Perceptions of Batangueños Towards Palliative Care

Asia Pacific Journal of Education, Arts and Sciences
Vol. 6 No.1, 48-57
January 2019
P-ISSN 2362-8022
E-ISSN 2362-8030
www.apjeas.apjmr.com
ASEAN Citation Index

Cybelle Anne L.Cultura, Anjanette D. Roallos, Dennis L. Silva, Abby Jayne B.Ubaña & Bella P. Magnaye, Cecilia C. Pring
College of Nursing, Lyceum of the Philippines University, Batangas City, Philippines

Date Received: October 28, 2018; Date Revised: January 10, 2019

***Abstract** – The study aimed to explore the perceptions of Batangueño families towards palliative care. Specifically, it aimed to assess the level of understanding of Batangueños towards palliative care, to determine factors affecting the level of understanding of Batangueños towards palliative care, to assess the readiness of the family to engage in palliative care and lastly, to assess the available facilities or resources on palliative care. Quantitative descriptive research design was used in the study. The findings revealed that the Batangueños' understanding of palliative care is limited and focuses only on the patients' comfort and dignity amidst the onset of a life-threatening disease. Financial constraints and limited awareness on the concept of palliative care affect the acceptance of palliative and create doubts in terms of practicing palliative care. Despite the difficulties that the family of patients with chronic diseases faced, they are willing and ready to engage in palliative care if it would provide comfort to the patient. Furthermore, the sense of hope motivates them to engage in palliative care. The most important palliative care available is the knowledge for the patients' families which is extremely important given the close family ties traditions and culture of the respondents while the issue of full insurance coverage is yet to be offered in the palliative care program.*

***Keywords** – Palliative Care, life-threatening disease*

INTRODUCTION

There are two groups of people facing the impending death; they are the aged and the terminally ill. For the former, it seems to be a natural process that life will end up one day. Though the fact is still true for the latter, the process to face the impending death is complicated.

When curative treatment is no longer available, palliative care can be offered to the dying patient. The patient, as well as his/her loved ones has to face and prepare themselves for approaching death. For a person being diagnosed with an incurable disease, it means that he/she has to make a transition from a healthy life to an existence with physical unhealthy and where life has a known terminal point but don´t know when it will be. It can be substantial changes in the patients´ and loved ones lives, from mental, physical and practical view and a new life situation raises questions not only about physical, social, psychological but also of existential character.

As the traditional acute hospitals do not cater for the special needs of the dying patients, worse still, being left unattended and isolated in the ward make the dying process more difficult. Palliative care is one of the attempts to improve the care of the terminally ill. Effort is made to improve the psychosocial care and the quality of life of these patients.

According to the 4-part typology developed by the International Observatory on End of Life Care, the Philippines is categorised as a country in Group 3: that is, with localised palliative care provision. In the Philippines, 34 organisations provide 108 hospice and palliative care services. Alongside these providers, a wide range of groups give compassionate care to the dying. The movement towards palliative and hospice services in the Philippines began in the 1980s and took a significant step forward when pain relief became incorporated into the government's Cancer Control Programme in 1990. The following year, the Philippine Cancer Society founded the first home care programme and offered support to other interested groups. Seventeen years later, 34 hospice-palliative care organisations provide end of life care to needy members of the Philippine population [1].

Hospice and palliative care concepts and principles are part of the curriculum in major medical and nursing schools in the Philippines and palliative care training programmes are delivered to health providers and volunteers [2].

Key concepts to consider in understanding the Filipino perspective on death and dying include cultural values and beliefs related to religion, family, and interpersonal harmony. Religion holds a central place in the life of Filipinos [1]. Miranda and colleagues found that deeply religious Filipinos tended to attribute illness to reasons of God or a higher power. The predominant belief in the causes of disease was the ‘will of God’, even though individuals also believed in personal responsibility [1].

In the Province of Batangas, hospitals do not have a special area for patients with chronic diseases. On the other hand, a typical Filipino, or a Batangueños for that matter would want to enhance the quality of the patients’ remaining life by keeping them comfortable in a familiar environment surrounded with family and friends and not in a sterile environment where visitation hours are managed.

The fact that the Batangueños culture is characterized by its tough nature and strong positive thinking gives the researchers the idea that during the times of peril, they may apply such traits with ease and of course, with accompanied assistance to overcome the doom and face death and die thinking positive towards afterlife as well as for their fellow Filipinos.

In the tragic battle between life and its end, nurses take the front-line for their patients and do their responsibilities as part of the medical team to empower the minds of patients who need them. As for the people as well as the Batangueños, this study will serve as another source of understanding and perspective towards palliative care.

