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Research article

Current Challenges and Evolving Strategies in Implementing Cancer and Palliative Care Services in the Philippines

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Abstract

Cancer is the third leading cause of morbidity and mortality in the Philippines. At least one in every ten registered deaths in the country is attributable to cancer, hence it remains a national health priority with significant implications for individuals, families, communities, and the healthcare system. The turning point for the palliative care movement came in 1990, at least 10 years after its initiation into the healthcare system, when the Pain Society of the Philippines supported the government's Cancer Control Programme. This led the way for the Philippine Cancer Society to establish the first home care programme, which naturally sits well among Filipinos because it allowed family members in close-knit family structures to default towards the culturally-ingrained task of caring for their sick and dying at home. For the longest time however, palliative care is synonymous with pain control, and hospice care with death and dying. Amidst the fragmented efforts of the various stakeholders in the implementation of palliative services, the government realizes the need to address all the challenges with appropriate strategies especially the need to establish integrated networks of accredited Cancer Care Centers in strategic areas of the country. To date, 36-palliative care organizations are now listed in the Global Directory of Palliative Care Services and Organizations as members of the International Association for Hospice and Palliative Care. Notwithstanding these challenges, and in the face of enormous need, hospice-palliative care advocates of the Philippine Society for Hospice and Palliative Medicine strive to improve the quality of life of their patients and ensure that, when the time comes, these vulnerable members of Philippine society die with an element of dignity.

Keywords: cancer, palliative care, hospice care, Philippines

Introduction

The Philippines is one of the ten independent member countries of the geopolitical and economic ASEAN organization. It is an archipelago of 7,107 islands nestled between the Philippine Sea and the South China Sea. Its 300,000 square kilometers of land and sea is divided into 17 regions with 81 provinces and 136 cities. Its political, social and economic center located in the capital city of Manila, the second-largest city (population of 1.78 million in 2016) is one of 16 cities that comprise the National Capital Region (population of 13,698,889 in 2019) [1].

The Philippines has a young population. Its current population based on the latest United Nations estimates is 107,357, 495 (as of January 12, 2019), that is equivalent to 1.4% of the total world population with a growth rate of 1.52% and a life expectancy at birth of 69.2 years old. The Commission on Population estimates that there will be 108,885,096 Filipinos by December 31, 2019 and the number of senior citizens or those aged 60 and above are expected to increase by 8.2% in 2019 from around 7.5% in 2015. The United Nations Human Development Index 2018 Report ranks the Philippines 113 out of 189 countries worldwide (value 0.699) which places the Philippines in the group of countries with medium human development, and one of the East Asia and Pacific countries belonging to the lower-middle-income economies [2,3].

The Burden of Cancer

In the Philippines, cancer remains a national health priority with significant implications for individuals, families, communities, and the health system. Cancer is the third leading cause of morbidity and mortality in the country after diseases of the heart and the vascular system and one in every ten registered deaths in the country is attributable to cancer (Philippine Health Statistics 2018) [4]. As of 2012, the International Agency for Research on Cancer (IARC) estimated that in the Philippines, up to eight deaths per day for childhood cancer and up to 11

new cases and seven deaths every hour for adult cancer [5]. This computes to a figure of approximately 110,000 new cancer cases and over 66,000 cancer deaths each year.

Among Filipino men, the 5 most common cause for age-standardized cancer mortality were lung (including trachea and bronchus), prostate, liver, mouth and oropharynx and colon/rectum. Among Filipino women the 5 most common cause for age-standardized cancer mortality were breast, cervix, colon/rectum, liver and lung (including trachea and bronchus). Cancer incidence according to site for males were: lung, liver, prostate, colon rectum and leukemia; and for females were: breast, cervix, colorectum, lung and ovary. The Philippines has the highest prevalence of breast cancer among 197 countries.

The comparative age-standardised DALYs lost per 100,000 from all cancers by country however showed the lowest total burden of cancer in the Philippines (1411 DALYs lost per 100,000) as compared to Laos with the highest total burden of cancer (1941 DALYs lost per 100,000) [6].

