

2023 NATIONAL STRATEGY FOR PALLIATIVE CARE

A REPORT

CONTENTS

Acknowledgement	3
Foreword	5
Executive Summary	7
Background	10
Stocktake and Gaps Analyses	13
NSPC Framework	24
Recommendations and Implementation Plans	25
Conclusion	43
Glossary	44

ACKNOWLEDGEMENT

We would like to thank the members and Secretariat of the National Strategy for Palliative Care Review Workgroup, as well as our many partners in government, healthcare, community, and the palliative care sector, who contributed significantly to this report.

This report was developed by the **National Strategy for Palliative Care (NSPC) Review Workgroup:**

Dr Angel Lee Onn Kei (Chairperson)	Medical Director, St. Andrew's Community Hospital
A/Prof Edward Poon Wing Hong (Vice-Chairperson)	Chief Nurse and Academic Director, St. Luke's ElderCare
Prof Pang Weng Sun (Advisor)	Vice-Dean, Lee Kong Chian School of Medicine Senior Consultant, National Healthcare Group
A/Prof Allyn Hum Yin Mei	Centre Director, Palliative Care Centre for Excellence in Research and Education
A/Prof Lee Geok Ling	A/Prof, Department of Social Work, Faculty of Arts and Social Sciences, National University of Singapore
Prof Eric Andrew Finkelstein	Executive Director, Lien Centre for Palliative Care (LCPC)
A/Prof Noreen Chan Guek Cheng	Undergraduate Medical Education Director for Palliative Medicine, Yong Loo Lin School of Medicine, National University of Singapore Head and Senior Consultant, Division of Palliative Care, National University Cancer Institute Singapore (NCIS)
Dr Norhisham bin Main	Head, Division of Supportive Care and Palliative Medicine, Department of Medicine, Ng Teng Fong Hospital Cluster Head, National University Health System
A/Prof Patricia Neo Seok Hui	Head, Division of Supportive and Palliative Care, National Cancer Centre Singapore Head, SingHealth and Duke-NUS Supportive & Palliative Care Centre
Dr Chong Poh Heng	Medical Director, HCA Hospice Ltd

A/Prof Wu Huei Yaw	Deputy Chairman, Medical Board (Division of Integrated and Community Care), Woodlands Health Cluster Head, National Healthcare Group
Dr Michael Wong Tack Keong	Group Director, SingHealth Office of Regional Health System Senior Consultant, SingHealth Polyclinics
Ms Melissa Chua Hui Ling	Deputy Chief Allied Health Officer, Ministry of Health Deputy Director, Allied Health, Sengkang General Hospital
Ms Tan Ching Yee	Head, Psychosocial Services, HCA Hospice Ltd
Dr Wong Loong Mun	Chief, Care and Integration Operations Division and Customer Experience Division, Agency for Integrated Care
Ms Sylvia Lee Ling Ling	Advanced Practice Nurse, Dover Park Hospice
Ms Kay Chew Lin	Pastoral Counsellor, Dover Park Hospice
Ms Gillian Magdalene Beins	Acting Director of Nursing, St Theresa Nursing Home

With Support of:

A/Prof Alethea Yee Chung Pheng	Senior Consultant, Division of Supportive and Palliative Care, National Cancer Centre Singapore (NCCS) Deputy Head, SingHealth Duke-NUS Supportive and Palliative Care Centre
Asst Prof Chetna Malhotra	Deputy Director of Research, Lien Centre for Palliative Care
Asst Prof Grace Yang Mei Juan	Senior Consultant, National Cancer Centre Singapore Director of Research, SingHealth Duke-NUS Supportive and Palliative Care Centre
Asst Prof Shirlyn Neo Hui Shan	Senior Consultant, Division of Supportive and Palliative Care, National Cancer Centre Singapore
Asst Prof Zhuang Qingyuan	Consultant, Division of Supportive and Palliative Care, National Cancer Centre Singapore
Ms Tay Ri Yin	Senior Research Executive, Palliative Care Centre for Excellence in Research and Education Speech Therapist, Dover Park Hospice

Secretariat

MOH Ageing Planning Office

AIC Primary and Community Care Development Division

FOREWORD

“As Singapore ages, the number of patients in Singapore requiring holistic palliative care will also increase. Having high quality palliative care is therefore not just a public health priority, but also a key pillar of a compassionate healthcare system, the path to a dignified peaceful death.”

– Mr Ong Ye Kung (Minister of Health) in his speech at the 2021 Dover Park Hospice Virtual Sunflower Dinner.

We have witnessed great progress in our healthcare delivery and the advancement of medical technology. As of 2022, our average life expectancy stands at 83 years, amongst the highest globally. In tandem with this is the expected increase in the number of patients diagnosed with life-threatening illnesses such as advanced cancer and chronic illnesses. The delivery of palliative care services must adapt promptly and effectively in response to these evolving needs.

With Healthier SG, the approach to healthcare delivery has also evolved, placing renewed focus on primary care and community care, and re-defining roles and priorities within the healthcare system. For the palliative care sector, this means stronger partnerships between regional health systems and community care providers to better coordinate and organise palliative care across different care settings. There is also an increased urgency to prepare our population with greater awareness and understanding of end-of-life needs.

There is thus an urgent need for a refreshed NSPC to articulate the way forward towards better palliative care as one of our national healthcare priorities and meet the aspirations of our population.

With the recommendations put forth by the NSPC Review Workgroup in this report, we believe that its implementation will improve palliative care for all in Singapore.

On behalf of the Workgroup, we are grateful to palliative care community, Cluster representatives, the Agency for Integrated Care, staff from various Ministry of Health divisions and other members of the healthcare fraternity for helping to map out a refreshed strategy since the last NSPC in 2011, in line with the national direction.

Sincerely,

Dr Angel Lee & A/Prof Edward Poon

2023 NSPC Review Workgroup Chairperson and Vice-chairperson

EXECUTIVE SUMMARY

Palliative care refers to an approach that aims to improve the quality of life and alleviate the suffering of patients, and their families, facing challenges associated with life-threatening illness. Since the first NSPC was formulated in 2011, significant progress has been achieved in the palliative care sector, including the establishment of the National Guidelines for Palliative Care (NGPC), implementation of financing schemes to enhance affordability and the significant expansions in overall capacity for palliative care services.

With an ageing population and increasingly diverse healthcare needs, the demand for palliative care services is projected to rise. The NSPC Review Workgroup was convened in 2022 to evaluate gaps in the existing provision of palliative care, chart out a vision for the sector over the next decade, and formulate recommendations and guidance for implementing plans to achieve this vision.

This report summarises the Workgroup's findings, and proposes a new NSPC 2023 framework, which sets the future direction for the palliative care development in Singapore. The framework focuses on three focus areas of **Access, Quality** and **Palliative Care Environment**, with **eleven** recommendations, implementation plans and indicators to track progress.

NSPC 2023 Vision: Ensuring that all Singaporeans, including their caregivers, have access to quality palliative care services, delivered by trained professionals, supported by a conducive palliative care environment.

Focus Area 1: Access

All patients with life-threatening illnesses are able to access palliative care that meets their needs in a timely manner.

1. Establish adequate palliative care capacity and supply of trained manpower across settings and service tiers to meet national palliative care needs.
2. Implement a sustainable palliative care model that provides an appropriate level of support to individuals with varying levels of palliative care needs through tiered services, and ensures timely identification and access to palliative care.
3. Conduct a comprehensive review on financing frameworks for palliative care services and financial support schemes, and implement measures to ensure affordable end-of-life (EOL) care.
4. Conduct a comprehensive evaluation of controlled drugs protocol and provide access to appropriate use of controlled drugs across palliative care settings to enable quality of life.

Focus Area 2: Quality

All patients with life-threatening illnesses receive quality palliative care and providers strive for continuous improvement beyond minimum standards.

5. Enhance National Guidelines for Palliative Care (NGPC) to include general palliative care providers, and to ensure greater coverage of psycho-social-spiritual domains.
6. Measure outcomes and implement sector-wide performance tracking to ensure high quality standards in palliative care delivery.
7. National benchmarking and tracking of process and outcome measures should be developed for all specialist palliative care providers.