Batangueños are well-known for being conservative, physically, mentally and spiritually resilient with the help and support of their family thus, the proponents chose this study to inform the readers primarily and to create a new perspective and point-of-view for the people specifically Batangueños towards palliative care and how it affects the lives of the individuals involved.

OBJECTIVES OF THE STUDY

The study aims to explore the perceptions of Batangueños families towards palliative care. Specifically, it aims to: (1) assess the level of understanding of Batangueños towards palliative care; (2) determine factors affecting the level of understanding of Batangueños towards palliative care; (3) assess the readiness of the family to engage in palliative care; and (4) assess the available facilities or resources on palliative care.

METHOD

Research Design

The study is descriptive in nature because it describes and documents aspect of a situation as it naturally occurs. On the other hand, it is also qualitative as it quantified the perceptions of the respondents with respect to the subject area for analysis.

Participants

The participants of the study are clients with terminally ill patients and who are permanent residents or clients that are in out-patients’ status, and the clients who are willing to participate.

Instrument

The researchers used a self-made questionnaire which is divided into four parts. The first part is the level of understanding of Batangueños regarding palliative care. The second part is the factors affecting the acceptance/practice of palliative care. The third part is the readiness of the family to engage in palliative care. And lastly, the assessment of the available facilities/resources on palliative care. The questionnaire was used to gather necessary information that was needed in the study. Statements in the questionnaire were formulated based on varieties of books, journals, internet resources, and previous theses and modified self-made questions of the researchers.

Data Collecting Procedure

The research was conducted with the use of systematic procedure. First, the researchers chose an interesting topic that would be analysed and approved by the chairman of the panelist. To meet the needed information, the researchers constructed the questionnaires which were validated by experts. After the necessary validation was obtained, the researchers sought the approval of the Dean, the adviser and the management of the two healthcare institutions in the distribution of the questionnaire.

Data Analysis

After the collection of the questionnaire, the answers were tallied, tabulated and analysed to better present and interpret the gathered data. After the answers to the survey question have been recorded different statistical treatment was used.

To determine the assessment of the respondents regarding their understanding of palliative care, a four-point Likert Scale was used. Answers were statistically treated using weighted mean and ranking to show the level of understanding. The given scale was used to interpret the result of the data gathered: 3.50 – 4.00 = Highly Understood; 2.50 – 3.49 = Understood; 1.50 – 2.49 = Somewhat Understood; 1.00 – 1.49 = Not Understood.

RESULTS AND DISCUSSION

Table 1 presents the level of understanding of Batangueños regarding palliative care. It was found that the respondents understood the notion on palliative care with a composite mean of 3.27.

Table 1. Level of Understanding of Batangueños Regarding Palliative Care

Palliative Care…	WM	VI	Rank
1. focuses more broadly on improving and providing comfort to people of all ages with serious, chronic, and life-threatening illnesses.	3.47	Understood	1
2. allows patients and family continually develop and change the care plan.	3.35	Understood	6
3. focuses on controlling patient symptoms and all aspects of patient care.	3.36	Understood	5
4. assists to achieve quality of life even when patient's illness is progressive or/and incurable.	3.39	Understood	3
5. means while patients are being given all comforts, treatments will be stopped.	2.96	Understood	10
6. involves individualized patient care focusing on physical, psychological, spiritual needs of the patient.	3.42	Understood	2
7. maybe offered at any time or stage of the patient's illness.	3.14	Understood	8
8. establishes realistic goals based on patient's preferences, priorities, values and spiritual perspective.	3.06	Understood	9
9. does not focus solely on the patient but rather encompasses both the patient and family as units of care.	3.37	Understood	4
10. provides professional support in terms of counselling, respite care, financial counselling and bereavement support.	3.23	Understood	7
Composite Mean	**3.27**	**Understood**	

Among the items enumerated, palliative care focuses more broadly on improving and providing comfort to people of all ages with serious, chronic, and life-threatening illnesses ranked first which obtained a weighted mean score of 3.47, followed by involves individualized patient care focusing on physical, psychological, spiritual needs of the patient and assists to achieve quality of life even when patient's illness is progressive or/and incurable with 3.42 and 3.39 respectively. These findings revealed that the relatives of the patients haven't given up hope for a recovery. In addition, their understanding also revealed that while their loved ones are suffering, they believe that providing comfort and individualized care will help improve the patient's condition.

According to Meier, M. [3] palliative care is genuinely patient-centered, meaning they ask the patient what's important to them and what their major priorities are. Based on what the patients or the family tell them, they then develop a care plan and a strategy that meets the patient's goals and values.