The Philippines has a reliable though limited local patient registry, the Philippine Cancer Society—Manila Cancer Registry which is a member of the International Association of Cancer Registries [8]. This was the first population-based cancer registry in the Philippines, established in 1974 as one of the activities of the Community Cancer Control Programme of the province of Rizal. It covers the 26 municipalities of the original province of Rizal [9]. Currently, there are three population-based cancer registries operating in the Philippines, two in Metro Manila and one in Metro Cebu.

Palliative Care

Palliative and end of life care aim to improve the quality of life of patients with life-limiting, complex and chronic illnesses or those experiencing progressively debilitating diseases beyond any benefit from curative treatment. The World Health Organization (WHO) has highlighted the importance of palliative care in the developing world, yet many countries provide limited or no palliative care services. According to the 2006 mapping exercise of the International Observatory on End of Life Care based on the study by Wright, Lynch, & Clark (2008), the Philippines is categorized as under Group 3 in the 4-part typology depicting levels of hospice-palliative care development across the globe [10]. In 2011, a re-mapping exercise was done and two additional levels of categorization (groups 3a and 3b/4a and 4b) were included, and the Philippines is a part of Group 3a. In both instances, the Philippines is categorized together with other countries that have localized palliative care provision.

It is estimated that 30–50% of cancer patients in all stages of the disease will experience pain and 70–95% with advanced disease will have significant pain, but only a fraction of these patients receive adequate treatment. In a study on cancer pain among Filipino patients, 73% had pain related to their disease, 60% of which was persistent. The DOH–PCCP identified cancer pain relief as a priority activity in 1989. It was the first activity that led the way to the Outreach Patient Services (the Hospice-At-Home Concept), pioneered by the Philippine Cancer Society. It primarily implements the WHO analgesic ladder, in a modified way cutting the ladder down to two steps (using weak opioids e.g., tramadol HCl in the second step) [11].

Palliative and hospice care however, is not just about caring for cancer patients, since there is also need to address predominant regional causes of death and terminal illness, such as infectious diseases, e.g., tuberculosis, AIDS, rabies, stroke, dementia, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF),18 end-stage liver disease (ESLD), end-stage chronic kidney disease (CKD) [12-20]. Data from WHO showed that in 2012, about 300,000 of the estimated 515,000 reported deaths in the Philippines were due to noncommunicable diseases such as stroke, heart attack, cancer, chronic lung disease, and diabetes.

While the movement towards palliative care in the Philippines started in the 1980s, the watershed moment came in 1990 when the Pain Society of the Philippines supported the government's Cancer Control Programme [21]. This paved the way for the first home care programme founded by the Philippine Cancer Society. The home care programme naturally sits well among Filipinos because its close-knit family structure allowed family members to default towards the culturally-ingrained task of caring for their sick and dying at home. Back then, and up until now however, palliative care is synonymous with pain control and hospice care with death and dying. Twenty-nine years later, 36-palliative care organizations are listed in the Global Directory of Palliative Care Services and Organizations as members of the International Association for Hospice and Palliative Care [22]. Several hospitals provide training programs accredited by the Philippine Society of Hospice and Palliative Medicine, for interested diplomates in family medicine who want to pursue a subspecialty path in palliative and hospice care. The Philippine Society for Hospice and Palliative Medicine, a member of the Asia-Pacific Hospice Palliative Care Network is taking on the burden of advocating for the integration of all government and private initiatives regarding the implementation of palliative care services in the country.

Current Challenges

As an archipelago, the Philippines' lack of healthcare professionals trained in palliative and hospice care in critical areas like geographically-isolated and disadvantaged area (GIDA) e.g., island provinces, mountainous terrains, and even just rural areas that are far from, or structurally excluded from the cities; lack of infrastructure; mismanagement of resources especially in devolved healthcare systems; limited or no access to academic or continuing professional development among healthcare professionals; and, limited research into specific needs or limited knowledge about appropriate methodologies to use for specific research questions such as in palliative care. Access to healthcare services are limited with fewer cancer prevention and screening services.

The Philippines ranked 78th out of 80 countries in the 2015 Quality of Death Study Index making it one of the worst places to die, next only to Iraq and Bangladesh [23]. The poor rating in terms of the quality of end-of-life care available can be attributed to several challenges as categorized in Table 2.

Evolving Strategies

Amidst the fragmented efforts of the various stakeholders

Table 1. Philippines Cancer Rank by Type [7].

