

The 2015 Quality of Death Index

Country profiles



Commissioned by

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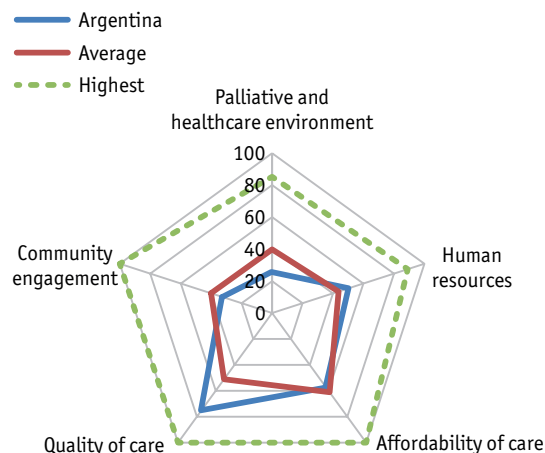
About this document

This document contains summaries of the status of palliative care in each country covered in the 2015 Quality of Death Index. This analysis is based on interviews with palliative care experts in each country, except where noted. Please refer to the full report for a detailed explanation of the Index findings and methodology.

1. Argentina



	Rank/80	Score/100
Quality of Death overall score (supply)	32	52.5
Palliative and healthcare environment	59	25.8
Human resources	29	50.7
Affordability of care	=44	57.5
Quality of care	26	75.0
Community engagement	=38	32.5



SNAPSHOT

Lack of national strategy results in uncoordinated delivery efforts. Supported by the public health system, services are affordable where available. Quality of services is uneven due to lack of standards enforcement and availability gaps are significant.

IN DETAIL

Limited sub-national programmes have attempted to remedy insufficient government attention to palliative care. Few research centres collect data and they receive no public funding.¹ The subject of palliative care is not included in mandatory medical curriculums, with general courses on the topic offered in only 6 of 27 medical faculties, leading to persistent misconceptions in the medical establishment. Non-governmental associations handle unofficial accreditation for their members. The number of specialist workers falls short of the country's needs.²

Most palliative care is provided through the public system without charge, and private insurance providers may also pay for services depending on the patient's insurance coverage. In theory, senior citizens are covered under the PAMI social security system but the lack of

infrastructure and specialised workers limits access to care.

The Health Ministry updated a set of robust non-compulsory guidelines in 2011.³ Inadequate monitoring and enforcement result in patchy application of standards, but quality of care in Argentina is relatively high compared to other countries in the region. Patients and families can count on free psychological assistance and have adequate access to pain-alleviating therapies and a legal right to 'do not resuscitate' (DNR).⁴ Physicians and specialists are reluctant to conduct transparent communications with patients, who are typically not privy to prognosis or diagnosis disclosures. The system also lacks institutional channels to respond to grievances, and there is no evidence of the use of patient satisfaction surveys.

The number of volunteers remains very low but they are given basic training and interact directly with patients. Perceptions of palliative care have gradually shifted towards a more nuanced understanding of the issue among the general public.

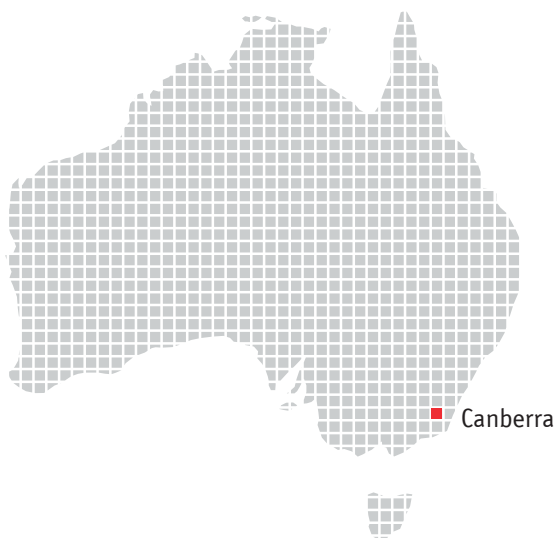
¹ Pastrana, T., L. De Lima, R. Wenk, J. Eisenchlas, C. Monti, J. Rocafort, C. Centeno, *Atlas de Cuidados Paliativos de Latinoamérica ALCP*, 2012.

² Ibid.

