kong, the number of persons aged 65+ has increased over 85% in the past 20 years, from 502,400 in 1991 to 940,600 in 2011.

Life expectancy at Birth
- Women: 86.4 Years
- Men: 80.7 Years

- World ranking: 37 of 195 in 2012
- World ranking: 12 of 195 in 2050
Health Status of the Rising ‘Sliver’ Population

- Chronic Diseases and Illnesses among the aged in Singapore:
  - 9 out of 10 seniors have at least 1 chronic health condition
  - 43% have at least 3 comorbid chronic diseases
  - 13% suffers from depression and 6% suffers from Dementia
  - 4.1% was hospitalized at least once per year
  - Account for 35.6% of all hospital admissions
  - 57% dies in hospitals

- Chronic Diseases and Illnesses among the aged in Hong Kong:
  - 73.7% have a chronic health condition
  - 58% to 98% of have multi-morbidity
  - 1 out of 10 suffers from Dementia
  - 60% uptake of all in-patient days at public hospitals
  - Account for nearly 60% of all hospital admission
  - 99% die in hospitals
Quality of Death in Singapore and Hong Kong

- In 2010, Singapore ranked 18th and Hong Kong ranked 20th out of all 40 regions investigated. 5 years later, Singapore impressively raised to 12th place, while Hong Kong dropped to 22nd place.

<table>
<thead>
<tr>
<th>4 Assessment Criteria</th>
<th>SG 2010</th>
<th>SG 2015</th>
<th>HK 2010</th>
<th>HK 2015</th>
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<tr>
<td>Basic End-of-Life Healthcare Environment (20%)</td>
<td>30th</td>
<td>12th</td>
<td>31st</td>
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<td>Quality of End-of-life care (30%)</td>
<td>11th</td>
<td>8th</td>
<td>8th</td>
<td>20th</td>
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<tr>
<td>Availability of care/ Human Resources (20%)</td>
<td>16th</td>
<td>8th</td>
<td>24th</td>
<td>20th</td>
</tr>
<tr>
<td>Cost of care/ Affordability (20%)</td>
<td>20th</td>
<td>6th</td>
<td>24th</td>
<td>18th</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>18th</td>
<td>12th</td>
<td>20th</td>
<td>22nd</td>
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</tbody>
</table>
Development of Hospice and Palliative Care in SG

- 1985: St. Joseph's Home set aside 16 beds
- 1986: St. Joseph's Home was featured in Straits Times
- 1987: Hospice Care Group by Singapore Cancer Society
- 1988: Assisi Nursing Home set aside 12 Hospice beds
- 1989: Dr Rosalie Show recruited from Australia
- 1992: HCG to Hospice Care Association National Home Hospice Program
- 1993: Dover Park Hospice Opens
- 1996: First Palliative Care Unit opens in Public Hospital
- 2001: Metta Hospice Care Opens
- 2007: Bright Vision Hospital Opens
- 2011: Lien Centre for Palliative Care Opens
- 2016: National Strategies of Palliative Care Establish
- 2017: Expansion of Assisi Hospice
- 2017: Expansion of Dover Park
Development of Hospice and Palliative Care in HK

- 1982: Palliative Care support team at Our Lady of Maryknoll Hospital
- 1986: Society for the Promotion of Hospice Care (SPHC) Opens
- 1988: Palliative Care program at Haven of Hope Hospital Opens
- 1992: Bradbury Hospice Opens
- 1995: Expansion of Palliative Care Service in Public Hospitals
- 1996: Hong Kong Society of Palliative Medicine Opens
- 1998: Hong Kong Hospice Nurses Association Opens
- Palliative Medicine as a medical specialty
- 2012: LKSIF Heart of Gold Hong Kong Hospice Service Opens
- Jockey Club Home of Hospice Opens
- 2015:

Timeline:
- 1982
- 1986
- 1988
- 1992
- 1995
- 1996
- 1998
- 2012
- 2015
Current State of the Art in Singapore