For some people, Meier says, the goal or value might be to live as long as possible -- no matter what the quality. The patients understand the odds and that's their choice. And then they will do everything in their power to make sure that their goals are respected and adhered to.

In a study published in August 2010 in the New England Journal of Medicine, researchers at Massachusetts General Hospital found that advanced lung cancer patients who received early palliative care actually had lower rates of depression and better quality of life than patients who received standard treatment only [4].

The study of 151 patients, who were randomly assigned to get standard lung cancer care alone or to get standard care and palliative care at the same time, also yielded a surprise: The palliative care patients tended to live about 2.7 months longer. This may have been due to more effective treatment of depression, better management of symptoms, or less need for hospitalization.

In addition, the respondents of the study also understood that palliative care does not focus solely on the patient but rather encompasses both the patient and family as units of care with a weighted mean of 3.37. This means that while the patients need care and understanding regarding their health status, the caregivers also need support as caring for patients can also be physically and emotionally tiring.

The respondents also understood that palliative care focuses on controlling patient symptoms and all aspects of patient care with weighted mean of 3.36. This means that caring also involves monitoring the symptoms of sickness and all aspects of caring for the patient.

Furthermore, allowing patients and family to continually develop and change the care plan is also a part of palliative care that the respondents understood with weighted mean of 3.35 at rank 6. This means that palliative care is not a habitual process of caring but instead, continuous modification of care plan in order to improve the condition of the patient.

Palliative care also provides professional support in terms of counselling, respite care, financial counselling and bereavement support with weighted mean of 3.23 and ranked 7th in the understanding of the respondents. The respondents understood the palliative care does not end in the death of their loved ones. It also includes support for those who are left behind.

However, palliative care maybe offered at any time or stage of the patient's illness (3.14), establishes realistic goals based on patient's preferences, priorities, values and spiritual perspective (3.06) and means while patients are being given all comforts, treatments will be stopped (2.96) got the lowest weighted mean value though verbally interpreted understood.

The perception reveals that the relatives of the patient's main priority is comfort and cure. They believe that palliative care is not only for the dying but even for those who can be cured but with treatments that are highly extensive.

According to Robe et al [5], the focus of palliative care is to relieve physical suffering, improve communication with patients and their families, and provide the most ethical and highest quality of care. The process of matching the high technology treatments available to patients' needs could sometimes be challenging for palliative care workers and requires extensive exploration of the patient's values and expectations. Furthermore because of technology and new therapies, it becomes hard to know when enough is enough—when the burdens of those treatments outweigh the benefits. For that reason, palliative care teams are truly interdisciplinary, addressing far more than just the patient's clinical condition. Hospital-based teams generally consist of at least one board-certified palliative care physician, hospitalists, nurse specialists, social workers, and pastoral care. In addition, the referring doctor and other staff members involved in the patient's care such as pharmacists, dieticians, and respiratory therapists, can be involved. Mason terms the concept, "total pain"—that is, addressing more than just the physical pain. Sometimes, explained Chaplain Pat H. Davis, Baton Rouge General's Director of Pastoral Care and a member of the palliative care team, families feel guilty about ceasing certain treatments or making certain decisions even if that's not what the patient would have wanted. But no one had that conversation, no one brought it up. It's supporting that family, so they don't feel like they are making these decisions on their own. Palliative care team is helping families accept the reality of what's taking place.

Furthermore, in a study conducted by Patient and Client Council located in Northern Ireland on April 2013, the findings revealed that while the majority of respondents reported that they had heard the term palliative care, most people revealed they had little or no knowledge of its meaning. Despite this lack of knowledge, when asked to reflect on the aims of palliative care, the majority cited delivery of comfort (82%), pain relief (81.3%) and dignity (76.3%) as key. Furthermore, participant's knowledge and perceptions of palliative care was largely influenced by their personal experience, expectations for palliative care services included providing holistic support, effective symptom management; good communication; and practical support to enable choice and carer support, although the family home was most often identified as the preferred place of care for a patient with palliative care needs, the majority believed that palliative care was delivered in hospice and at home followed by hospital and the majority believed that a member of the generalist practice team (general practitioner or district nurse) or a specialist hospice nurse (n=367, 61.2%) would be best placed to discuss palliative care needs.

Table 2 presents the factors affecting the acceptance/practice of palliative care. The study revealed that the respondents agree that the items enumerated above affect their acceptance/practice of palliative care with a composite mean of 2.65 and verbally interpreted as Agree.

