

Dying at Home

By Dr Jeremy Lim, Editorial Board Member

“The financial system as it stands, however, often makes community and home care, which are considerably cheaper than acute hospital care, paradoxically more expensive for the patients and their families because of the relative lack of subsidy or support. Sadly, many patients who are discharged from tertiary care have already exhausted the financial resources of their families, and even highly subsidised community-based care may become prohibitively expensive.”

– Excerpt from the study “What do doctors say about care of the dying”

Academics Dr Jacinta Tan and Dr Jacqueline Chin are to be commended for their work in highlighting challenges of palliative care in the aforementioned study. One key issue identified is the perversion of healthcare financing against dying at home, which surveys overwhelmingly describe as patients’ strong preference.

Why does this happen? I would put forward three causes, all of which do not stand up to careful scrutiny and should be rectified.

Firstly, government subsidies have always been skewed towards hospital and inpatient services. This may have been reasonable a decade ago, when outpatient charges were indeed modest and inpatient fees potentially catastrophic. But Medicine has transformed in the last decade. So much more can be done in the outpatient and community setting with comparable safety and quality but much higher patient satisfaction and wellbeing. Policy makers need to expunge this unfounded bias towards hospital-based funding and move towards equal funding for equivalent outcomes.

Secondly, the obsession with moral hazards and co-payments is an unhealthy

one unmeritorious when blindly applied to palliative care. Moral hazards are very real but in end-of-life care, should we be too concerned? After all, we can only die once. And as Tan and Chin allude to in the above quote, patients often leave tertiary care financially devastated and a second unkind blow imposed by ill-informed application of co-payments is unhelpful. Do we mean test primary education? No. Should we mean test palliative care subsidies?

Finally, the elephant in the room which no one speaks about is the relatively low emphasis placed on subjective wellbeing and the disproportionate reliance on “objective” metrics. Hence in the name of good governance and “demonstrating value”, many palliative care initiatives may be stillborn. “Hard” key performance indicators (KPIs) such as costs or hospital utilisation may not be impacted, and “soft” KPIs such as psychosocial wellbeing, acceptance of death by grieving relatives etc, are hard to objectively document outside scientific studies. In fact, I would argue that the funders’ lack of familiarity may be the largest impediment to advancement of end-of-life care. One senior Health Ministry official

remarked to me that unless one experienced the benefits of palliative care directly through the “good death” of a loved one, it would be very hard to truly appreciate its value. This is the failing of the palliative care community; we must do better.

The former Minister for Health Khaw Boon Wan was a great advocate for palliative care and proclaimed in Parliament last year: “We know that many terminally ill patients prefer to spend their last days at home, in familiar surroundings accompanied by their loved ones. We should support these preferences as far as practicable by growing community support services for home palliative care.”

Less than half of these patients’ deaths occur in the familiarity of home with loved ones beside; it’s time to improve this horrible statistic. **SMA**



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