**Homecare Hospice**
- 7 Major Homecare Hospice Providers:
  - HCA Hospice Care [Nation Wide]
  - Agape Methodist Hospice
  - Assisi Hospice
  - Bright Vision Hospital
  - Metta Hospice Care
  - Methodist Hospice Fellowship
  - Singapore Cancer Society
- Usually accepts patients with prognosis of up to about 1 year
- Provides homecare support in medical, nursing & psychosocial care
- Subsidized, blended means-tested
- 24/7 coverage & Free of Charge

**Inpatient Hospice**
- 4 Main Hospices:
  - Assisi Hospice
    - (37 beds... to 85 beds w/ Dementia Ward)
  - Dover Park Hospice
    - (50 beds... expand to 100 beds)
  - Bright Vision Hospital (32 beds)
  - St. Joseph’s Home & Hospice (22 beds)
  - Accept patients with prognosis of about 3 months or less
  - Government Subsidized; means-tested
  - Payable via Medisave
  - Medifund (Assisi Hospice and Bright Vision Hospital)
  - Out of Pocket Expenses
Current State of the Art in Singapore

Hospital Palliative Care Services

- Service offered by:
  - Singapore General Hospitals
  - Tan Tock Seng Hospital
  - National University Health System
  - Khoo Teck Puat Hospital
  - Changi General Hospital
  - KK Women’s and Children’s Hospital
- Manages patients with life-limiting illness who are admitted to the hospital
- Subsided, and payable through 3M
- Out of pocket expenses

Day Care

- Service offered by:
  - Assisi Hospice
  - HCA Hospice Care
- Patients who are well enough can be enrolled
- 2-way transport provided
- Volunteer and staff run activities
- Funded by National Council of Social Services
- Out of pocket expenses
Current State of the Art in Hong Kong
2011 Singapore National Strategy for Palliative Care

**Goal 1:**
All patients with life-limiting illnesses should be identified and their palliative care needs assessed.

**Goal 2:**
All patients with life-limiting illnesses should be cared for by health care professionals using a palliative care approach. Patients with complex needs should have access to specialised palliative care services.

**Goal 3:**
Palliative care should be delivered in a coordinated manner that ensures continuity of care across settings and over time.

**Goal 4:**
Palliative Care should be affordable to all who need it and quality care should be provided in a cost-effective manner.

**Goal 5:**
There should be adequate health care professionals with the appropriate training to meet the needs of patients at the end-of-life.
Goal 6: 
There should be adequate capacity to meet the palliative care needs of patients.

Goal 7: 
There should be local standards of care to ensure the delivery of good quality palliative care.

Goal 8: 
The acceptance and public awareness of palliative care services, advance care planning and bereavement services should be promoted.

Goal 9: 
Palliative care research should be promoted to improve the quality of palliative care and inform policy making.

Goal 10: 
There should be leadership and governance to guide the development of palliative care services in Singapore.
Hong Kong Strategy for Palliative Care
Pushing Forth Advice Directives and Care Planning

- Emphasis on Patient Self-Determination
- SG Introduced Advanced Medical Directives (1996)
  - Protect patient autonomy and respect their wishes in care
  - Help patients plan for the end-of-life through making informed decisions of care before one becomes incapacitated
  - Avoid unnecessary and fertile treatments which would cause more harm than good to the well-being of patients
  - Permits peace of mind

MAKING OF ADVANCE MEDICAL DIRECTIVE
THE ADVANCE MEDICAL DIRECTIVE ACT 1996 [ACT 16 OF 1996, SECTION 3]
THE ADVANCE MEDICAL DIRECTIVE REGULATIONS 1997

(Please tick)

PERSON MAKING THE ADVANCE MEDICAL DIRECTIVE

Name: 
NRIC No.:  
Sex:  Male  Female
Date of Birth:  DD MM YYYY (must be at least 21 years of age)
Address: 
City:  Singapore
Home Telephone:  
Office Telephone:  

THE DIRECTIVE

I hereby make this advance medical directive that if I should suffer from a terminal illness and if I should become unconscious or incapable of exercising rational judgment so that I am unable to communicate my wishes to my doctor, no extraordinary life-sustaining treatment should be applied or given to me.