Age-Standardized Death Rate (per 100,000 population)					
	Rate	**World Rank**		**Rank**	**World Rank**
1. Breast Cancer	23.02	25	9. Leukemia	4.41	62
2. Lung Cancer	16.99	72	10. Stomach Cancer	3.07	154
3. Prostate Cancer	13.44	114	11. Lymphomas	2.98	137
4. Liver Cancer	11.42	29	12. Pancreatic Cancer	2.78	105
5. Colon-rectum Cancer	11.26	64	13. Uterine Cancer	1.74	107
6. Cervical Cancer	9.15	84	14. Esophageal Cancer	1.01	153
7. Ovary Cancer	4.80	78	15. Bladder Cancer	0.76	167
8. Oral Cancer	4.75	45	16. Skin Cancer	0.63	153
https://www.worldlifeexpectancy.com/country-health-profile/philippines					

Table 2. Current challenges and evolving strategies to improve implementation of cancer and palliative care services in the Philippines.

Categories	**Current Challenges**	**Evolving Strategies**
National, Regional and Local Healthcare Network	1) Health inequities still abound especially in geographically isolated and disadvantaged areas ● Unfavorable political, administrative and economic environment leads to catastrophic cancer treatment costs and high out-of-pocket expense for the patients ● Limited number of government subsidies or programs for individuals accessing palliative care services ● High incidence of preventable cancer and other preventable chronic noncommunicable diseases in geographically isolated and disadvantaged areas ● Shortage of essential medicines and devices ● Lack of adequate physical structure in health units ● Severe shortage of specialized palliative care professionals and inability to maintain a pool of trained and available volunteers in palliative and hospice care ● Uncoordinated research efforts regarding palliative and hospice care in cancer and chronic communicable and noncommunicable lifestyle diseases	1) Minimize health inequities so all patients regardless of status are provided with cure and symptom relief; ● Promote favorable political, administrative and economic environment through healthcare financing to make cancer treatment and care affordable and ensure less out-of-pocket expense for the patients. PhilHealth Z-Benefit Package for catastrophic diseases (breast, prostate, cervical cancers and childhood acute lymphocytic leukemia) is an in-patient package which includes mandatory diagnostics, operating room expenses, doctor/professional fees, room and board, and medicines. ● Scale up investments in the different components and patient pathways of cancer control ● Provide high-quality, adequately resourced, geographically distributed and connected networks of patient and family-focused integrated cancer care services for the whole cancer care continuum ● Provide for access to quality and affordable essential medicines and drug delivery devices for curative, supportive and palliative care; and ensure the quality of imported off-patent essential medicines in generic formats from distributors with international certification of Good Manufacturing Practices (GMP). ● Build physical structures for palliative and hospice care in national, regional and local

		health units ● Ensure career-pathing and succession planning for palliative care providers in the healthcare network ● Provide a national framework for the conduct of palliative and hospice care research on cancer and chronic communicable and noncommunicable lifestyle diseases
Implementation Process	2) Fragmented efforts among the stakeholders in the implementation in palliative care services ● Physical distance between some health units and palliative care providers ● Lack of physical structure for palliative care services in local health units, and in some areas, palliation outside tertiary hospitals are very inconsistent or non-existent ● Irregular home daily visits by providers of palliative care services. ● Limited or no palliative and hospice care services in hospitals and community centers ● Lack of an electronic medical record system for proper and timely documentation in local, regional and national levels ● Registries and population databases limited to cancer only ● Unawareness of some healthcare administrators regarding palliative care ● Lack of support structure for cancer treatment and care of patients and families ● Lack of support structure for referral of cancer and other terminally-ill patients; recovery and reintegration to society of people living with cancer/terminally-ill patients, survivors, their families, and carers. ● Mismanagement of resources especially in devolved healthcare systems	2) Integration of all efforts to come up with a concerted approach to the implementation in palliative care services ● Provide means of transportation to ensure that palliative care providers gain access to far-flung areas ● Provide physical structure in local health units (barangay or municipal level) to guarantee the promotive–preventive–curative-rehabilitative continuum of palliative care from hospital and into the community / home ● Bridge the families' distance from district hospitals and local clinics through daily home visits by providers of palliative care services ● Provide timely access to optimal cancer treatment and care for all cancer patients, and regular palliative and hospice care services in strategically located hospitals and community centers ● Establish electronic medical record system in palliative and hospice care centers for proper and timely documentation ● Establish registries and population databases for different diseases, other than cancer that require palliative and hospice care needed to establish the database for generation of real world evidence ● Conduct information campaign regarding the need for palliative care services in healthcare units ● Improve the experience of cancer treatment and care for patients and families through the Patient Navigation Program / Medicine Access Program. ● Support referral and eliminate the various forms of burdens, as well as support the recovery and reintegration to society of people