Focus Area 3: Palliative Care Environment

All stakeholders (e.g. professionals, caregivers, and public) are able to leverage a supportive and growing palliative care environment.

8. Provide caregivers of palliative care patients with adequate support within the community through enhancing respite care provision, caregiver training and increasing workplace support.
9. Implement a coordinated communications and engagement strategy to encourage death literacy and build a compassionate community.
10. Develop a leadership pipeline across the palliative care fraternity (hospital and community settings) with experience in the community sector.
11. Prioritise research focusing in areas in line with national policy direction, such as delivering and funding palliative care with a population health approach.

With the submission of the Workgroup's report, an Implementation Committee will be formed to implement the recommendations, in phases, over the next few years.

BACKGROUND

1. Palliative Care in Singapore

- 1.1. Palliative care refers to an approach that aims to improve the quality of life and alleviate the suffering of patients, and their families, facing challenges associated with life-threatening illness¹. Palliative care services support patients in their end-of-life stage in accordance with their wishes and alleviate the caregiving burden borne by their caregivers, through the provision of the necessary physical, psychological, social and spiritual support.
- 1.2. By the year 2030, 1 in 4 Singapore citizens will be over the age of 65². With an ageing population, our healthcare system will need to shift towards a greater emphasis on population health and aged care systems, to complement the acute care system. This will allow us to better meet the needs of Singaporeans.
- 1.3. With our ageing population and increased life expectancy, more are expected to live longer and suffer from chronic illnesses. In recent years, there has been an upward trend in the number and proportion of individuals with chronic illnesses such as kidney, heart and neurological diseases³ who will need palliative care as their disease progresses. Consequently, the demand for palliative care is projected to increase.
- 1.4. Singaporeans prefer to spend their last days and pass on at home, with recent surveys consistently showing more than 70% of Singaporeans expressing such a preference^{4,5}. Family caregivers play an important role to support this desire. However, with family units becoming smaller, caregiving burden is expected to increase. Coupled with the growing demand for palliative care services, there is an urgent need for adequate and quality palliative care services, and improved support for caregivers of patients with life-threatening illnesses.

¹ World Health Organisation (2023). Palliative Care.

² National Population and Talent Division. Citizen Population Scenarios.

³ National Neuroscience Institute (2018). 22% increase in Singaporeans afflicted with neurological conditions.

⁴ Lien Foundation (2014). Survey on Death attitudes.

⁵ Singapore Management University (2019). End-of-life communication and sentiments towards palliative care in Singapore.

2. A Palliative Care Strategy for Singapore

- 2.1. The Government recognises the growing demand for palliative care and has taken steps to expand and improve the provision of palliative care services. Following the development of palliative care services as a ground-up movement in the 1980s, the Government has funded palliative care services in the community since 1995⁶. In 2006, Palliative Medicine was recognised as a sub-specialty and the number of healthcare workers trained in palliative care has since grown.
- 2.2. In 2011, the Ministry of Health (MOH) commissioned the Lien Centre for Palliative Care (LCPC) under Duke-NUS to formulate the first National Strategy for Palliative Care (NSPC), in consultation with key stakeholders in the palliative care sector. Based on a review of the existing system and services and taking into consideration local and overseas best practices and evidence-based interventions, the NSPC outlined ten broad goals and recommendations to develop Singapore's palliative care sector.
- 2.3. Following the 2011 NSPC report, the first National Guidelines for Palliative Care (NGPC) were created by the Singapore Hospice Council (SHC), with support from MOH and other key stakeholders, as a first step towards achieving minimum standards in three key domains: (i) patient care, (ii) caregiver support, and (iii) staff and volunteer management. The ensuing years saw the initiation of new programmes and care models in hospitals and the community, the establishment of new services and growing awareness, and receptivity towards palliative care.
- 2.4. Over the last decade, there has also been significant growth in the number of palliative care providers and capacity for palliative care patients. Specifically, capacity for inpatient hospice care has doubled, while that for home palliative care services has increased by more than 75%. Day hospice services have also become integral in the overall delivery of palliative care, offering respite for caregivers, and providing a supportive and safe environment for patients.

⁶ Goh, C. R. (1996). Singapore: Status of cancer pain and palliative care. *Journal of pain and symptom management*, 12(2), 130-132.

2.5. The efforts and initiatives launched by the organisations and individuals in the palliative care sector over the years have culminated in palliative care becoming an established and essential service, both within hospitals and in the community, and generating broad interest at the national level.

3. Beyond The NSPC: What is Next for Palliative Care In Singapore

- 3.1. Given that more than a decade has passed since the formulation of the first NSPC, it is timely to review its progress by charting out a refreshed strategy that better meets our future needs and aligns with broader shifts in the healthcare system, such as Healthier SG.
- 3.2. The NSPC Review Workgroup was thus convened in mid-2022 to take stock of the nation's progress in palliative care and propose future-forward recommendations for the sector.
- 3.3. This report shares the findings from the analyses undertaken by the Workgroup. The findings encompass the achievements and gaps in the current palliative care landscape, and a suite of recommendations and guidance on implementation plans.

STOCKTAKE AND GAPS ANALYSIS

4. Notable Developments in Palliative Care

4.1. Over the past decade, Singapore has made significant progress in the ten broad palliative care goals, as outlined in the NSPC 2011 report. The key achievements since the NSPC 2011 are listed in [Table 1](#) below.

Table 1. Table of key palliative care achievements since 2011

Access
<i>Capacity</i>
1. Increased capacity of palliative care services from 2014 to 2021. Inpatient beds per 100,000 population increased by 80% from 2014 to 2021 (from 3.6 to 6.6), day hospice clients per 100,000 population increased by nearly 50% from 2016 to 2021 (from 7.1 to 10.5), and home palliative care clients per 100,000 population increased by 40% from 2015 to 2021 (from 132 to 185)⁷ 2. Launch of the Inpatient Hospice Palliative Care Service (IHPCS) in 2020 to provide a common service framework based on patient's needs, and streamline inpatient services offered in community hospitals and inpatient hospices into a single service type. 3. Increased partnerships between nursing homes and Regional Health Systems (RHS) under pilot programmes to build capabilities in nursing homes and improve care continuity for nursing home residents
<i>Affordability</i>
4. In 2015, the MediSave (MSV) withdrawal limit for inpatient hospice services was increased from \$160/day to \$200/day. With the introduction of IHPCS in 2020, this was replaced with MSV limits of \$250/day and \$350/day for general and specialised palliative care respectively. MediShield Life was also extended, under the limits of \$250/day and \$350/day for general and specialised palliative care respectively.

⁷ Administrative data from the Ministry of Health.

5. In 2015, the MSV lifetime withdrawal limit for home palliative care was raised from \$1,500 to \$2,500, with no limit for those with terminal cancer and end-stage organ failure, and using their own MSV. In 2021, the MSV lifetime limit was removed for patients with advanced dementia as well.
6. Since 2016, government funding and MSV use were extended to day hospice services under the same MSV withdrawal limits for home palliative care. Since 2014, there was a shift towards monthly funding for home palliative care.

Manpower

7. Launch of Graduate Diploma in Palliative Medicine in 2014, by the Division of Graduate Medical Studies, NUS Yong Loo Lin School of Medicine.
8. Post-registration programmes for Nursing (e.g. Advanced Diploma in Palliative Care Nursing and Specialist Diploma in Palliative Care Nursing) were offered since 2011 by Nanyang Polytechnic (NYP) and since 2012 by Ngee Ann Polytechnic (NP).
9. Numerous palliative care courses for allied healthcare professionals have been developed and offered over the years. These include courses for nurses, therapists, pharmacists and social workers run by the Lien Centre for Palliative Care under Duke-NUS, and the Palliative Care Centre for Excellence in Research and Education (PaIC).
10. The number of healthcare professionals trained in palliative care increased significantly from about 100 in 2011 to more than 3,800 in 2021, through courses run by AIC-appointed Learning Institutes, SHC, LCPC, NUS, NP and NYP.
11. The Palliative Nursing Competency Framework (PCNF) was established in October 2022 for the acute, primary and community care setting, providing a guide on the roles, responsibilities and competencies for nurses working in palliative care settings.