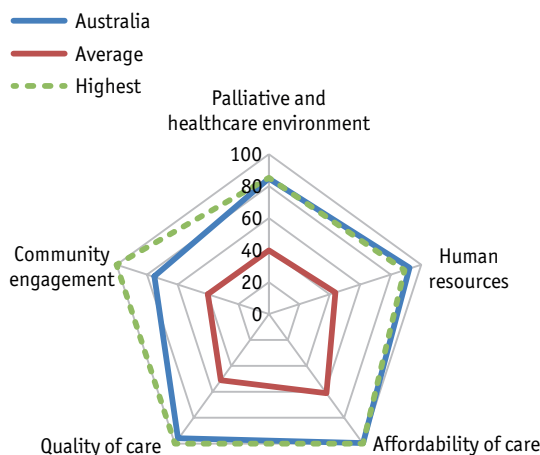
³ Ibid.

⁴ "Argentina approves production of morphine tablets by a state laboratory," eHospice, July 3 2014.

2. Australia



	Rank/80	Score/100
Quality of Death overall score (supply)	2	91.6
Palliative and healthcare environment	3	84.1
Human resources	1	92.3
Affordability of care	=1	100.0
Quality of care	3	96.3
Community engagement	=9	75.0



SNAPSHOT

Australia’s strong performance places the country as one of the world’s leaders in the provision of palliative care. Robust quality standards are woven into the universal health scheme, which provides specialised and affordable care.

IN DETAIL

Informed policymaking and extensive data gathering are the hallmark of Australia’s responsive government approach to palliative care. Publicly funded research centres inform the national debate,¹ while advanced training and continuing education opportunities abound for professionals.² Courses on pain management are mandatory for GPs but concerns about addiction are yet to be entirely stamped out. National and local authorities have articulated a range of long-term initiatives³, with some aimed to tackle the lack of care availability in more rural areas.

Robust public spending reduces the financial burden for all patients, including retirees. The national Pharmaceutical Benefits Scheme expands

access to prescribed opiates while palliative consultations fall under the Medical Benefits Scheme.⁴ Bereavement care is also provided for caregivers and family although psychological assistance may not always be available in remote areas. Private insurance is used as a source of financing in 15% of cases.⁵

A balanced system of self-assessment and ministerial oversight strengthens care delivery. Widespread use of patient satisfaction surveys bolsters overall transparency;⁶ feedback is used effectively to improve services. Thanks to efforts by government-backed Palliative Care Australia, awareness is on the rise among the general public along with heightened visibility in mainstream media. Trained volunteers are a common sight in the health sector but are engaged inconsistently across states.

¹ Australian Institute of Health and Welfare, “Trends in palliative care in Australian hospitals”, 2011.

² Australia Department of Health, “National Palliative Care Projects,” 2014.

³ Australia Department of Health, “National Palliative Care Strategy,” 2010, and “National Palliative Care Program,” 2015

⁴ Australian Institute of Health and Welfare, “Palliative care services in Australia 2013.”

⁵ Ibid.

⁶ State Government of Victoria, “Victoria’s Palliative Care Program: Funding and Data,” 2014.

3. Austria



	Rank/80	Score/100
Quality of Death overall score (supply)	17	74.8
Palliative and healthcare environment	7	77.8
Human resources	12	71.4
Affordability of care	=36	65.0
Quality of care	=13	87.5
Community engagement	=15	57.5

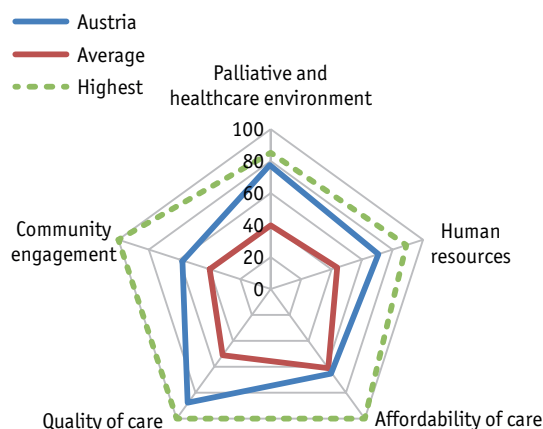
SNAPSHOT

Austria’s quality of palliative care reflects the high standards of its national health system. Practices vary in different counties due to its federated government structure but a complete overhaul is expanding the reach of its public care services.