2. I understand that "terminal illness" in the Advance Medical Directive Act 1996 means an incurable condition caused by injury or disease from which there is no reasonable prospect of a temporary or permanent recovery where -
   (a) death would within reasonable medical judgment be imminent regardless of the application of extraordinary life-sustaining treatment; and
   (b) the application of extraordinary life-sustaining treatment would only serve to postpone the moment of death.

3. I understand that "extraordinary life-sustaining treatment" in the Advance Medical Directive Act 1996 means any medical procedure or measure which, when administered to a terminally ill patient, will only prolong the process of dying when death is imminent, but excludes palliative care.

4. This directive shall not affect any right, power or duty which a medical practitioner or any other person has in giving me palliative care, including the provision of reasonable medical procedures to relieve pain, suffering or discomfort, and the reasonable provision of food and water.

5. I make this directive in the presence of the two witnesses named on page 2.

Signature / Thumb Print  
Date

INSTRUCTIONS ON THE REGISTRATION OF ADVANCE MEDICAL DIRECTIVE

1. The person making the advance medical directive should complete this form and send it in a sealed envelope by mail or by hand to the Registrar of Advance Medical Directives at the address given below. Faxed copies will not be accepted.

2. The advance medical directive is only valid when it is registered with the Registrar of Advance Medical Directives. The Registrar will send the maker of the directive an acknowledgement when the directive has been registered.

The advance medical directive is valid for five years from the date of registration, subject to renewal.

The Registry of Advance Medical Directives
Ministry of Health, College of Medicine Building, 16 College Road, Singapore 169854
Tel: 63259136  Fax: 63268212

Note: As a guide for the purposes of determining whether the maker of the directive is of sound mind, the medical practitioner should ascertain whether the maker -
   (a) understands the nature and implications of the directive;
   (b) is oriented to time and space; and
   (c) is able to name himself and his immediate family members.

SECOND WITNESS (This witness must be of at least 21 years of age)

Name: 
NRIC No.:  
Home Address:  
City:  Singapore
Home Telephone:  
Office Telephone:  

I declare that this directive is made and signed in my presence together with the witness named above.

Signature  
Date

FORM 1 - PAGE 2
Current State of Advance Directives

- Despite a low take up rate in SG, Advance Directives are gaining great popularity in the Western World.
  - In the US, all 50 states and the District of Columbia have passed legislation on AD, of which is mandatory rather than optional.
  - 15 to 20% of adults, and 70% of community-living older adults have AD

- Advanced Directives and Outcomes (Silveira et al., 2010):

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Living Will (N=444)</th>
<th>No Living Will (N=552)</th>
<th>Adjusted Odds Ratio (95% CI)</th>
<th>DPAHC (N=589)</th>
<th>No DPAHC (N=407)</th>
<th>Adjusted Odds Ratio (95% CI)</th>
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<tbody>
<tr>
<td>% of subjects</td>
<td>% of subjects</td>
<td>% of subjects</td>
<td>% of subjects</td>
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<tr>
<td>Death in a hospital</td>
<td>38.8</td>
<td>50.4</td>
<td>0.71 (0.47–1.07)</td>
<td>38.2</td>
<td>55.8</td>
<td>0.72 (0.55–0.93)</td>
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<tr>
<td>All care possible</td>
<td>8.1</td>
<td>27.7</td>
<td>0.33 (0.19–0.56)</td>
<td>13.4</td>
<td>27.0</td>
<td>0.54 (0.34–0.86)</td>
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<td>Limited care</td>
<td>80.6</td>
<td>66.0</td>
<td>1.79 (1.28–2.50)</td>
<td>75.4</td>
<td>68.1</td>
<td>1.18 (0.75–1.85)</td>
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<td>Comfort care</td>
<td>96.8</td>
<td>91.3</td>
<td>2.59 (1.06–6.31)</td>
<td>95.9</td>
<td>90.6</td>
<td>2.01 (0.89–4.52)</td>
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</tbody>
</table>