Quality

Holistic care

12. Incorporation of Advance Care Planning (ACP) into care planning process, within a national framework with accreditation and standardised training curriculum, allowing patients to better decide the type of care they would like to receive.
13. Provision of support and respite for caregivers through the Home-Based Respite Care service launched in 2019.

Standards

14. Formulation of NGPC in 2014⁸ to articulate palliative care standards across the various healthcare settings, commissioned by MOH and implemented by SHC.
15. Biennial voluntary self-assessments of specialist providers showed an overall improvement in service metrics from 2015 to 2021, such as timely identification, reducing barriers to care, ACP and patient-centred care. Other metrics that have improved include better pain control, better holistic assessment of patients' end-of-life symptoms such as nausea and vomiting, and better holistic assessment of patients' anxiety and depression.
16. Setting up of National Palliative Care Minimum Dataset (MDS) and National Caregiver Response Survey (CaRES) by the SHC to inform standards and quality improvement.

Palliative Care Environment

Leadership

17. Setting up of dedicated palliative care teams in the Ministry of Health and the Agency for Integrated Care (AIC) to oversee and implement palliative care strategies on the ground.
18. Expansion of roles of SHC to champion quality improvement and public communications.

Research

19. Two well-established research institutes in Singapore that advance palliative care research and drive palliative care education i.e. LCPC and PaIC. Since LCPC's inception in 2008 and PaIC's inception in 2017, the two Centres have published nearly 500 academic articles on various topics related to palliative and end-of-life care.
20. In the past decade, research has extensively covered caregiver support, understanding end-of-life preferences, and the evaluation and implementation of interdisciplinary models of care with palliative care, such as the National Health Group's (NHG) Programme Impact (focusing on non-cancer patients) and

⁸ Singapore Hospice Council's official website.

Programme Dignity (focusing on dementia patients), which had helped shaped funding for palliative care.

Community Engagement

21. Appointment of SHC and AIC to lead public engagement efforts including media publicity and annual roadshows to raise awareness of palliative care and ACP respectively.
22. Awareness and familiarity amongst healthcare professionals with palliative care services have increased⁹. In 2014, 38% of doctors and 45% of nurses surveyed consider themselves to be familiar or very familiar with palliative care, while 57% of doctors, nurses and other healthcare professionals were familiar or very familiar with hospice and palliative care in 2020.
23. Notably, most healthcare professionals surveyed in 2020 (89%) viewed ACP as important or very important, with most (54%) being comfortable with facilitating ACP with patients. These results reflect the impact of ACP training and education in influencing healthcare professionals' attitudes and practices in ACP.
24. Amongst the general public, there has also been a slight increase in awareness and comfort levels in end-of-life discussions. In 2014, only 50% of Singaporeans surveyed were aware of hospice palliative care, while in 2019, some 53% of Singaporeans surveyed were comfortable discussing this topic¹⁰.

5. Gaps and Opportunities in Palliative Care

- 5.1. Despite the notable progress, there continues to be room for improvement. We have identified gaps and opportunities in three key domains: access, quality, and palliative care environment.

⁹ 2014 Lien Foundation Death Attitudes Survey (Doctors and Nurses) and 2020 SHC survey on Awareness and Understanding of Hospice and Palliative Care among Healthcare Professionals.

¹⁰ Singapore Management University (2019). End of life communication and sentiments towards palliative care in Singapore.

5.2. Accessibility of Palliative Care in Singapore

Lack of timely identification of palliative care patients

5.2.1. **A significant proportion of patients with life-threatening illnesses do not receive palliative care.** Only about 40% of decedents in Singapore received specialist care services between 2017 to 2020¹¹. This is lower than the estimated demand (69% to 82% of deaths) in high-income countries^{12,13,14}, indicating suboptimal access to palliative care for the dying in Singapore. The overall median time duration of palliative care from referral to death is short, at 22 days¹⁵. While the proportion of non-cancer patients amongst those who accessed palliative care has increased from 25% in 2017 to 29% in 2020¹⁶, non-cancer patients were referred much later than cancer patients. The median duration of palliative care before death for non-cancer patients at 9 days, and 33 days for cancer patients from April 2021 to March 2022¹⁷. This highlights the need for better and more timely identification of patients who might benefit from palliative care, especially for non-cancer patients.

5.2.2. **Palliative care provision in community settings (e.g. nursing homes), is low and poorly tracked.** While access to palliative care services has been made possible with palliative care partnerships established within these care settings, such as in nursing homes¹⁸, it is still inadequate as such programmes

¹¹ Singapore Hospice Council (2022). National quality improvement project – Minimum data set.

¹² Etkind, S. N., Bone, A. E., Gomes, B., Lovell, N., Evans, C. J., Higginson, I. J., & Murtagh, F. E. M. (2017). How many people will need palliative care in 2040? Past trends, future projections and implications for services. *BMC medicine*, 15(1), 1-10.

¹³ Finucane, A. M., Bone, A. E., Etkind, S., Carr, D., Meade, R., Munoz-Arroyo, R., ... & Murray, S. A. (2021). How many people will need palliative care in Scotland by 2040? A mixed-method study of projected palliative care need and recommendations for service delivery. *BMJ open*, 11(2), e041317.

¹⁴ Murtagh, F. E., Bausewein, C., Verne, J., Groeneveld, E. I., Kaloki, Y. E., & Higginson, I. J. (2014). How many people need palliative care? A study developing and comparing methods for population-based estimates. *Palliative medicine*, 28(1), 49-58.

¹⁵ Singapore Hospice Council (2023). National quality improvement project – Minimum data set.

¹⁶ Singapore Hospice Council (2022). National quality improvement project – Minimum data set. Median time from referral to death ranged from 27 to 35 days for those with a cancer diagnoses and 11 to 13 days for those with non-cancer diagnoses.

¹⁷ Refer to footnote 16.

¹⁸ These nursing home programmes include Tan Tock Seng's Project CARE programme, Khoo Teck Phuat's GeriCare programme, Changi General Hospital's EAGLECare programme, St Luke's Hospital Nursing Home Support Team programme and St. Andrew's Community Hospital's Violet Programme.

are unevenly spread throughout the community and with varying levels of capabilities within these settings. There is a need to expand general palliative care capabilities to right-site patients according to their needs.

Inadequate access to opioids

- 5.2.3. **Access to opioids to support palliative care, particularly in the community, is inadequate.** Access to and medical use of opioids are surrogate measures of good palliative care¹⁹. While medical use of opioids has increased over time in Singapore²⁰, several challenges continue to pose as a barrier to the access to and medical use of opioids for pain management in the community. For example, in nursing homes, access to opioids is impeded by lack of manpower to administer opioids at night; and lack of clarity over requirements for storing and administering controlled drugs²¹.

Perceived unaffordability of palliative care across care settings

- 5.2.4. **Majority of patients and caregivers perceive palliative care to be unaffordable.** Despite significant government subsidies (see [Table 2](#)), charity dollars, and financial support schemes that have enabled majority of palliative care patients to pay no to low out-of-pocket expenses for palliative care²², 64% of Singaporeans surveyed still perceived palliative care services as costly, with 43% of Singaporeans surveyed citing cost as a potential barrier to uptake²³.

¹⁹ World Health Organisation (2021). Assessing the development of palliative care worldwide: a set of actionable indicators.

²⁰ Zin, C. S. (2020). Ten years of strong opioid analgesics consumption in Malaysia and other Southeast Asian countries. *Journal of Pharmacy & Bioallied Sciences*, 12(Suppl 2), S846.

²¹ From 2019 study by MOH of palliative care in home and nursing home settings, which revealed that nursing homes faced challenges in providing end-of-life care to their residents due to manpower constraints, lack of trained nursing capabilities, limited communication skills, and insufficient medical and medication support.

²² Patients and families receive financial support and assistance to offset the cost of care, such as the Home Caregiving Grant (HCG), the Seniors' Mobility and Enabling Fund (SMF) and Pioneer Generation Disability Assistance Scheme (PioneerDAS). Those who are severely disabled may also be eligible to receive payouts from CareShieldLife and other disability grant schemes.