		living with cancer/terminally-ill patients, survivors, their families, and carers. ● Impose adequate control measures to prevent addiction, corruption and diversion of opiates
Healthcare Team	3) Unawareness of the healthcare professionals about the need for palliative care not only in cancer but especially in chronic, non-cancer diseases. ● Limited knowledge / low interest in palliative and hospice care ● Lack of understanding about the implementation of palliative care services ● Lack of understanding about individual roles in the interdisciplinary healthcare team ● Low number of physicians with S2 license that is essential to prescribe opiates	3) Build capacities through continuing professional development in palliative care for all health workers, with a focus not only in cancer but also in chronic, non-cancer disease. ● Provide continuing professional development opportunities to learn about the tenets of palliative and hospice care ● Provide Training of Trainers on Palliative and Hospice Care, and enhance and strengthen the oncology related competencies of health providers in all levels of care especially regarding the prescribing, dispensing and administering of anti-cancer drugs and opiates ● Form healthcare providers into interdisciplinary teams for coordinated provision of palliative and hospice care through capacity building and human resource mobilization ● Assistance in availing of S2 license for physicians engaged in palliative and hospice care
Patients	4) Impaired health and medication literacy among patients so they may resist or be unaware of the need for early treatment and palliation ● Lack of awareness about the evidence-based information for the prevention and treatment of cancer ● Lack of knowledge among patients about the proper timing to plan and seek for palliative care services ● Lack of knowledge about prevention of cancer recurrence and secondary cancer among survivors and people living with cancer. ● Lack of awareness about the need for palliative care among patients who are terminally-ill with communicable and/or chronic lifestyle diseases ● High rate of abandonment or discontinuance of treatment	4) Improve health and medication literacy to alleviate fear, anxiety and stigma among patients so they may seek early treatment and palliation; ● Intensify the cancer awareness campaign and provide the latest evidence-based information for the prevention and treatment of cancer including practical advice and the need for compliance to medication. ● Educate patients so they may understand palliative care and the need to plan while they are not sick and their minds are clear, and to discuss with family members how they want to be cared for. ● Prevent cancer recurrence and secondary cancer among survivors and people living with cancer through patient education ● Educate patients about the spectrum of diseases that are amenable to palliative and hospice care ● Conduct medication literacy campaigns regarding rational drug use

in the implementation of palliative services, the government realizes the need to address all the challenges with appropriate strategies especially the need to establish integrated networks of accredited Cancer Care Centers in strategic areas of the country. In response to the growing and alarming epidemic of cancer, it was deemed necessary to revisit and strengthen the Philippine Cancer Control Program which started in 1990 through Administrative Order No. 89-A s. 1990, amending A.O. No. 188-A s. 1973. Hence, the National Cancer Control Committee (NCCC) developed the National Cancer Prevention and Control Action Plan (NCPCAP) 2015-2020 which now addresses the issues under several clusters, namely: 1) policy and standards development, 2) research and development, 3) information management and surveillance, 4) advocacy and promotions, 5) service delivery, and 6) capacity building and resource mobilization [24]. Seven government hospitals, namely: Philippine General Hospital, Jose Reyes Memorial Medical Center, East Avenue Medical Center, Rizal Medical Center, Amang Rodriguez Memorial Medical Center, Philippine Children's Medical Center and Bicol Regional Training and Teaching Hospital are involved in Training the Trainers in the Patient Navigation Program/Medicine Access Program initiated by the Department of Health.