* Percentages are weighted and were derived with the use of sampling weights from the Health and Retirement Study. DPAHC denotes durable power of attorney for health care.
An Closer Examination on Advance Directives

- Longitudinal Study on Older Americans who decreased from 2002 to 2010 from the United States (Health and Retirement Study HRS)
  - In total, 5,550 participants died between 2002 and 2010.
    - 1,753 had durable power of attorney for healthcare but with no AD
    - Final sample size was 3,797
    - 2,446 individuals completed an AD = 64.4%
    - The average age at death was 80.7 years; females at 54.6%.

- Physical Health in Final Days of Life (Exit Interview by family proxy):
  - **Presence of disease**: cancer, lung, heart, stroke, memory problems
  - **Pain level**: often trouble by pain during the last year or so of life? [yes-no]
  - **Pain intensity**: how bad was the pain most of the time? [mild-moderate-severe]

- Psychosocial Health in Final Days of Life (Exit Interview by family proxy):
  - **Depression**: at least 1 month when the elder had depression? [yes-no]
  - **Agitation**: at least 1 month when the elder had uncontrolled outbursts of temper? [yes-no]
### Factors associated with QoL in Final Days of Life

<table>
<thead>
<tr>
<th>(Odd Ratios)</th>
<th>Pain</th>
<th>Pain Intensity</th>
<th>Depression</th>
<th>Agitation</th>
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<tbody>
<tr>
<td>Advance Directives</td>
<td>1.41***</td>
<td>1.40***</td>
<td>1.63***</td>
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<tr>
<td>Year of death</td>
<td>-</td>
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<td>1.04***</td>
<td>1.06***</td>
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<tr>
<td>CES-D at 1998 (Control for Depression)</td>
<td>1.17***</td>
<td>1.15***</td>
<td>1.17***</td>
<td>1.09***</td>
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<td>-</td>
<td>1.63***</td>
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<tr>
<td>Female</td>
<td>1.49***</td>
<td>1.39***</td>
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<td>0.79***</td>
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<tr>
<td>Age at death</td>
<td>0.97***</td>
<td>0.97***</td>
<td>0.97***</td>
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<td>Education</td>
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<tr>
<td>High school</td>
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<td></td>
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<td>0.72***</td>
</tr>
<tr>
<td>Some college</td>
<td>-</td>
<td>-</td>
<td></td>
<td>0.66***</td>
</tr>
<tr>
<td>College and above</td>
<td>0.67***</td>
<td>0.71***</td>
<td>-</td>
<td>0.48***</td>
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<td>Race (ref: non-Hispanic white)</td>
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<tr>
<td>Non-Hispanic black</td>
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<td>0.69***</td>
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<tr>
<td>Hispanic</td>
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<td>Others</td>
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<td>Physical Condition</td>
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<td>Cancer</td>
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<td>-</td>
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<td>Lung disease</td>
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<td>Stroke</td>
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<td>1.25***</td>
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<td>Memory-related disease</td>
<td>0.69***</td>
<td>0.68***</td>
<td>1.41***</td>
<td>2.42***</td>
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</table>

Pain, Depression & Agitation over Time

Model implied probability of experiencing pain, depression, and agitation over time.