²³ Lien Foundation (2014). Survey on death attitudes (Doctors and Nurses)

Table 2: Subsidy framework for each care setting (Singapore Citizens)

Acute inpatient	Community hospital	Inpatient hospice	Day hospice and home palliative care
50% – 80%	30% – 80%	0% – 75%	0% – 80%

5.2.5. There is a significant difference in out-of-pocket expenses between acute and community care, as well as across community care settings. Current financing frameworks pose a barrier to right-siting of care.

Based on the current financing frameworks for palliative care across care settings, most patients have higher out-of-pocket expenses in community care settings, such as inpatient hospices, than in acute settings. Hence, this deters the transition of care from the acute hospital to community settings. In addition, patients who are stepped down from home palliative care to home medical care also incur higher out-of-pocket costs as they can no longer benefit from more generous charity support in the palliative care sector.

Relatively long wait times from referral to assessment

5.2.6. The median wait time between referral to assessment for both home and inpatient palliative care is relatively long at 5 days²⁴. One in four patients experienced longer wait times of more than 8 and 7 days respectively. This could be attributed to inadequate manpower in the specialised palliative care services and sub-optimal geographical distribution of capacity²⁵, as well as inefficiencies in existing workflows.

²⁴ Singapore Hospice Council (2023). National quality improvement project – Minimum data set. Admission proxied by date of first assessment.

²⁵ The data should be interpreted with caution, for the following reasons: (i) referrals from acute hospitals may be raised in advance of patient being ready for discharge, to minimise delays in discharge, (ii) timeliness of assessment for home care patients may be affected by factors beyond provider's control (e.g., availability of caregiver).

Inadequate trained palliative care manpower especially in non-palliative settings

5.2.7. **There remains an inadequate pool of healthcare workers trained in palliative care, particularly in the non-medical professions and general palliative care settings.** Despite the increased emphasis on palliative care education and number of palliative-trained healthcare workers since 2011, about half of healthcare workers surveyed in 2020 considered pre-service and in-service training in palliative care as inadequate²⁶.

5.2.8. **There is a lack of an overarching palliative care training framework particularly for general palliative care.** Palliative care training and capability building is decentralised today, with the onus on the individual and the healthcare institutions. There is no common understanding of the expected palliative care skillsets which different professions and providers should possess. There is thus a need to develop an overarching competency and training framework that articulates these desired palliative care skillsets across specialties and disciplines, and corresponding training programmes, particularly for general palliative care.

5.3. **Quality of Palliative Care in Singapore**

Need for increased caregiver support of palliative care patients

5.3.1. **Caregivers can be better supported in their informational needs and in grief and bereavement.** Caregivers of terminally ill patients face a disproportionate amount of stress. Based on SHC's 2021 National Caregivers Survey (CaRES), caregivers were least equipped with information on coping with demands of caregiving and preparation for their loved ones' imminent death. More can also be done to support caregivers in grief and bereavement, with only 68% of caregivers surveyed responding positively to having such

²⁶ Singapore Hospice Council (2020). Awareness of hospice and palliative care among healthcare professionals 55.5% of respondents cited inadequate pre-service training and 51.% cited that they had received in-service training on hospice and palliative care.

needs met. According to PalC's 2022 study, close to 40% of caregivers of palliative patients are at risk of depression, with the risk increasing when there is a lack of practical assistance and emotional support from family and friends²⁷.

Need for improved continuity of care across settings and providers

5.3.2. **There is room to improve care continuity as patients transit across settings and providers.** In today's healthcare landscape, care has become fragmented, with multiple providers involved in supporting each patient. Despite majority of acute hospitals having a network of care with the community partners, a lack of joint accountability for the care delivered and barriers to data-sharing and seamless communications can impact the quality of palliative care delivered²⁸.

Need for unified outcome monitoring in palliative care

5.3.3. **There is currently no single outcome monitoring framework covering specialised and general palliative care provision across settings. Participation in NGPC self-assessments is not mandatory, with most specialised palliative care providers participating on a voluntary basis, and no participation from general palliative care providers.** With the need to expand general palliative care to meet the rising demand for palliative care, there is a need to enhance the guidelines for general providers and encourage their participation, to hold them to higher standards. In the longer term, a single monitoring framework with national benchmarking will provide greater clarity on the quality and standards Singapore aspires towards.

²⁷ The Straits Times (6 Apr 2023). Over 40% of caregivers at risk of depression amid challenging environment: Survey.

²⁸ In a 2022 survey conducted by PalC of all acute hospitals in Singapore, only 64% of hospitals have processes to ensure care continuity under palliative care post-discharge, and only 27% of hospitals are aware and jointly accountable for the outcomes of care delivered with the community palliative care providers.

5.4. Palliative Care Environment in Singapore

Need to strengthen leadership pipeline in the palliative care sector

- 5.4.1. **Singapore has adequate governance and oversight over the development of its palliative care sector, but there is a lack of a leadership pipeline with exposure to community settings.** In a 2017 online survey²⁹ that aimed to assess global palliative care development of WHO member states, Singapore was found to have met the areas of having (i) a dedicated national palliative care strategy, and (ii) a dedicated unit within the government with responsibility for palliative care. Singapore also has palliative care organisations such as SHC, that leads national efforts in quality improvement and community engagement. However, leadership in the community care sector is overall lacking, with most palliative care leaders concentrated in acute care. There is a need to systematically develop cross-sectoral leadership and provide future leaders in palliative care exposure to the community setting.

Need for continued palliative care research to shape and align with national priorities and policies

- 5.4.2. **LCPC and PalC have been instrumental in promoting high quality research in Singapore, but more can be done to align research with national priorities and to amplify research impact.** Moving forward, research should continue to be aligned to government's priorities, including but not limited to the efficient and effective use of technology, effective financing models, care for complex patients and their caregivers with a focus on allied health and multi-disciplinary team-based care. Apart from conducting research, there is also room to improve the sharing of these research findings with the public through conferences and symposiums,

²⁹ Clelland, D., van Steijn, D., Whitelaw, S., Connor, S., Centeno, C., & Clark, D. (2020). Palliative Care in Public Policy: results from a global survey. *Palliative Medicine Reports*, 1(1), 183-190.

instead of only at peer-reviewed journal publications and scientific conference presentations, which have limited reach to policy-makers and the general public.

Low awareness and comfort levels

5.4.3. **Awareness and comfort levels toward palliative care amongst the general public and healthcare professionals remained low over the past few years.** There has been only a modest increase in the level of awareness and comfort level when discussing end-of-life matters amongst the general public³⁰. Amongst healthcare professionals, despite an increase in the level of familiarity with hospice and palliative care, comfort level in discussing palliative care was low³¹. This suggests that despite the communication efforts led by SHC, more can be done to raise awareness amongst the public and healthcare professionals, for instance, by better anchoring communications efforts within the community, and tailoring messaging for specific target groups.

³⁰ Singapore Management University (2019). End of life communication and sentiments towards palliative care in Singapore.