IN DETAIL

Austrians can rely on excellent infrastructure and public support. A plan to integrate hospice care into the national health care system, launched in 2005, is now half completed.¹ Redefining the boundaries of service delivery is expected to produce marked improvements in underserved regions. Annual surveys by independent organisations collect relevant data, although it is unclear to what extent these findings inform public policy.² The restructuring has yet to build momentum and garner support from current health administrators.³

Austria’s four medical schools graduate large numbers of qualified professionals, and most have mandatory coursework in palliative care.⁴ Funding streams differ across the country’s federated regions but some level of public spending in



support of palliative care is always present. Evaluation and quality-enforcement mechanisms are centrally directed.

Painkillers and opioids are widely available and patients can rely on a robust network of psychological support and bereavement services. DNR is a recognised legal right and patients’ views are taken into consideration through feedback surveys. Public awareness is growing through the efforts of Hospice Austria, which receives some government funding.⁵ The culture of volunteerism is an essential element of care; over 3000 volunteers are actively working with patients.⁶

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Austria," *EAPC Atlas of Palliative Care in Europe 2013*.

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

4. Bangladesh



SNAPSHOT

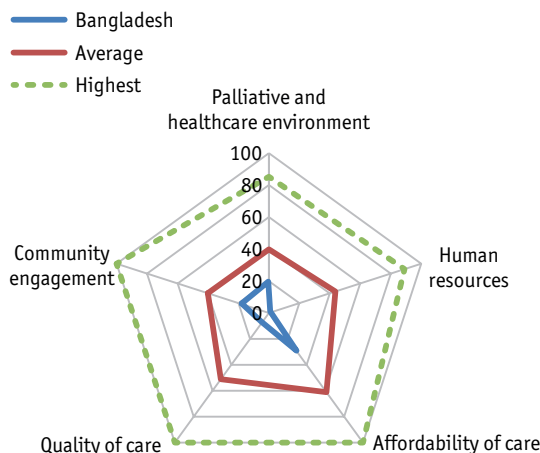
Palliative care remains an unresolved hurdle in Bangladesh’s path to provision of quality public health services. Policy obstacles and underinvestment plague the health sector but domestic and international organisations are tackling the challenge.

IN DETAIL

Only a fraction of people in Bangladesh have access to basic palliative care. The government has expressed its commitment to formulate a National Cancer Control Strategy and Plan of Action, in collaboration with the WHO, that will include a chapter on palliative care. Concurrently, the National Palliative Care Society of Bangladesh is drafting a more specific plan to submit to the authorities. Pending approval, palliative care remains undefined and chronically underfunded. Data is scarce but one government-backed “situation analysis” programme is trying to address the problem.

Patient choices are severely limited. For a population of 160m, there are just a handful of foreign-trained specialists in Dhaka. Health infrastructure lags behind basic needs. A few international training projects have sought to compensate for the lack of educational opportunities and awareness among health

	Rank/80	Score/100
Quality of Death overall score (supply)	79	14.1
Palliative and healthcare environment	71	19.0
Human resources	80	1.3
Affordability of care	=72	30.0
Quality of care	77	7.5
Community engagement	=66	17.5



care professionals; charitable organisations also provide some essential training, but no accreditation is given. The medical profession has yet to grasp the importance of palliative care.

Charities are at the forefront of care provision. Although rarely available, their assistance is generally free of charge. In contrast, public hospitals only cover 30% of costs with the remainder borne by the patient. Access to painkillers is limited by bureaucratic red tape resulting in very low per capita consumption of opioids, and expensive opioids require contributions from patients. Conventional therapeutic components like psycho-social support, bereavement care, volunteer support and feedback processes are rare. DNR is not widely available but patients are increasingly expecting more information about their prognosis, challenging an entrenched reluctance to engage in transparent doctor-patient communications.

5. Belgium



SNAPSHOT

Belgium offers top-notch quality palliative care that is also affordable. Patients' rights are at the core of its transparent and efficient service.

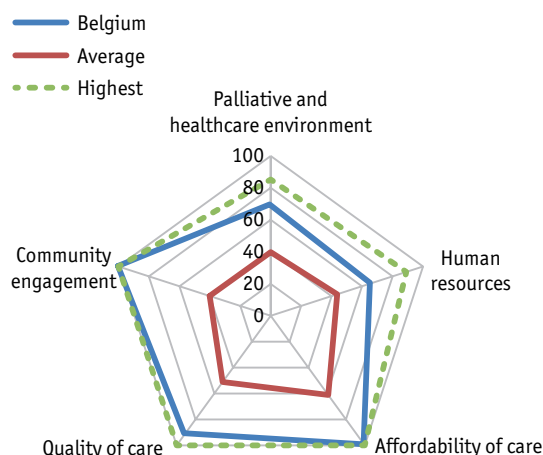
IN DETAIL

Belgians benefit from one of the most robust policy frameworks regulating euthanasia and palliative care. Service provision is comprehensive and widely accessible even without a national strategy.¹ Updated guidelines and responsive monitoring mechanisms ensure consistent quality nationwide, although availability of training for medical professionals is uneven.² Palliative care is taught but is not always a compulsory component of medical training.