We have no money to fully assess the comfort that palliative care can provide to our sick family member ranked first with a weighted mean of 3.07 and verbally interpreted as Agree. This is followed by Hospitals do not provide palliative care and we have no medical background to fully understand palliative care with weighted mean of 2.72 and 2.70 respectively.

The findings revealed that most of the respondents are not from well-to-do families as evident by the financial difficulties they experienced in practicing/accepting palliative care. Moreover, not all hospitals in the country provide palliative care especially here in Batangas City or in the entire province for that matter. In addition, the findings revealed that the respondents are in doubts regarding the full benefits of palliative care because of lack of medical background. It is understandable to doubt something that is relatively new especially in the area of medicine.

Table 2. Factors Affecting the Acceptance/Practice of Palliative Care

Indicators	WM	VI	Rank
1. We have no money to fully assess the comfort that palliative care can provide to our sick family member.	3.07	Agree	1
2. We fear that palliative care will only drag our loved ones to death.	2.64	Agree	4
3. Hospitals do not provide palliative care	2.72	Agree	2
4. If we favour palliative care, it will mean giving up our own trusted doctor's professional care.	2.62	Agree	5.5
5. Palliative care is only for old patients and patients with cancer.	2.52	Agree	9
6. Only those with private insurances can get accepted in the palliative care program	2.49	Disagree	10
7. We have no medical background to fully understand palliative care	2.70	Agree	3
8. Palliative acre won't allow me or my family to be involved in the decision making.	2.61	Agree	7
9. 9A patient, once in, cannot get out of the Palliative Program even if the condition improves.	2.55	Agree	8
10. Palliative care can only be provided in clinics, home, hospital and skilled facilities.	2.62	Agree	5.5
Composite Mean	**2.65**	**Agree**	

Legend: 3.50 – 4.00 = Strongly Agree; 2.50 – 3.49 = Agree; 1.50 – 2.49 = Disagree; 1.00 – 1.49 = Strongly Disagree

Although strictly speaking palliative care is not a new concept, for a country like the Philippines, traditions and the culture of close family ties dictates the family to take charge of the sick relative's care. The findings revealed that culture and traditions greatly affect the acceptance and practice of palliative care.

In a palliative country report featuring the Philippines (Author Unknown), two features figure prominently. First, is the range of settings under which palliative care is given. In the Philippines, less than 40% of hospitals belong to the government and many of the private hospitals achieve a level of investment which the government cannot match. As a result, patients with money are attracted to private care; those who are poor gravitate towards government facilities. Some public hospitals provide whatever they can free of charge; others have 'pay' wards alongside 'charity' wards. As both public and private hospitals offer palliative and hospice care, a range of services – inpatient, outpatient and home care – may be accessed by patients on a 'pay' or 'charity' status. Alternatively, the community-based hospice organisations usually make free-of-charge provision for patients who are admitted to their programmes.

The respondents also assess that they fear that palliative care will only drag their loved ones to death with a weighted mean of 2.64 and verbal interpretation of Agree. Batangueños are known to be resilient and for always keeping the hope alive in all aspects especially when it comes to the health of their loved ones. And the fear of losing loved ones is very common prevents them from truly accepting palliative care. It can be that the respondents think that by accepting palliative care they are giving up on the idea that their loved one will recover.

The misconception that by favouring palliative care meant giving up their own trusted doctor's professional care also prevents the respondents from accepting palliative care. They think the palliative care no longer provides treatment but just to keep the remaining days of the patient comfortable and happy. Of course, this is not true since palliative care combines treatment as well. Furthermore, thinking that palliative care can only be provided in clinics, home, hospital and skilled facilities also prevents them from acceptance. This is because most of the respondents are not well-to do which means it would be difficult for them to provide the facilities needed. In addition, caring for the patients away from their home is not something that is common for the Batangueños of the Filipinos in general.

The respondents also feel that palliative care won't allow them or their family to be involved in the decision making in terms of caring for the patient. Caring for the patient, just like any other concerns, is a decision that involves all family members. By allowing non-family members to design care plan for their patient gives them a feeling of hopelessness and the feeling of not being in control.

On the other hand, a patient, once in, cannot get out of the Palliative Program even if the condition improves, Palliative care is only for old patients and patients with cancer and Only those with private insurances can get accepted in the palliative care program received the lowest weighted mean of 2.55, 2.52 and 2.49 respectively though all are still interpreted as Agree.