The Philippine Health Insurance Corporation or PhilHealth has expanded current benefits to include screening, detection, diagnosis, treatment assistance, supportive care, survivorship follow-up care and rehabilitation for all types and stages of cancer in both adults and children. The PhilHealth Z-Benefit Package for catastrophic diseases (breast, prostate, cervical cancers and childhood acute lymphocytic leukemia) now includes an in-patient package which includes mandatory diagnostics, operating room expenses, doctor/professional fees, room and board, and medicines [24].

Another policy enactment is Republic Act 9994 otherwise known "Expanded Senior Citizens Act of 2010" [25]. Although not directly about palliative care, it nevertheless supports the goals of palliative care in its objectives which among other things, provide support for the vulnerable population of senior citizens who might be afflicted with cancer and/or suffering from other chronic debilitating conditions: to wit, "…encourage their families and the communities they live with to reaffirm the valued Filipino tradition of caring for the senior citizens; …(and) provide a comprehensive health care and rehabilitation system for disabled senior citizens to foster their capacity to attain a more meaningful and productive ageing." Privileges of the senior citizen include the grant of twenty percent (20%) discount and exemption from the value-added tax (VAT), if applicable, on the purchase of medicines; on the professional fees of attending physician/s in all private hospitals, medical facilities, outpatient clinics and home health care services; on diagnostic and laboratory fess in all private hospitals, medical facilities, outpatient clinics, and home health care services, in accordance with the rules and regulations to be issued by the DOH, in coordination with the Philippine Health Insurance Corporation (PhilHealth); and, on funeral and burial services for the death of senior citizens.

There are also several legislative initiatives to institutionalize a national integrated cancer control program and palliative and hospice care into the Philippine healthcare system. On August 10, 2016, House Bill No. 2826 AN ACT INTEGRATING PALLIATIVE AND HOSPICE CARE INTO THE PHILIPPINE HEALTH CARE SYSTEM was filed in the Lower House [26]. Its counterpart, Senate Bill No. 1555 was filed in the Upper House on August 16, 2017 [27]. The passage of the bill on palliative and hospice care would decongest government hospitals and stop the draining of public hospital resources intended for indigent patients because it would encourage the development of home-based palliative and hospice care programs at the grassroots level, which would increase the poor's access to quality health service.

On November 12, 2018 the Philippine Senate has approved on third and final reading the Senate Bill 1570 and House Bill 8626 or the National Integrated Cancer Control Act intended to institutionalize an integrated multidisciplinary, multisectoral, nationwide cancer control and management for all types of cancer, for all genders and ages. The Act shall serve as the framework to integrate all cancer-related activities of the government in order to achieve a progressive and sustainable increase in its response capacity, as well as build expected future needs and requirements [28].

The Philippine Cancer Center, under the control and supervision of the University of the Philippines-Philippine General Hospital (UP-PGH), will be established for the treatment and accommodation of cancer patients. The Center will initiate research, in collaboration with other universities, hospital and institutions, for cancer prevention and cure. Likewise, regional cancer centers will be established nationwide for the treatment and care of cancer patients. The center will also undertake and support the training of physicians, nurses, medical technicians, pharmacists, health officers and social workers on good practice models for the delivery of responsive, multidisciplinary, integrated cancer services.

Public funds and institutional resources allocation, and reimbursement for services rendered will be coursed through health insurance programs. On September 2017 HB 5784 was passed in Congress and on October 10, 2018, the Senate approved its counterpart Senate Bill 1896 or The Universal Health Care Bill of the Philippines. It is expected to be passed into law soon whereby palliative and end of life care services to patients with life-threatening diseases will soon be covered by Philhealth. Under the proposed measure, "every Filipino shall be granted immediate eligibility and access to preventive, promotive, curative, rehabilitative, and palliative health services"[29].

When the Universal Health Care Law passes, the Philippine healthcare system will not only work on curing and preventing sickness, it will also promote people's well-being, especially when they are enduring intense pain and suffering from chronic diseases. This measure guarantees the right of Filipinos to quality health care throughout their entire life cycle. The Universal Health Care Bill is a step forward in ensuring that every Filipino family can be given proper care and assistance during the most challenging stages of illness.

Notwithstanding these challenges, and in the face of enormous need, hospice-palliative care activists strive to improve the quality of life of their patients and ensure that,

when the time comes, these vulnerable members of Philippine society die with an element of dignity.

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