Financial assistance from the social security system is extensive, subsidising most aspects of palliative care. Strong funding streams help to cover pharmaceutical bills and support retirees, and more recently paediatric patients. However, payment for home care services is inconsistent.

Pain therapy is embedded in medical practice; morphine and opioids are available via prescription. DNR has legal status and the law guarantees patient rights. Transparent

	Rank/80	Score/100
Quality of Death overall score (supply)	5	84.5
Palliative and healthcare environment	10	69.4
Human resources	17	66.0
Affordability of care	=1	100.0
Quality of care	7	91.3
Community engagement	=1	100.0



information flow between doctors and patients concerning both diagnosis and prognosis is the norm, and psychologists provide support for patients and families along their clinical journey.

Hospitals and hospices customarily hand out feedback forms, but these are used for internal purposes rather than to inform national policies. Numerous campaigns and extensive regional networks have raised public understanding of the issue.³ Trained volunteers are frequent visitors to palliative care wards.

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Belgium," *EAPC Atlas of Palliative Care in Europe 2013*.

² Ibid.

³ Ibid.

6. Botswana



SNAPSHOT

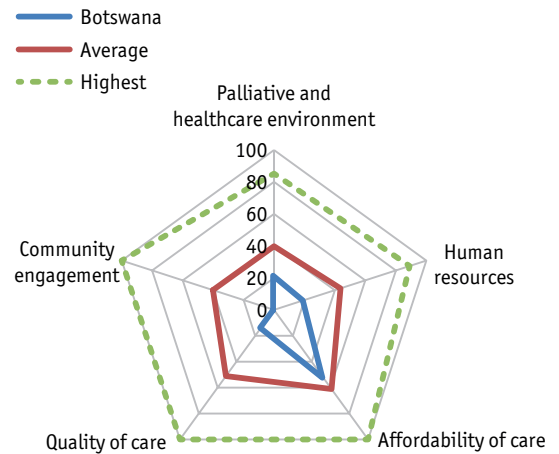
Botswana’s implementation programmes for palliative care exist on paper but limited in practice. Pain therapies are unavailable to most citizens due to a lack of skilled workforce, subsidies and infrastructure.

IN DETAIL

The government’s palliative care strategy remains a broad aspirational statement of intent without practical implementation.¹ Assessment is hampered by a lack of data; research is limited and not publicly funded.² Education opportunities for medical professionals are minimal and the quality of training is poor³, resulting in a chronic shortage of specialists and enduring prejudices against administering painkillers and providing psychological support. There is no professional body of accreditation.

Where available, basic palliative care is reserved for those who can afford it, as the government allocates no funding support. The national pension scheme also fails to cover care. In addition to financial constraints, patients face shortages of opioids and morphine, delivery of which is also restricted by red tape. Significantly, more than 64% of HIV and cancer patients

	Rank/80	Score/100
Quality of Death overall score (supply)	72	22.8
Palliative and healthcare environment	67	21.5
Human resources	72	19.6
Affordability of care	=49	52.5
Quality of care	=71	13.8
Community engagement	=78	0.0



report having unmanaged pain during their hospitalisations.⁴

Physicians see their role as mainly curative and typically withhold information on diagnosis and prognosis. However, patients are entitled to express binding preferences on treatment options as DNR has legal standing. Opportunities for feedback are rare as channels such as satisfaction surveys or data collection are nonexistent.

The general public has a limited grasp of palliative care tenets. There is no evidence of awareness campaigns by the government and little information is available at the community level. Volunteers are few and untrained.

¹ African Palliative Care Association, “Palliative Care in Southern Africa,” 2012.

² Gwyther, L., C. Blanchard, E. Namisango, F. Mwangi-Powell and R.A. Powell, “Palliative care research in southern and central Africa,” *European Journal of Palliative Care*, 2013.