The findings revealed that while the respondents understand the concept of palliative care, they have no intention of permanent dependency on palliative care workers. At some point, their moral obligations dictate that the patient still needs to leave the care of the worker and the full responsibility will be placed on their shoulders. In addition, the notion that only old patients and cancer patients should receive palliative care somehow gives them the end-of-the-line feeling, meaning the condition of their patient is hopeless and that is something that Filipino relatives refuse to believe. Furthermore, on the aspect of medical insurance, not all Filipino families are insured, medically speaking. Unlike other countries, private medical insurance is not a common practice. Philhealth offers medical insurance but it is government owned and controlled and it has limited coverage.

Funding for medical services in the Philippines comes from a mixture of public and private sources that include insurance schemes and out-of pocket payments. In 2005, the government's share of total health expenditure declined to 29% whereas out-of pocket payments increased to 48%, a rise of 5% since 2001 [6].

In this situation, the financial burden on families is very high. In its country profile on the Philippines, WHO states:

Paying for health care is an issue because of its poverty impacts. Under the current health care financing arrangements, low income families are pushed into poverty due to payments for health care. Almost 80% of total health expenditure is spent on personal health care services. In contrast, only 10% is used for public health care services. The same percentage is also used for the administrative spending needed to run the entire health system. These are signs that the Philippines is not spending enough or effectively for health. Health care financing resources are largely spent on hospital-based curative services and not enough on preventive and promotive health services, and subsidies for health services are poorly targeted.

Additionally, the study of Mcllfatrick, Hasson, McLaughlin et al. [7] revealed that overall the key barrier cited was reluctance among the general public to talk about death and dying. This was attributed to fear and a taboo within society to openly, address such issues. The second barrier was the lack of knowledge or information held about palliative care, leading to the general public making assumptions which was reinforced by a lack of continuity and coordination between health care services and finally, it was attributed to a lack of funding and resources to promote palliative care.

Table 3. Readiness of the Family to Engage in Palliative Care

Indicators	WM	VI	Rank
1. Our family is ready whatever the outcome is despite being in the palliative program.	3.33	Ready	1
2. The patient can opt out of the palliative care if the patients changed his/her mind.	3.18	Ready	4
3. Our family has enough medical knowledge to provide palliative care.	2.90	Ready	9
4. Our family is able to provide care for patients while dealing and coping with our own emotions.	3.05	Ready	6
5. Our family had chosen a facility for our sick loved ones.	2.94	Ready	8
6. My family has all the financial resources needed in providing palliative care.	2.87	Ready	10
7. All family members are willing to take turns in caring for our sick relative.	3.24	Ready	3
8. Our family members can cope with the physical demands of caring for our sick relative	3.28	Ready	2
9. Our family is aware that pain the other symptoms will be professionally managed by a highly trained health care team.	3.06	Ready	5
10. Our family is able to act as the proxy or surrogate for reporting symptoms and making medical decisions.	2.95	Ready	7
Composite Mean	**3.08**	**Ready**	

Legend: 3.50 – 4.00 = Highly Ready; 2.50 – 3.49 = Ready; 1.50 – 2.49 = Somewhat Ready; 1.00 – 1.49 = Not Ready

Table 3 presents the readiness of the family to engage in palliative care. Our family is ready whatever the outcome is despite being in the palliative program ranked first with a weighted mean of 3.33 with a verbal interpretation of Ready. This is followed by coping with the physical demands of caring for our sick relative and willingness to take turns in caring for our sick relative with a weighted mean of 3.28 and 3.24 respectively, both with a verbal interpretation of ready.

The patient can opt out of the palliative care if the patients changed his/her mind received the 4th highest weighted mean of 3.18 and verbally interpreted as ready. This is followed by being aware that pain the other symptoms will be professionally managed by a highly trained health care team with a weighted mean of 3.06 and verbal interpretation of ready.

The respondents understood that at the end of the day, it is still the patient and his family to decide on matters regarding palliative care. It is a fact that they accept and understood and taken into consideration.

In addition, providing care for patients while dealing and coping with our own emotions received a weighted mean of 3.05 and verbal interpretation of ready. This means that respondents are able to check and hold their emotions for the benefit of their patient. They are also willing to set aside their own emotional issues in favor of the patients.

Furthermore, being able to act as the proxy or surrogate for reporting symptoms and making medical decisions is at rank 7 with a weighted mean of 2.95. This means that in the course of the palliative care, they are ready to note observations regarding the status of the patient and report the same to the doctors especially in times when the patient can no longer decide on medical concerns.

The over-all assessment of the respondents is ready with a weighted mean of 3.08. The findings revealed that while the families are not losing hope, they do not believe in false hope either and they are ready to accept the fate of their patient. In addition, the respondents' assessment revealed that caring for their sick relative is not really a burden and that the physical demands of caring for the sick is not an issue within their family which also proves their willingness to take turns in caring for their sick relative.