Advance Directives & QoL by Disease Group

<table>
<thead>
<tr>
<th>(Odd Ratio)</th>
<th>Cancer</th>
<th>Lung Disease</th>
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<td><strong>Pain Intensity</strong></td>
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<td><strong>Depression</strong></td>
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<td>Year of Death</td>
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<td>1.07***</td>
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<tr>
<td>Nursing Home placement</td>
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<td>2.72***</td>
<td>2.71***</td>
<td>-</td>
<td>2.10***</td>
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</table>

From Advance Directives to Holistic Advance Care Planning

- A continuous dialogue rather than a single legal process
- A relationship rather than a bureaucratic procedure
- An interdisciplinary team for patient-family centered care
- A way of planning for future medical care while understanding the social care needs of patients and families so as to maintain overall QoL at EoL
- A mechanism for ensuring that care received matches patients’ values and goals, while also respecting the needs of the families
- A invaluable trust building opportunity between patients, families and professional care teams
- An imperative need to establish the professional specialty of Advanced Care Planner and expand the field of Palliative Social Work

What is Advance Care Planning

Advance Care Planning (ACP) is the process of planning for your future health and personal care. Having ACP conversations with your loved ones allows you to:

- Share your personal values and beliefs
- Explore how your values and beliefs affect your healthcare preferences in difficult medical situations
- Think about who among your loved ones can be your voice if you become very ill one day

By making your wishes known, your loved ones and caregivers do not have to guess what you might want or not want.

How do I begin

Advance care planning is a lifelong journey that begins with having an open conversation with your loved ones. Remember, there is no right or wrong way of care planning, and you certainly don’t have to finish the conversation all at once.

ACP can be carried out informally by discussing your end-of-life wishes with trusted loved ones. You don’t have to write down your wishes, although it can be helpful for your loved ones to refer to in the future. You may even want to share your wishes with your doctor. For patients with more complex conditions, ACP discussions may need to be facilitated by a trained healthcare professional. These facilitators are currently available in most public hospitals.

4 Simple Steps to Carrying out Advance Care Planning

Think about it

- Consider what you need to live meaningfully and what would be important to you at the end of life.
- If you have a health condition, understand what your progress and treatment options are.

Talk with loved ones

- Discuss your wishes and goals for care with your trusted loved ones to help them better understand your decisions.
- Choose one or two trusted loved ones who can be your voice. Involve them as you make your decisions.

Put your wishes into a plan

- Record your decisions and wishes on a document which you can share with loved ones, such as the Advance Care Planning Workbook.
- Share and discuss your choices for future healthcare with your family doctor.

Review your preferences

- You can always change your mind after your plans are made. If that happens, be sure to update your ACP documents and make new copies for the people you trust.
When this line goes flat and the beeping stops, call me!
OUR VISION
Redefining Medicine
Transforming Healthcare

OUR MISSION
Equipping doctors who advance
the science and practice of medicine
for the good of humanity.
The doctors you and I would
like to have caring for us.

World-Class Education
An innovative, cutting-edge,
forward-thinking
and highly relevant
world-class curriculum

Transformative Research
Impactful multi-disciplinary
collaborative research
to improve healthcare
and hence lives

Synergistic Partnerships
Leveraging partnerships
with our education, research
and healthcare partners
for innovative solutions

KEY FOCUS AREAS OF OUR MISSION

OUR VALUES

Humility
We serve with
humility and
appreciate our
individual
and collective roles
towards advancing
medicine and
transforming healthcare.

Compassion
We serve with
compassion and
dedicate our actions
to benefit our
patients, society
and positively impact
lives today
and tomorrow.

Integrity
We adhere firmly to our
principles of ethical conduct
and will never compromise the
trust others have placed in us.

Professionalism
We perform to the
highest standards
and seek excellence
in the science and
practice of medicine.

Continuous Learning
We commit ourselves to
continuous learning, innovation
and improvement for the
advancement of healthcare
in Singapore and beyond.
DEPARTMENT OF INDIFFERENCE

DAVE COPPERNEER

SO WHAT
Humans of Palliative Care Singapore
www.hopcsrg.wix.com/hopalliativecare
We make progress in society only if we stop cursing and complaining about its shortcomings and have the courage to do something about them.

Elisabeth Kubler-Ross

Thank you
andyhyho@ntu.edu.sg