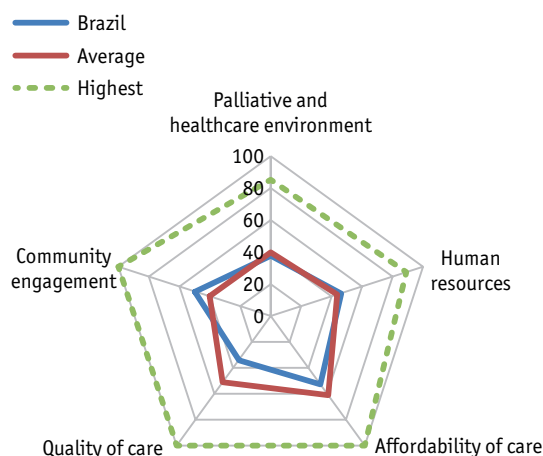
³ Conference report, “Palliative care: An essential part of medical and nursing training,” 24–25 March 2011.

⁴ African Palliative Care Association, “Palliative care country profile: Botswana.”

7. Brazil



	Rank/80	Score/100
Quality of Death overall score (supply)	42	42.5
Palliative and healthcare environment	=36	38.0
Human resources	33	46.2
Affordability of care	=49	52.5
Quality of care	=51	33.8
Community engagement	=22	50.0



SNAPSHOT

Palliative care provision in Brazil has a large margin for improvement. Primary hurdles are the overall health care environment and limited access to trained professionals and painkillers, especially outside major cities.

IN DETAIL

Brazil's national strategy on palliative care is still being formulated but is expected to cover three areas: drug policies, human resource training and assistance networks. Current arrangements include universal provisions for home care but despite this programme being well-funded, implementation is not uniform. Numerous research groups collect data but their findings are not directly influencing policy.¹ In 2012 formal accreditation for specialists was established. Professionals are highly trained but their numbers fall short of national needs.² Only 3 out of 180 medical schools now offer palliative care content but training courses are increasing in scope and number.³

The National Health System shoulders all costs but basic availability of care is still lacking in many regions. The lack of guidelines means that

local improvements are often uncoordinated and vary in quality. The last ten years saw a loosening of regulations on opioid access, but essential painkillers are hard to come by outside Brazil's main cities.⁴ Professional teams providing psycho-social support and bereavement care have been assembled through initiatives at specific institutions rather than as a result of coordinated planning.⁵ Patients can choose to limit or suspend treatment options according to government directives issued in 2006.⁶

Younger doctors are being trained to share diagnosis and prognosis with patients, but older physicians still avoid discussing the subject of death, seeing their role as essentially curative. Questionnaires are infrequently deployed; feedback tends to be informal. Public campaigns have raised awareness in mainstream media but the general public still has a limited understanding of palliative care.

¹ Pastrana, T., L. De Lima, R. Wenk, J. Eisenchlas, C. Monti, J. Rocafort, C. Centeno, *Atlas de Cuidados Paliativos de Latinoamérica ALCIP*, 2012.

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Torres, R.S.D. and K.T. Batista, "Do not resuscitate" order in Brazil, ethical aspects," *Comunicação em Ciências da Saúde*, 2008.

8. Bulgaria



	Rank/80	Score/100
Quality of Death overall score (supply)	62	30.1
Palliative and healthcare environment	74	12.6
Human resources	=76	11.6
Affordability of care	=44	57.5
Quality of care	=44	40.0
Community engagement	=66	17.5

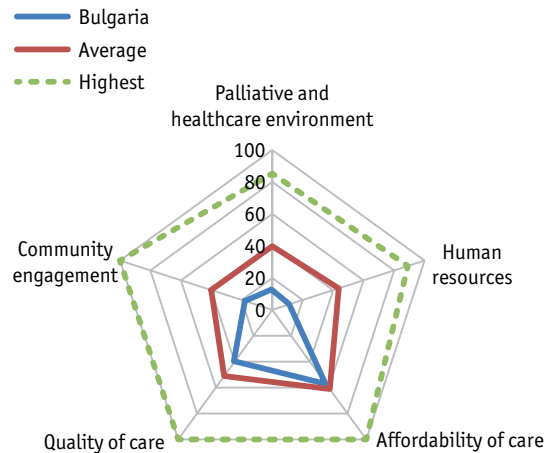
SNAPSHOT

Bulgaria lags behind other European countries in the quality and scope of palliative treatment. There is significant room to improve in expanding care to other medical conditions besides cancer.