During the period of illness of a life-threatening disease the contact between the loved ones and the patient can be close or distant, depending on their relationship. The patient is always in focus and the one who decide how much the loved one should be involved, both in terms of daily life and in knowledge about the course of the disease. Both patient and loved one have to face the reality of the illness but can use different strategies in order to manage the daily life. How these strategies manifested is individual and can never really be predicted. Everyone has their own way of using coping strategies to regain a sense of equilibrium and to manage daily life [8].

Loved one and patient have to create a new pattern for daily life. It can influence the loved ones psychological and physical health and can also lead to changes in relationship and personality as well as other functions. The loved ones can be carers for the patient, meaning that they live close together in new circumstances in the presence of an incurable disease. They can try to be strong and positive and to live as normal a life as possible. There are positive effects for the loved ones in personal growth deriving from caring for someone close, and despite the necessity and adversity the loved ones can be proud of having been helpful to the patient. The cooperation between patient and loved ones can also be highly valued. Hope will help both the patient and the loved one during this time. Definitions of hope vary but it generally includes a positive orientation towards the future. But the loved ones are vulnerable because they have to hold the balance between burden and capacity, in their need to raise the quality of life [8].

On the other hand, choosing a facility for our sick loved ones, having enough medical knowledge to provide palliative care and having all the financial resources needed in providing palliative care received the lowest weighted mean of 2.94, 2.90 and 2.87 respectively. In relation to Table 2, these items received the highest weighted mean in terms of the factors affecting the acceptance/practice of palliative care and are now at the bottom in terms of the family's readiness to engage in palliative care. Again, the financial factor, the availability of facilities and their limited medical background prevent their full readiness to engage in palliative care.

There is a view among hospice-palliative care practitioners that government funding has become more restricted since the last change of administration. In part, this is thought to be because the previous Minister of Health was sympathetic to palliative care due to his personal experience of his wife's cancer. Whether or not this is the case, there is no doubting the effects of reduced funding on service provision, outlined here by Dr Celina Vilches, leader of the pain and palliative care clinic at Iloilo Mission Hospital in Western Visayas as cited in the Philippine Country Report on Palliative Care [6]

"The problem with us was that we were not thinking of generating our own income and we became so dependent on the funding of the PCSO that when the funding was removed we had nothing. The first thing that went was the pain medications; so, you can just have a free consultation. The next day we could not give chemo drugs. We can do the chemotherapy with the help of our doctor, but patients have to buy their own chemotherapy drugs; so, it's kind of sad. Then after that, the ambulance driver has to go because we don't have any funds for the driver any more. And later on, we even have to give the ambulance to the hospital because we could not anymore continue the maintenance of this ambulance. So now what we are left with, instead of the multidisciplinary team, is only one nurse which the hospital was kind enough to provide. So, if we can charge the patient, we charge. If the patient does not have money, then they become our charity patients. And we still do home visits with them, but this time we use our own car and everything. We still have this office here, and we still do our own type of hospice care, but it's not as ideal or as multidisciplinary as it was before because of lack of funding."

Table 4. Assessment on the Available Facilities/Resources on Palliative Care

Items	Yes		No	
	F	%	f	%
1. There is a team or group that manages the patient's pain and symptoms may it be at home, hospital or any skilled facilities.	95	87.2	14	12.8
2. The healthcare team is composed of certified and highly-trained professionals.	93	85.3	16	14.7
3. Palliative care provides needed drugs, medical supplies and equipment's.	97	89.0	12	11.0
4. Palliative care can provide inpatients care when condition becomes too difficult to manage.	92	84.4	17	15.6
5. We have financial resources to cover what our insurance doesn't.	78	71.6	31	28.4
6. Palliative care provides assistance for the patient with emotional, psychosexual and spiritual aspects of the patient.	89	81.7	20	18.3
7. We have the options in choosing among a home, clinic, hospital, retirement home or skilled facility.	85	78.0	24	22.0
8. Palliative care provides bereavement care and counseling to surviving family and friends.	95	87.2	14	12.8
9. Palliative care provides crash training for the family on how to care for the patient.	100	91.7	9	8.3
10. 1Palliative care delivers special services like speech, physical therapy, dieticians and chaplains when needed.	91	83.5	18	16.5

Table 4 presents the respondents' assessment on the available facilities/resources on palliative care. It can be observed on the table that there are 87.2% of the respondents who said that there is a team or group that manages the patients' pain and symptoms may it be at home, hospital or any skilled facilities. It shows that the respondents have been in constant coordination with the medical team regarding pain management of their loved ones.