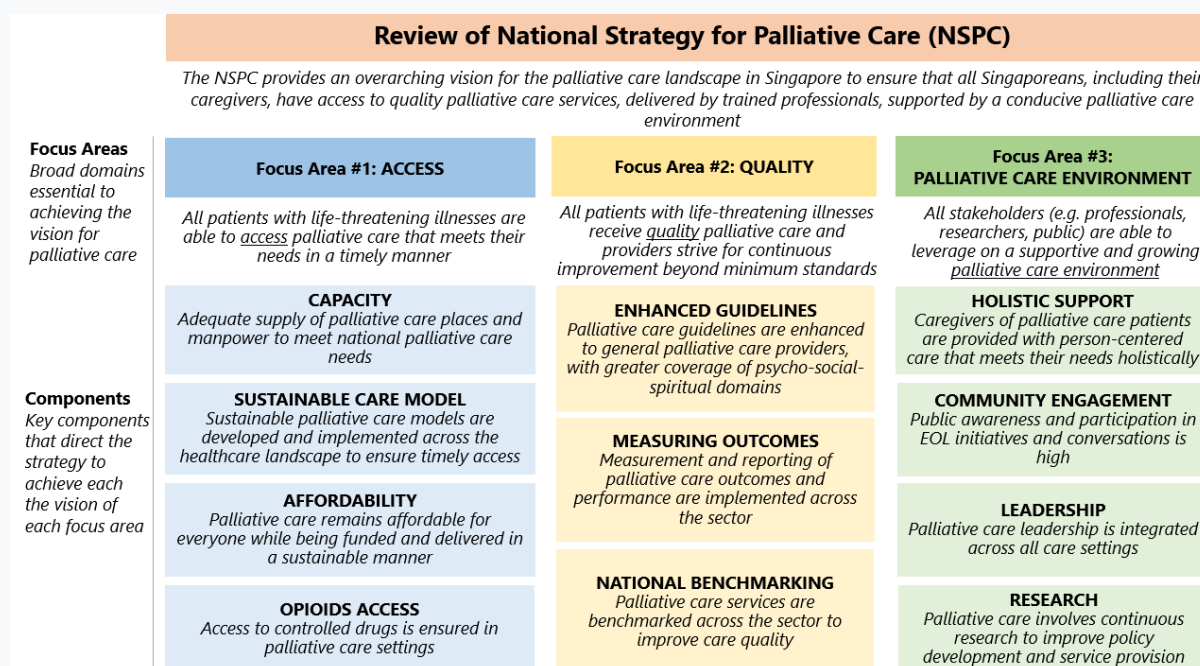
³¹ Singapore Hospice Council (2020). Awareness and understanding on hospice and palliative care among healthcare professionals in Singapore

NSPC FRAMEWORK

6. New NSPC 2023 Framework

- 6.1. Based on the review, the Workgroup developed a new NSPC 2023 framework, which comprises three focus areas, namely Access, Quality, and Palliative Care Environment. The goal for each focus area is articulated in the framework as shown in the [Diagram 1](#) below.

Diagram 1. NSPC 2023 Framework



- 6.2. The framework aims to provide a vision for these focus areas of palliative care in Singapore. It also provides a structure to formulate the key recommendations for the refreshed NSPC, taking reference from the gaps analyses. The following section lays out the recommendations and implementation plans for the sector for the next decade.

RECOMMENDATIONS AND IMPLEMENTATION PLANS

7. Focus Area 1: Access

- 7.1. **Vision:** All patients with life-limiting illnesses are able to access palliative care that meets their needs in a timely manner.

Recommendations

Recommendation 1

- 7.1.1. **Establish adequate palliative care capacity and supply of trained manpower across settings and service tiers to meet national palliative care needs.**

- 7.1.1.1. Adopt a population-based approach to assess and project the future demand for palliative care, and build capacity to meet the demand. National projections for (i) palliative care demand, and (ii) capacity required for specialised and general palliative care services and settings should be regularly refreshed, taking into account plans to progressively raise capabilities of general palliative care providers.
- 7.1.1.2. Establish and regularly review (i) staffing norms for community palliative care settings and (ii) overall manpower staffing needs for the sector, across professions and across care settings. This should inform training capacity to be made available and ensure adequate manpower in the palliative care sector to deliver services, conduct research, and serve in sector leadership.
- 7.1.1.3. Establish training roadmaps for each profession (doctors, nurses, allied health professionals) across settings and clearly define roles and responsibilities of each healthcare profession across settings. Review and enhance existing training programmes, in particular, introduce more comprehensive palliative care curriculum in undergraduate, residency, nursing and social work programmes.

- 7.1.1.4. Define minimum training requirements for specialised palliative care providers, and aspirational training requirements for general palliative care providers. This will provide a common understanding of the expectations of providers in terms of manpower training.

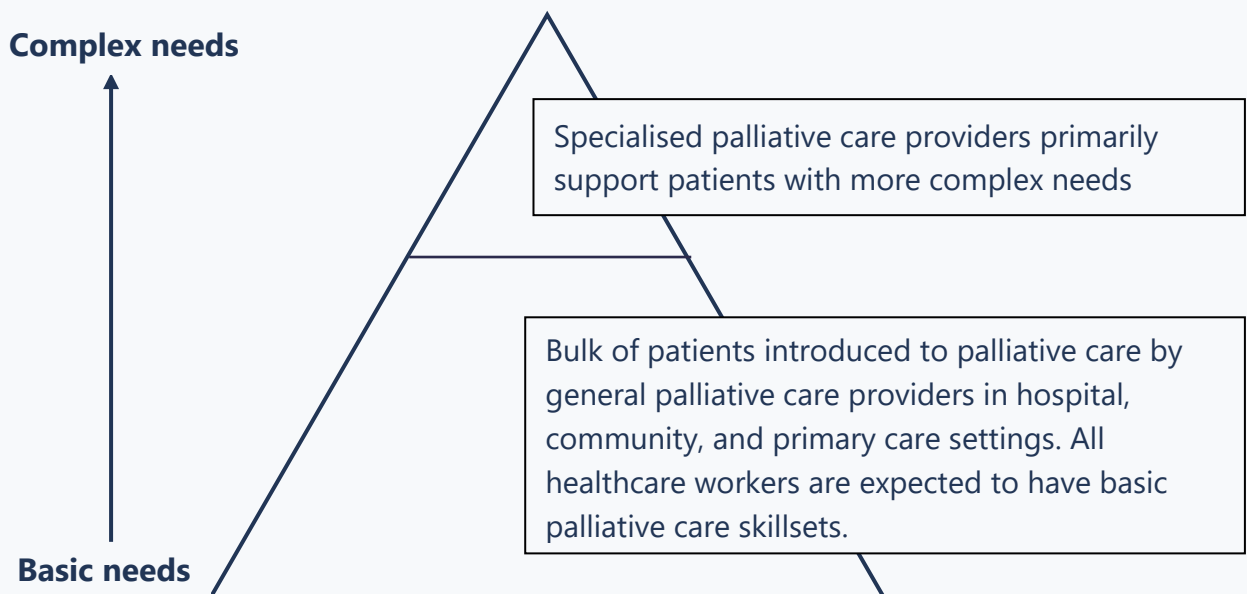
Recommendation 2

- 7.1.2. **Implement a sustainable palliative care model that provides an appropriate level of support to individuals with varying levels of palliative care needs through tiered services, and ensures timely identification and access to palliative care.**

- 7.1.2.1. Develop and expand generalist-led, specialist-supported model of care in the hospital and community to ensure that palliative care can be delivered in a sustainable manner. Such a model of care should be enabled through incorporating general palliative care into various care settings such as nursing homes, home care, and primary care, as part of standard and routine care (see [Diagram 2](#)). Targeted implementation approaches should be adopted for each setting, leveraging existing partnerships and national programmes. For instance, primary care involvement in palliative care should leverage the Healthier SG strategy, under which residents will be enrolled to a family doctor. Pilots to develop care models involving home care³² and nursing home providers should be evaluated and mainstreamed if successful.

³² For instance, the Integrated Home Health pilot to be launched in July 2023, to build capabilities and develop partnerships between Home Medical and Home Nursing providers, and palliative care services.

Diagram 2. Sustainable provision of palliative care within a population



- 7.1.2.2. Develop and adopt clear and standardised definitions for specialised and general palliative care across healthcare settings. The service scope and skillsets required for both specialised and general palliative care provision are to be clearly defined and reviewed from time to time to account for baseline increase in capabilities. By providing a common definition, healthcare providers will have a shared understanding of the scope of palliative care to be provided, which in turn facilitates identification and right-siting of patients into the appropriate palliative care services.
- 7.1.2.3. Implement systematic palliative care screening criteria targeting patients at various stages of their illness trajectory in hospital and community (viz. nursing homes, home care, and primary care). Touchpoints for screening should be guided by screening criteria and implemented to enable (i) timely identification of patients who are at risk of deteriorating health, prompting introduction to palliative care and (ii) timely identification of patients who are at a risk of dying, prompting the activation of specialised palliative care services where needed. Examples of such palliative care screening criteria include

symptom severity, advanced stage of disease, estimated prognosis of less than 1 year and unplanned hospital admissions as an indicator of palliative care needs.