IN DETAIL

Government directives have focused almost entirely on care for cancer patients,¹ and the system does not extend to cover other types of illnesses.² Palliative care is not recognised as a distinct treatment modality. The Bulgarian Association for Palliative Care gathers data but does not have the authority to implement changes. There is no accreditation system and specialist education is exclusive to university oncology departments.³ Consequently, physicians operating in other clinical fields have limited understanding of palliative care.

Subsidies are limited to terminally ill cancer patients, who are eligible for twenty days of hospice treatment every six months.⁴ Other medical conditions require patients to pay all expenses out-of-pocket. Monitoring and evaluation mechanisms are not well-established and health guidelines are only loosely enforced. Access to morphine is not always assured and the



range of available painkillers is significantly less than in Western Europe.⁵

Psychologists and social workers receive publicly funded training but lack of data makes it unclear how frequently they are providing care in hospice wards. Evidence suggests that doctor-patient communications are constrained by a reticence to disclose clinical information. Awareness of palliative care among the general public is low, and efforts to raise the issue in mainstream media have been limited.⁶

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Bulgaria," *EAPC Atlas of Palliative Care in Europe 2013*.

² Cancer Index, "Bulgaria," Jan 2015.

³ Centeno et al, 2013.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

9. Canada



	Rank/80	Score/100
Quality of Death overall score (supply)	11	77.8
Palliative and healthcare environment	18	57.5
Human resources	6	78.0
Affordability of care	=22	77.5
Quality of care	6	92.5
Community engagement	=9	75.0

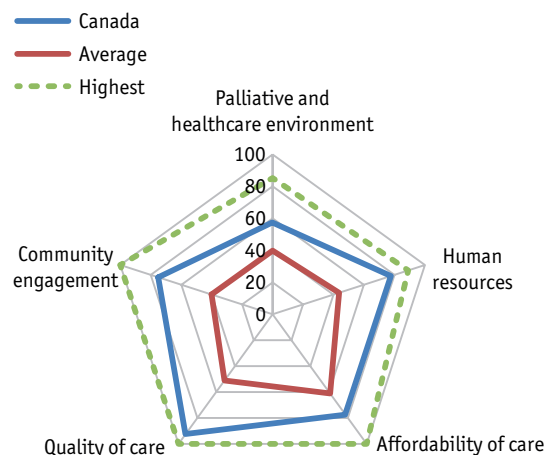
SNAPSHOT

Palliative care patients in Canada enjoy a high quality of service provision, characterised by ease of access, transparency and overall affordability due to support from the national health care system.

IN DETAIL

A roadmap to fully integrate palliative care into public policy was completed by civil society associations in early 2015 with government support.¹ The province of Alberta, along with several medical associations, has already utilised the new framework. Research is sporadic but available data is used for advocacy programmes and feeds into policy recommendations. Palliative care is included in most medical and nursing curricula but is not always mandatory.² The Royal College of Physicians and Surgeons of Canada accredits advanced one-year post-degree certifications.³

Palliative care provided in hospitals is free, and is generally accessible but availability of specialised treatments may be more limited, especially in geographically remote areas.⁴ Only 6 of 13 health jurisdictions provide 24-hour assistance seven days a week.⁵ Families choosing home-based care



often pay 25% of costs associated with additional services.⁶ Charitable donations are instrumental in sustaining residential hospices and enabling psycho-social support to be offered in most palliative care centres. Doctors and patients are partners in care, and patients have a legal right to DNR. Transparency is characteristic of the palliative care system overall, which is receptive and responsive to feedback; satisfaction forms are widely circulated and used to improve care.

The government backs awareness campaigns and disseminates information through an official online health portal, and the level of public understanding is rising. Volunteers provide essential support throughout the country.

¹ This is a reference to “The Way Forward” project led by the Quality End-of-Life Care Coalition of Canada and managed by the Canadian Hospice Palliative Care Association. The results of this project were not factored into the index as the findings were published after the EIU’s data gathering phase. More information can be found at: <http://www.hpcintegration.ca/resources/the-national-framework.aspx>

² Canadian Society of Palliative Care Physicians, “Background: Palliative Care Education,” January 2015.

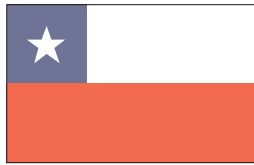
³ Royal College of Physicians and Surgeons of Canada, “Palliative Medicine,” 2014.

