

International access to palliative care: the need to improve

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More than 40 million people around the world require palliative care annually (1) and the number will increase as populations get older, with a greater burden of non-communicable diseases and chronic illnesses. However, it is estimated that only 10% of this need is currently met (2).

Many countries are poorly equipped to provide high quality palliative care despite the advances made in the specialty. Only 34 countries scored above average in the 2015 Quality of Death Index (3)—approximately 13% of the global adult population. Richer countries with older populations have means to supply the large demand for high quality palliative care. The pressure is less in many developing countries, allowing for time for possible development. However, worryingly, are countries with already large and increasing demands yet poor supply such as Greece, Cuba and China (3). Developing their palliative care will relieve the strain and may be a cost-effective model of healthcare.

The importance of palliative care and its benefits palliative care has been sorely underestimated thus far. The looming future demands calls for removal of barriers preventing the implementation of effective palliative care in societies.

Barriers

Financing of palliative care

Income levels have been a strong indicator of the availability and quality of palliative care (3).

However, this has not prevented outstanding palliative care being developed in Mongolia (3). Within 15 years, Mongolia has integrated palliative care into its health and social welfare legislation and national cancer control

programme. Non-cancer palliative provisions are available too, creating an efficient system ranking 28th (3).

With innovation, lack of resources is no excuse for poor provision. In fact, developing countries may have an advantage as they have no existing system to be entrenched within and able to avoid problems that other societies may have experienced while picking good schemes to adapt from (3). But such advancement could only be made with the realisation of the importance palliative care bears.

Understanding of palliative care

The specialty of palliative care is young, coming into prominence only after medications to control symptoms had been developed (4). Some languages do not even have a term for palliative care, and a lack of awareness of its existence still exists (3).

Paired with are misconceptions. With its tight relation to oncology, people have narrowed its application to cancer patients. They have also concluded palliation happens only when treatment attempts have been stopped, associating it to giving up hope. Hence the belittling attitude they can hold towards palliative care.

What needs to be done to is greater exposure of palliative care to the public:

- ❖ Understanding the aims of palliative care when caring for patients- how it falls in lines with many people's desire to die well without pain or suffering and have control over symptoms they experience (5);
- ❖ Understanding palliative care is for anyone in need of symptom management;
- ❖ Understanding how palliative care works with patients to manage their symptoms;

- ❖ Understanding that the dying experience involves the patient as well as people around them.

First, governments need to truly be convinced of such benefits and be on board, supporting palliative care with appropriate local policies, not merely agreeing to international consensus. It will enable the creation of avenues to create greater awareness among the public, while making palliative care integral to healthcare systems and creating access for patients.

With greater appreciation of palliative care's function, society would be more willing to invest into it, and attract talents to the field to supplement the small global number of specialists. The ratios of palliative care services to population can be more equal as they vary greatly internationally, with Pakistan having 1 professional for every 100,000,000, to Netherlands with 1,785 for that 100,000,000 currently (6).

Restricted opioid access

Opioids are frequently used in palliative care, being effective at controlling cancer pain and severe chronic pain. However, opioids access is tightly controlled due to its toxicity at high doses and many avoid using it due to lack of experience with it or fear, even in countries with developed palliative care systems. If this can be remedied, it would be a revolutionary change to how pain is managed.

In Uganda, collaboration with local narcotic officers have made access easier, enabling registered prescribers to prepare coloured morphine solutions for patients to take home with a marked cup for dosing to avoid taking overly high doses (7). The colours indicate the strength and prevent confusion with water. The government sensibly provides morphine for free: low costs, yet high returns—patients live higher quality days in comfort as they can focus on things that matter instead of being distracted by their pain.

More countries need to overcome their opiophobia and embrace the difference good pain relief makes. Categorising morphine as an essential medication is simple, yet holds great impact as it signals to prescribers to adopt a change in attitude to opioids. Opioids need to be more accessible, and while current measures of dispensing limited amounts at each time may possibly tackle the problem of addiction, it disadvantages those in rural areas most who firstly local access may be limited, and superimposed is supply not being sufficient to support their needs.

Conclusions

Pain is a universal phenomenon and everyone should have access to healthcare that can help them control their pain best. There is a need to start development as we anticipate greater needs from the changing global demographics. It needs to be made a global health priority, with countries working together to ensure international access to high quality palliative care. It needs to thrive in their country's political and social climate. We need to afford people their right to health. We may be unable to empathise the suffering of patients, but no way should we prevent others from means to relieve such pain: we should endeavour to help them. Even from a selfish personal viewpoint, would one not want access to such care for their selves—to be able to live with dignity and die with dignity?

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Footnote

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