- 7.1.2.4. Implement co-management protocols for general and specialised palliative care teams, across and within settings, and establish referral workflows that guide the appropriate transitions of patients to specialised teams (including community palliative care), or into the community and primary care settings, according to their palliative care needs.
- 7.1.2.5. Implement harmonised compassionate discharge³³ processes across acute hospitals and home palliative care providers, including standard checklists and resources, to ensure timely discharge of end-of-life patients to home.

Recommendation 3

7.1.3. Conduct a comprehensive review on financing frameworks for palliative care services and financial support schemes and implement measures to ensure affordable end-of-life care.

- 7.1.3.1. Conduct a comprehensive review of Singapore's financing framework for palliative care services, including to smoothen the financing gradients across palliative care settings to support right-siting and to enable a smooth care transition.
- 7.1.3.2. Enhance financial support schemes to reduce total and out-of-pocket cost of end-of-life care across settings, such as providing greater financial support for necessary equipment to support a patient's care at home.

³³ Compassionate discharge refers to the discharge of patients who are critically/terminally ill or dying, with a prognosis of 7 days or less to return home or to nursing home.

- 7.1.3.3. Simplify the application process of financial support schemes and improve the care navigation experience and access to information, to ensure timely access to financial support schemes.

Recommendation 4

- 7.1.4. **Conduct a comprehensive evaluation of controlled drugs protocol and provide access to appropriate use of controlled drugs across palliative care settings to enable quality of life.**

- 7.1.4.1. Reduce barriers to access and use of opioids in the community (viz. nursing homes, home care and primary care settings) by ensuring that drug protocols in relation to the supply, storage, and administration of opioids to patients support the provision of palliative care. This includes working with relevant government agencies to ensure that legal and operational requirements are relevant and in place.

7.2. List of Access tracking indicators:

- 7.2.1. To measure the effectiveness of the recommendations in improving access to palliative care services in Singapore, the following indicators should be tracked:

Table 3: Tracking Indicators for Access

Tracking Indicators
Proportion (%) of decedents who received palliative care in the last year of life
Proportion (%) of deaths that occurred outside of acute hospital among decedents who received palliative care services in the last year of life
Time from first palliative care referral to death
Referral rejection and withdrawal rate from palliative services
Proportion (%) of patients who passed away in their preferred place of death
Proportion of institutions providing specialised palliative care with established referral workflows and co-management protocols of palliative care cases
Proportion (%) of nursing home and home medical and nursing care staff, and family doctors trained in basic palliative care
No. of healthcare workers trained in general and specialised palliative care, for each profession

8. Focus Area 2: Quality

- 8.1. **Vision:** All patients with life-limiting illnesses receive quality palliative care and providers strive for continuous improvement beyond minimum standards.

Recommendations

Recommendation 5

- 8.1.1. **Enhance National Guidelines for Palliative Care (NGPC) to include general palliative care providers, and to ensure greater coverage of psycho-social-spiritual domains.**

- 8.1.1.1. Enhance NGPC to general palliative care providers with initial focus on care in nursing homes and in home care services.
- 8.1.1.2. Enhance NGPC to ensure greater coverage of psycho-social-spiritual domains, such as supporting patients' and caregivers' spiritual and psycho-social needs, and provision of grief and bereavement care and support.
- 8.1.1.3. Enhance NGPC to guide providers to develop guidelines and protocols for referring and co-management of patients, including guidelines for referral to specialist palliative care, referrals and co-management for appropriate patients such as end-organ failure patients (e.g. cardiac, renal, respiratory, dementia) and in settings such as intensive care units (ICU).

Recommendation 6

- 8.1.2. **Measure outcomes and implement sector-wide performance tracking to ensure high quality standards in palliative care delivery.**

- 8.1.2.1. Revise the current palliative care minimum service requirements for MOH-funded palliative care providers to give guidance on outcome and performance tracking, such as participating in NGPC biennial assessments for all MOH-subsented specialist palliative care providers.

- 8.1.2.2. Develop measures to increase general palliative care providers' participation in NGPC self-assessments to ensure continuous quality improvement across settings.

Recommendation 7

8.1.3. National benchmarking and tracking of process and outcome measures should be developed for all specialist palliative care providers.

- 8.1.3.1. Implement national benchmarking³⁴ and tracking of process and outcome measures beginning with all specialised palliative care providers, using standardised tools and scales where possible, for international comparability. This will enable the palliative care sector to learn from best practices and improve quality of care.

8.2. List of Quality tracking indicators:

- 8.2.1. To measure the effectiveness of the recommendations in improving access to palliative care services in Singapore, the following tracking indicators are to be employed:

Table 4: Tracking Indicators for Quality

Tracking Indicators
Number of participating institutions in the NGPC biennial assessments for specialised and general palliative care providers
Number and proportion (%) of specialist palliative care providers participating in national benchmarking
Proportion of institutions achieving set minimum standards (80% and above all domains, including psycho-social-spiritual domains)

³⁴ Targets in national benchmarking indicators will be set once ready.

9. Focus Area 3: Palliative Care Environment

- 9.1. **Vision:** All stakeholders (e.g. professionals, caregivers, and public) are able to leverage a supportive and growing palliative care environment.

Recommendations

Recommendation 8

- 9.1.1. **Provide caregivers of palliative care patients with adequate support within the community through enhancing respite care provision, caregiver training and increasing workplace support.**
- 9.1.1.1. Enhance respite care provision services in scope and capacity to provide relief to and alleviate stress experienced by caregivers.
- 9.1.1.2. Develop more caregiver training courses and curate relevant training for caregivers of end-of-life patients, to empower and prepare them with relevant caregiving skills throughout the caregiving journey.
- 9.1.1.3. Explore ways to enhance caregiver support on a societal level by enhancing workplace support for caregivers. This may entail leave provision for caregivers, and/or compassionate leave to be expanded to enable one to care for family members in the dying phase, so that caregivers can have protected time to carry out their caregiving duties.
- 9.1.1.4. Implement an Equipment Rental Scheme to facilitate timely discharge from hospital to home and provide affordable and timely access to equipment for home palliative care patients, through subsidised equipment rental.

Recommendation 9

- 9.1.2. **Implement a coordinated communications and engagement strategy to encourage death literacy and build a compassionate society.**
- 9.1.2.1. Implement a sustained and coordinated communications and engagement strategy to raise awareness and increase uptake of

palliative care and pre-planning, and change attitudes towards death and dying.

- 9.1.2.2. Strengthen death and grief literacy in Singapore through the provision of more accessible information and conversation platforms, for the general public and healthcare professionals to obtain death and grief related information.
- 9.1.2.3. Harness the potential of community volunteers to serve as advocates of palliative care within the community and to provide support to end-of-life patients and caregivers at an individual and community level. This can be done through targeted engagements with partners such as grassroots organisations, faith- and ethnic-based organisations and schools.

Recommendation 10

- 9.1.3. **Develop a leadership pipeline across the palliative care fraternity (hospital and community settings) with experience in the community sector.**

- 9.1.3.1. Develop the next generation of palliative care leaders through proactive and informal engagements and mentorship for junior healthcare workers.
- 9.1.3.2. Set up framework for structured deployments of palliative-trained professionals from hospitals to the community for exposure, in recognition of the need to integrate the community and public healthcare institutions.

Recommendation 11

9.1.4. Prioritise research focusing on areas in line with national policy direction, such as delivering and funding palliative care with a population health approach.

- 9.1.4.1. Develop priority research areas that are in line with national policy direction. These areas should be reviewed from time to time to ensure relevance to ongoing evolution of palliative care. Examples of national priority research areas include: (i) gaps and challenges to palliative care, so as to improve the delivery and funding of palliative care in line with population health approach, (ii) ways to measure and improve both access and quality of palliative care; (iii) innovative models of palliative care, e.g. improved patient-physician communication, use of decision aids, shared decision-making, advance care planning, psychological interventions; (iv) use of technology in palliative care and; (v) implementation science, to better support the translation of palliative care research into policy and subsequent evidence-based practice
- 9.1.4.2. Develop and expand palliative care research programmes to ensure a strong research evidence base for ongoing palliative care development in Singapore. These research programmes should draw on both scientific and clinical expertise to formulate clinically impactful research questions and conduct clinically relevant research studies.
- 9.1.4.3. Strengthen research literacy among healthcare professionals and improve dissemination of research findings among policy-makers and the general public in order to facilitate translation of knowledge to clinical practice.