⁴ Canadian Hospice Palliative Care Association, “Fact Sheet: Hospice Palliative Care in Canada,” March 2014.

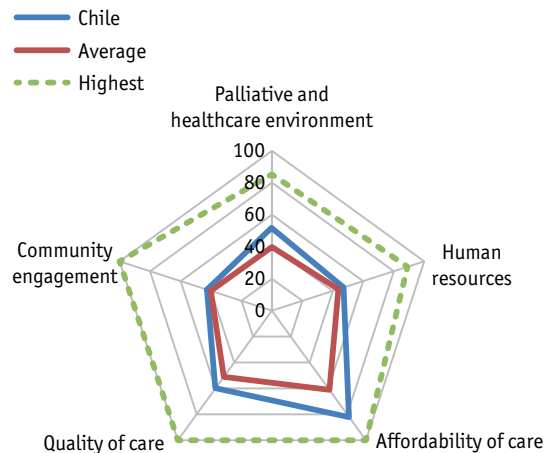
⁵ Ibid.

⁶ Ibid.

10. Chile



	Rank/80	Score/100
Quality of Death overall score (supply)	27	58.6
Palliative and healthcare environment	23	51.9
Human resources	32	47.4
Affordability of care	=18	82.5
Quality of care	=32	60.0
Community engagement	=27	42.5



SNAPSHOT

Chile performs marginally better than neighbouring countries but policy flaws leave non-cancer patients largely unassisted and with inadequate financial support.

IN DETAIL

Chile's first palliative care provisions date to 1994, when it pioneered an advanced programme for cancer patients. The situation remains essentially unchanged with no specific resources allocated for research or systemic enhancement.¹ There are only 70 specialists nationwide and these are unevenly distributed, leaving rural areas underserved.² Elements of palliative care are part of the curriculum in half of Chile's medical schools but there is limited professional training for specialists.³ Generalist training, occasionally offered through online courses, is seldom available for GPs.

The government provides free access for cancer patients to available palliative care units through its social safety net.⁴ But the paucity of resources and limited reach of services means

that additional in-house or hospice costs for treatment, especially for non-oncological treatment, must be paid by patients and families to independent providers.⁵ Private insurance coverage also does not fully cover treatment costs. Only cancer patients have consistent access to psychological support.

Physicians conceive of their role as mainly curative, but do inform patients of diagnosis and prognosis. No legal provisions are in place for DNR but access to opiates is effectively regulated to guarantee affordable access to painkillers.⁶ Patient satisfaction surveys are used sporadically. There are few efforts to increase awareness of palliative care amongst the general public, whose grasp of the subject tends to be full of misconceptions. Volunteers are linked to specific isolated initiatives, and are in short supply. A training facility for volunteers helps to equip beginners with essential skills.

¹ Pastrana, T., L. De Lima, R. Wenk, J. Eisenchlas, C. Monti, J. Rocafort, C. Centeno, *Atlas de Cuidados Paliativos de Latinoamérica ALCP*, 2012; Ministry of Health, "Pain relief for advanced cancer and palliative care," 2011.

² Pastrana, T, et al.

³ Ibid.

⁴ Ibid. The "Programa Nacional de Alivio del Dolor por Cáncer Avanzado y Cuidados Paliativos" is exclusively for cancer patients.

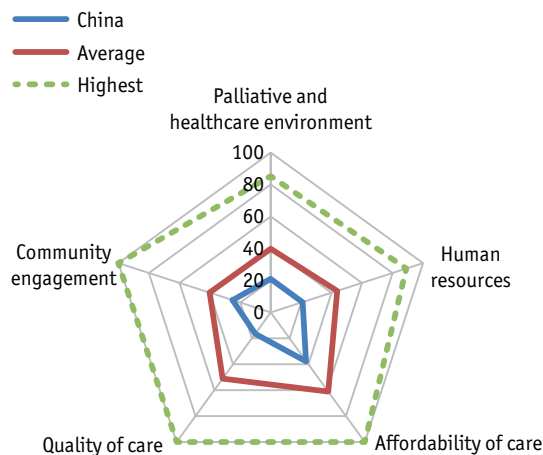
⁵ Ibid.

⁶ Cereceda, L., "Do not resuscitate order, some considerations on this problem." *Rev. Med. Clin. Condes*, 2011.