Furthermore, Ahmedzai et al., [9] also posited that palliative care is not restricted to a certain setting but takes place in different environments, both at home, in hospitals, in nursing and old-people's homes, in psychiatry and in hospices. In principle palliative care is of a multi-disciplinary nature; as core disciplines the doctor and the nurse can be regarded. In case of more specialised palliative care other disciplines can be involved, if desired, such as the social worker, the physiotherapist and the spiritual.

On the other hand, 12.8% of the respondents revealed otherwise which could mean that their patients have not yet progressed on a more progressive phase of palliative care or it could be that they have not yet received this kind of attention from the medical facilities.

Respondents also assessed that the healthcare team is composed of certified and highly-trained professionals with 85.3% who said Yes. This means that based on their experience, their palliative care has been in accordance with the accepted palliative care standard.

On the other end, 14.7% disagreed with the statement with is cognizant with the findings made by Center to Advance Palliative Care [10] which revealed that palliative care is relatively unknown to the public and poorly understood by many health care providers. Many physicians misunderstand palliative care and wrongly conflate it with hospice or end-of-life care, a finding that calls for better training at all levels from medical school students to mid-career practitioners.

In terms of providing needed drugs, medical supplies and equipment, 89% said Yes. This means that the palliative care is able to sustain the medical needs of their patients in terms of medicines and equipment. Furthermore, their assessment revealed that they do not have any problems in terms of access to the supplies needed by their loved ones.

On the other hand, 11% said No. This means that 14 of the total respondents expressed issues in terms of access to medical equipment and supplies. This is relative to a statement by Dr. Laudico as cited in the Country Profile of the Philippines in Palliative Care. Dr. Laudico posited that Drug distribution remains a barrier to morphine availability, however, because pharmaceutical companies do not have an efficient national distribution network: there have occasions when a hospital runs out of morphine and our system cannot respond quickly. There is clearly a need for better infrastructure to monitor needs and solve problems in the field. All of the smaller hospitals are under the control of local authorities, so mayors and governors can play an important role in expanding the programme to the grass-root level.

The table also revealed that in terms of the provision for inpatients care when conditions become too difficult to manage with 84.4% respondents saying yes. This revealed that they are able to turn to palliative facilities offering inpatient care when they can no longer take the risk of caring for their patients at home.

Most patients prefer to spend their remaining days at home. However, this has become too painful for their loved ones who are witness to the physical pain that the patients are experiencing. The assessment of the respondents revealed that when the situation has become too much for them to handle, there are facilities ready to accept their patient.

On the other hand, 15.6% disagreed and said No in the inpatients care provided by palliative care. The assessment shows that the respondents may feel that the inpatient care provided in the hospital is not sufficient to meet the needs of their loved ones and that the financial cost of putting their loved ones in an inpatient facility may be too expensive.

In terms of financial aspect, 71.6% said that they are able to pay financial needs of their patients to cover what their insurance doesn’t. This means that regardless of financial status, they make both ends meet in order to continuously provide palliative care to patients. On other hand, 28.4% said No.

Funding for medical services in the Philippines comes from a mixture of public and private sources that include insurance schemes and out of pocket payments. In 2005, the government’s share of total health expenditure declined to 29% whereas out of pocket payments increased to 48%, a rise of 5% since 2001.

A factor in this finding is that government funding is capped at pre-determined levels according to diagnosis and need. Even for patients with insurance, there is often a shortfall in benefits. Dr Andrew Ang explains that insurance in the Philippines has a widespread problem: it does not settle everything sometimes but only 25% of the bill. If you have a bill of 100,000 pesos, only 25,000 comes from the insurance and 75,000 is settled by the patient. So even if a patient has a good insurance policy, it still doesn’t cover all the bill. And hospice patients, who come late, don’t get anything [6].

Dr Elmer Pedregosa, the director of Iloilo Mission Hospital, is sympathetic to the needs of the pain and palliative care clinic. While appreciating the contribution of donors, he highlights the difficulties caused by the sudden withdrawal of funds. As a result, there has been a move towards greater self- determination in financial matters.

In terms of providing other services in palliative care like emotional, psychosexual and spiritual aspects of the patients, 81.7% said yes and 18.3% said no.

This means that most of the respondents have been receiving service not just for their medical needs but other areas of health as well. The palliative care they are receiving does not focus on physical wellness and understands that more than the physical aspect, it is also important to keep the patient’s spirit in good condition.