9.2. **List of Palliative Care Environment tracking indicators:**

9.2.1. To measure the effectiveness of the recommendations in improving access to palliative care services in Singapore, the following tracking indicators are to be employed:

Table 5: Tracking Indicators for Palliative Care Environment

Tracking Indicators
Proportion (%) of caregivers who reported positive caregiver experience score
Level of public awareness of palliative care
Level of comfort discussing own death
Level of comfort discussing death with someone who has a life-threatening illness
Percentage of Singapore residents with a progressive life-limiting condition who have done an ACP
Proportion (%) of specialised palliative care healthcare professionals being rotated to community setting for community exposure
No. of peer-reviewed journal publications on palliative care by authors whose main institutional affiliation is in Singapore

10. Implementation Timeline

10.1. Singapore's refreshed national palliative care strategy will be guided by the recommendations outlined above and their respective implementation plans. The responsibility for the successful implementation of the recommendations will rest with a dedicated cross-sector Implementation Committee. Implementation will take place over a five-year time frame, in phases (see pages 36 – 40).

Table 6: Implementation Timeline

2023	2024	2025	2026	2027
Recommendation 1: Establish adequate palliative care capacity and supply of trained manpower across settings and service tiers to meet national palliative care needs.				
<i>Adopt a population-based approach to assess and project the future demand for palliative care, and build capacity to meet the demand.</i>				
<i>Establish and review staffing norms for community palliative care and overall manpower staffing needs</i>				
<i>Establish training roadmaps for each profession across settings and clearly define roles and responsibilities</i>				
<i>Define minimum training requirements for specialised palliative care providers, and aspirational training requirements for general palliative care providers.</i>				
Recommendation 2: Implement a sustainable palliative care model that provides an appropriate level of support to individuals with varying levels of palliative care needs through tiered services, and ensures timely identification and access to palliative care.				
<i>Develop and expand generalist-led, specialist-supported model of care, in the hospital and community (from 2023), and primary care (from 2026)</i>				
<i>Develop and adopt clear and standardised definitions for specialised and general palliative care across healthcare settings</i>				
<i>Implement systematic screening in hospital and community</i>				
	<i>Implement co-management protocols for general and specialised care teams, across and within settings, including referral workflows that guide appropriate transitions of patients according to their palliative care needs</i>			

2023	2024	2025	2026	2027
Implement harmonised compassionate discharge processes across acute hospitals to facilitate timely discharge home				
Recommendation 3: Conduct a comprehensive review on financing frameworks for palliative care services and financial support schemes and implement measures to ensure affordable end-of-life care.				
Ensure correct financing gradients across palliative care settings and key referral settings by enhancing financing of palliative care				
Review and enhance financial support schemes to reduce total and out-of-pocket cost of end-of-life care across settings				
Simplify the application process of financial support schemes and improve the care navigation experience and access to information				
Recommendation 4: Conduct a comprehensive evaluation of controlled drugs protocol and provide access to appropriate use of controlled drugs across palliative care settings to enable quality of life.				
Reduce barriers to access and use of opioids in the community by ensuring that drug protocols support the provision of palliative care				
Recommendation 5: Enhance National Guidelines for Palliative Care (NGPC) to include general palliative care providers, and to ensure greater coverage of psycho-social-spiritual domains.				
	Enhance NGPC guidelines to general palliative care providers with initial focus on care in nursing homes and in home care services			

2023	2024	2025	2026	2027
	Enhance NGPC to ensure greater coverage of psycho-social-spiritual domains			
	Enhance NGPC to guide providers to develop guidelines and protocols for referring and co-management of patients			
Recommendation 6:. Measure outcomes and implement performance tracking sector-wide to ensure high quality standards in palliative care delivery.				
	Revise the current palliative care minimum service requirements for MOH-funded palliative care providers to give guidance on outcome and performance tracking			
	Develop measures to increase general palliative care providers’ participation in NGPC self-assessments to ensure continuous quality improvement across settings			
Recommendation 7: National benchmarking and tracking of process and outcome measures should be developed for all specialist palliative care providers				
Implement national benchmarking and tracking of process and outcome measures beginning with all specialised palliative care providers.				
Recommendation 8: Provide caregivers of palliative care patients with adequate support within the community through enhancing hospital discharge protocols, respite care provision, caregiver training and increasing workplace support.				

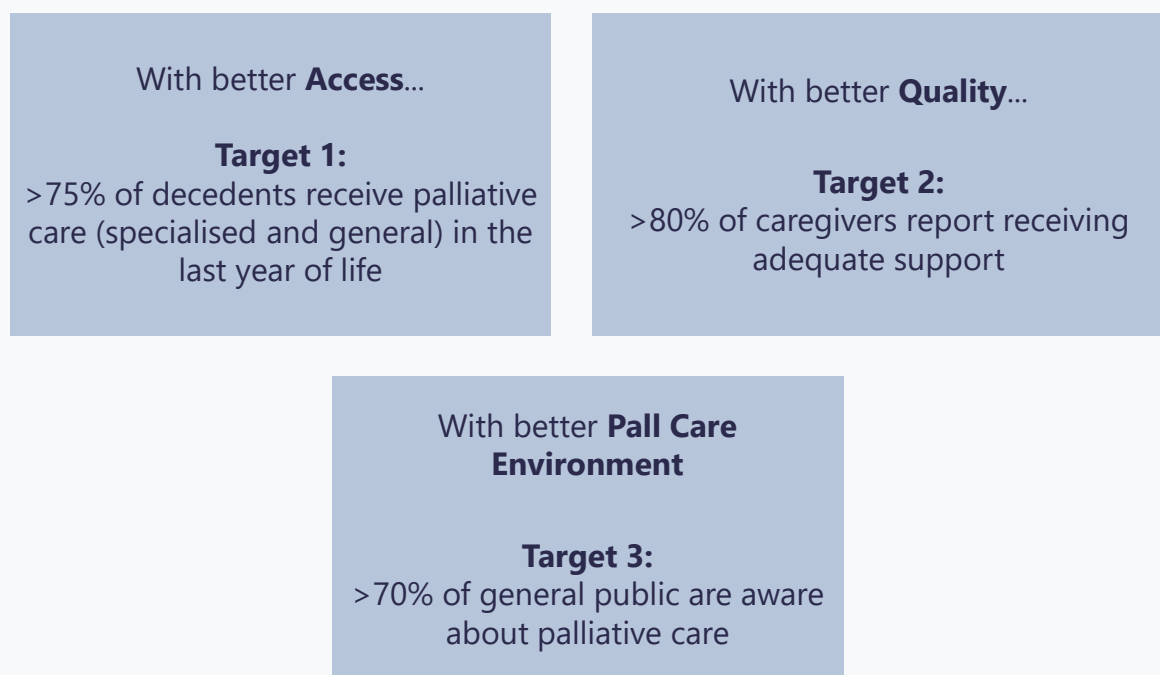
2023	2024	2025	2026	2027
Enhance respite care provision services in scope and capacity to provide relief to and alleviate stress experienced by caregivers				
	Develop more caregiver training courses and curate relevant training for caregivers of end-of-life patients, to empower and prepare them with relevant caregiving skills throughout the caregiving journey			
Explore ways to enhance caregiver support on a societal level by enhancing workplace support for caregivers				
Implement an Equipment Rental Scheme to facilitate timely discharge from hospital to home				
Recommendation 9: Implement a coordinated communications and engagement strategy to encourage death literacy and build a compassionate community.				
Implement a sustained and coordinated communications and engagement strategy to raise awareness of and increase uptake of palliative care and pre-planning				
Strengthen death and grief literacy through the provision of more accessible information platforms, for the general public and healthcare professionals to obtain death and grief related information				
Harness the potential of community volunteers to serve as advocates and provide support				
Recommendation 10: Develop a leadership pipeline across the palliative care fraternity (hospital and community settings) with experience in the community sector.				
	Develop the next generation of palliative care leaders through proactive and informal engagements and mentorship for junior healthcare workers			
	Set up framework for structured deployments of palliative-trained professionals from hospitals to the community for exposure, in recognition of the need to integrate the community and public healthcare institutions			