Good primary care is about caring for individuals from 'cradle to grave'. Providing good palliative care to individuals in the community can be one of the more demanding but ultimately satisfying parts of a GP's job. The multidisciplinary team can be large and, most often, the district nurses are the key players in orchestrating services around an individual's changing needs. In addition to the standard primary healthcare team, specialist community palliative care teams' input may be sought - services may include hospice at home, respite admissions, Macmillan nurse specialists, Marie Curie nursing and day centres (www.patient.co.uk).

This reveals that some of the most important aspects of palliative care are available for the patients and their families at the same time providing care for the surviving family and friends. In addition, the palliative care available respects the family’s desire to still care for their patients despite the ready facilities that can accommodate their sick loved ones.

CONCLUSIONS AND RECOMMENDATION

The Batanguenos’ understanding of palliative care is limited and focuses only on the patients’ comfort and dignity amidst the onset of a life-threatening disease. This is because palliative care is not a very common concept, especially since Batanguenos generally prefer to provide care for the patients in their own way. The selfless nature of the Batanguenos is also a factor in their limited understanding of palliative care. They feel that they do not need support and all attention should be given to the patient alone.

Financial constraints and limited awareness on the concept of palliative care affect the acceptance of palliative and create doubts in terms of practicing palliative care. Money is a huge consideration in the aspect of palliative care and their hesitation means that they have limited financial resources and cannot sustain the financial demands of palliative care.

Despite the difficulties that the family of patients with chronic diseases faced, they are willing and ready to engage in palliative care if it would provide comfort to the patient. Furthermore, the sense of hope motivates them to engage in palliative care. This means that they are willing to pool all their resources if it would mean a difference in the life of their patient.

The most important palliative care available is the knowledge for the patients' families which is extremely important given the close family ties traditions and cultures of the respondents while the issue of full insurance coverage is yet to be offered in the palliative care program.

It is recommended that Hospitals in Batangas City may engage in palliative care and should make awareness campaign to educate Batangueños that palliative care does not focus on end of life care alone but also provide support to the family. Local government should include medical coverage in palliative care in their health programs in order to alleviate the already difficult dilemma of the patients and their families.

Health practitioners involve in palliative care may encourage relatives of the patient to consult psychologists and counsellor for support. Furthermore, the services of counsellors and psychologists will provide a realistic and bigger picture of the status of the patients and the process that the families will go through at the end of palliative care.

A Regulatory Board should be created in order to monitor the capabilities of the palliative care centers in terms of availability of equipment, manpower and reasonable package and it is important that palliative care services be made available at all hospitals for patients with serious illness and their families.

REFERENCES

[1] Wright, Michael. Hospice and Palliative care in SOUTHEAST ASIA. (2010). Hospice and Palliative Care in Southeast Asia: A Review of Developments and Challenges in Malaysia, Thailand and the Philippines. Retrieved from http://books.google.com.ph

[2] Gorospe, E.C. and Bausa, A. B. (2006) Integrating Volunteers in palliative care: the Philippines experience. Journal of Palliative Care, 22(4):297-299.

[3] Meier, M. (2014). Palliative care service provision. Retrieved from http://www.eolcobservatory.net/global_analysis/pdf/philippines_country_report.pdf

[4] Temel, J. S. at e al, (2010) Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer N Engl J Med 2010; 363:733-742 DOI: 10.1056/NEJMoa1000678 https://www.nejm.org

[5] Robe, R. B. at e al (2011). The Role of Palliative Care at the End of Life https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3241069/

[6] Palliative care service provision (2008). Reimbursement and funding for services https://www.doh.gov.ph/sites/default/files/health_programs/Palliative%20and%20Hospice%20Report%20Philippines.pdf

[7] Mcllfatrick, S., Hasson, F., McLaughlin, D. et al. (2017). Public awareness and attitudes toward palliative care in Northern Ireland https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3848719/

[8] Benkel, I. (2011). Loved ones within palliative care – understanding, strategies and need for support. https://gupea.ub.gu.se/bitstream/2077/24502/1/gupea_2077_24502_1.pdf

[9] Ahmedzai, S.H., Costa, A., Blengini, C., Bosch, A., Sanz-Ortiz, J., Ventafridda, V., & Verhagen, S.C. (2004). A new international framework for palliative care. European Journal of Cancer, 40(15), 2192- 2200.

[10] Center to Advance Palliative Care (2011). A Report Based on Research by Public Opinion Strategies. Center to Advance Palliative Care https://media.capc.org/filer_public/18/ab/18ab708c-f835-4380-921d-fbf729702e36/2011-public-opinion-research-on-palliative-care.pdf