2023	2024	2025	2026	2027
Recommendation 11: Prioritise research focusing in areas in line with current policy direction, such as delivering and funding palliative care with a population health approach.				
<i>Develop priority research areas that are in line with current policy direction. These areas should be reviewed from time to time to ensure relevance to ongoing evolution of palliative care.</i>				
<i>Strengthen research literacy among healthcare professionals and improve dissemination of research findings among policy-makers and the public in order to facilitate translation of knowledge to clinical practice</i>				

11. Aspirational Goals

11.1. The 2023 NSPC strategy presents a multi-pronged approach with a comprehensive 5-year implementation plan to improve Access, Quality, and the Palliative Care Environment in Singapore. At present, with 40% decedents receiving palliative care in the last year of life³⁵, 68% of caregivers feeling adequately supported³⁶, and only 50% of public aware about palliative care³⁷, the refreshed NSPC aspires to achieve three aspirational targets in the next 5 years (see [Diagram 3](#)). These targets align to the national vision of a healthier Singapore, which includes the healthy patients, healthy caregivers, and healthy experiences of death and dying.

Diagram 3. Three aspirational targets of the 2023 NSPC in the next 5 years



11.2. With specific recommendations supporting the capacity expansion of home care services and enhanced caregiver support, achieving these aspirational targets will greatly support our ambition of shifting deaths from hospitals, from the current 61% to 51% over the next 5 years. This will greatly transform

³⁵ Refer to Para 5.2.1.

³⁶ Refer to Para 5.3.1.

³⁷ Refer to Table 1, Point 25.

the palliative care landscape of Singapore, to allow more Singaporeans will be able to fulfil their final wishes of being cared for and passing on at home.

CONCLUSION

12. The development and implementation of the NSPC is essential to meet the nation's needs for palliative care. By focusing on the 3 areas of Access, Quality, and Palliative care environment, the NSPC will serve as a guiding framework for Singapore's palliative care landscape over the next 5 years to expand access to palliative services, enhance the quality of care and promote a conducive environment for all stakeholders. It is also intended to inspire healthcare providers (both general and specialised), policymakers, communities, and stakeholders to collaborate and work towards a shared vision of improving palliative care in Singapore.
13. The Workgroup further recommends the setting up of an Implementation Committee involving key stakeholders, including SHC, AIC and specialised and general palliative care providers, to implement the recommendations, track progress, and periodically evaluate and refine the strategy.
14. The Workgroup is confident that the NSPC can truly make a positive impact and create a healthcare system that values and supports individuals facing serious illnesses, providing them with comfort, dignity and the highest quality of life possible.

GLOSSARY

Glossary of terms	Definitions
Advance Care Planning	A voluntary process of discussion between an individual and their care providers and persons close to them, with the purpose of clarifying a person's wishes and care preferences for future care should they become seriously ill in the future and are unable to make decisions and/or communicate their wishes to others
Agency for Integrated Care	Independent corporate entity under MOH Holdings (MOHH) to work with stakeholders and partners in developing the Community Care Sector
Caregiver	A person, often but not necessarily a family member, who undertakes to provide for the needs of the patient and who may take on additional technical tasks in the process, e.g. administration of medicines. The primary caregiver is the primary support person for the patient and does not include members of the healthcare team.
Community Hospitals	Community Hospitals are intermediate care facilities. They cater to patients who require a short period of continuing care, usually after their discharge from acute hospitals. The types of care provided at the Community Hospitals include medical, nursing and rehabilitation care.
Compassionate Discharge	Discharge of patients who are critically/terminally ill or dying, with a prognosis of 7 days or less to return home or to nursing home.
Controlled drugs	Any substance or product which is for the time being specified in Part 1, 2 or 3 of the First Schedule of the Misuse of Drugs Act or anything that contains any such substance or product; Includes opioids such as Fentanyl and Morphine.
Day Hospice	Day hospice care provides medical, nursing and psychosocial care in a centre-based environment to end-of-life patients
Death Literacy ³⁸	Death literacy is defined as a set of knowledge and skills that make it possible to gain access to understand and act upon end-of-life and death care options.
General Palliative Care	Palliative care provided as an integral part of standard clinical practice either by a single clinician, or a multidisciplinary team

³⁸ Noonan, K., Horsfall, D., Leonard, R., & Rosenberg, J. (2016). Developing death literacy. *Progress in Palliative Care*, 24(1), 31-35.

	of healthcare professionals who treat patients with life-threatening diseases.
Grief Literacy ³⁹	Knowledge, skills, and values that promote compassion for self and others in the face of loss.
Healthier SG	Transformation of Singapore's healthcare system to shift emphasis from reactively caring for those who are sick, to proactively preventing individuals from falling ill. The key is for our population to reshape their health-seeking behaviours and lifestyles.
Home Palliative Care	Delivers medical and nursing care to end-of-life patients and their families at the senior's residence. The focus of home palliative care is to improve the quality of the patient's remaining days through services such as pain control, symptom relief and nursing care. It also supports the families through bereavement care.
Home-Based Respite Care	Service to support caregivers of patients on home palliative care, including Compassionate Discharge patients, by helping them cope with their loved ones' care needs, and relieve their stress for a time-limited period. Provides an carer (i.e. care staff from a service provider) to care for end-of-life patients at home.
Inpatient Hospice Palliative Care Services	Provides palliative care for end-of-life patients who cannot be cared for at home and require inpatient care. These patients may be admitted for terminal care or a trial of treatment. Can be in inpatient hospices or community hospitals.
Life-limiting illness	Illnesses where there is little or no hope of cure, and it is expected that death will be a direct consequence of the illness. This includes cancer and non-cancer conditions.
MediSave	National healthcare savings scheme that helps individuals set aside part of their income to pay for their healthcare needs, especially in old age.
MediShield Life	Basic health insurance plan that protects all Singapore Citizens and Permanent Residents against large hospital bills and selected costly outpatient treatments for life, regardless of age or health condition.
National Caregiver Response Survey (CaRES)	Survey conducted to measure the experience of bereaved caregivers with regards to the care given to the patient and their caregivers in the last week of life in Singapore.
National Guidelines for Palliative Care	Guidelines to reflect core elements of good palliative care for all institutions in Singapore.

³⁹ Breen, L. J., Kawashima, D., Joy, K., Cadell, S., Roth, D., Chow, A., & Macdonald, M. E. (2022). Grief literacy: A call to action for compassionate communities. *Death studies*, 46(2), 425-433.

National Palliative Care Minimum Dataset	Data Set to provide information on the longitudinal trends in the demographic and clinical profile of patients being referred to palliative care.
Palliative Nursing Competency Framework	Guide to provide clarity on the roles, responsibilities and associated competencies for nurses working in the palliative care settings (first published in 2022).
Patients	Refers to the primary recipient of palliative care.
Population-health approach	Population Health is an approach adopted by many countries, which aims to improve physical and mental health outcomes, promote wellbeing, and reduce health inequalities across an entire population. It focuses on the wider determinants of health and activating people and empowering communities.
Regional Health Systems	Public healthcare system in Singapore is organised into three Integrated clusters - National Healthcare Group (NHG), National University Health System (NUHS) and SingHealth. Each cluster operates healthcare institutions with a range of facilities, capabilities, services, and networks across different care settings.
Respite Care	Respite care provides short-term care at nursing homes, centres or at home.
Singapore Hospice Council (SHC)	Umbrella body representing organisations that actively provide hospice and palliative care in Singapore. Registered charity and an Institution of a Public Character (IPC).
Specialised Palliative Care	Palliative care which is provided by a team of palliative multidisciplinary members who had undergone specialised training, and led by palliative medicine specialist(s) (i.e. doctors who have completed palliative sub-specialty training).