11. China



	Rank/80	Score/100
Quality of Death overall score (supply)	71	23.3
Palliative and healthcare environment	69	21.1
Human resources	70	21.0
Affordability of care	=65	37.5
Quality of care	69	16.3
Community engagement	=45	25.0



SNAPSHOT

End-of-life care provision in China falls far short of demand, with limited services available through the subsidized public health system. Education, public awareness, and overall quality have large margins for improvement.

IN DETAIL

Terminally ill patients in China are unlikely to receive palliative care. Service accessibility is limited with most hospices concentrated in urban areas.¹ Fully equipped palliative care units are an exception; most hospices have inadequate numbers of psychologists, social workers and volunteers. Medical schools rarely include palliative care in their curricula and no accreditation or specialist courses are offered, leading to a shortage of skilled and recognised professionals.

With no national strategy or guidelines for palliative care,² quality of care is uneven and enforcement of standards is weak. Clinical use of morphine is hampered by limited training in analgesia, concerns about addiction, a preference for prescribing alternative remedies, and the fear

that medications might be diverted for illegal use, leaving many patients without adequate pain relief.³

No official feedback process is in place to evaluate the patient experience or channel complaints. A widespread reticence on the part of physicians to fully inform patients of diagnosis and prognosis persists. While curative medicine continues to be the preferred treatment approach, public awareness of palliative care is gradually improving.

¹ Zou, M., M. O'Connor, L. Peters, W. Jiejun, "Palliative Care in Mainland China," *Asia Pacific Journal of Health Management*, April 2013.

² Ibid.

³ Ibid.

12. Colombia



SNAPSHOT

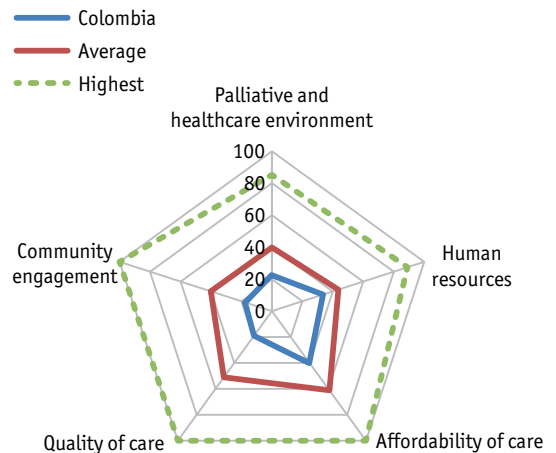
Colombia’s underperformance compared to neighbouring countries is due to insufficient resources, a lack of skilled professionals and restrictions on opioids.

IN DETAIL

Palliative care in Colombia is only nominally available. The government has enacted new legislation which should enhance access to palliative care, but in practice many patients, especially those with non-cancer illnesses, are not receiving full services.¹ Oncological patients are in theory entitled to consultation, medication, and treatment for symptom control.² However, a wide gap prevails between legal entitlements and implementation in practice. In addition, there are no mechanisms in place for data collection, research, quality assessment, regulatory updates, and monitoring.

Palliative care is accredited as a professional specialisation, but only 2 out of 57 medical faculties offer training. Physicians lack the interdisciplinary approach that encourages working in tandem with psychologists and social workers as a team. Severe shortages in personnel also limit delivery of psycho-social support.

	Rank/80	Score/100
Quality of Death overall score (supply)	68	26.7
Palliative and healthcare environment	62	22.7
Human resources	53	33.8
Affordability of care	=60	40.0
Quality of care	=67	18.8
Community engagement	=66	17.5



Access to affordable care is uneven. Although legal provisions for subsidies are outlined in the national government’s Mandatory Health Plan, reimbursement rates are low, often leaving patients to shoulder the entire financial burden.³ Private insurance rarely covers palliative care. Furthermore, high prices for strong painkillers and excessive bureaucracy limit access to pain-alleviating treatments.⁴

Most doctors tend to withhold information and have a predominantly curative approach. Physicians and families normally handle decisions without the patient being party to discussions. DNR has no legal standing. Institutions are required to conduct satisfaction surveys but this is not universal, and the results are not used to improve service quality. Recent media attention has brought palliative care into the spotlight but public understanding remains low. The number of volunteers falls short of need but available manpower receives adequate training.⁵

¹ Pastrana, T., L. De Lima, R. Wenk, J. Eisenchlas, C. Monti, J. Rocafort, C. Centeno, *Atlas de Cuidados Paliativos de Latinoamérica ALCP*, 2012.

² Ibid.

³ Ibid.

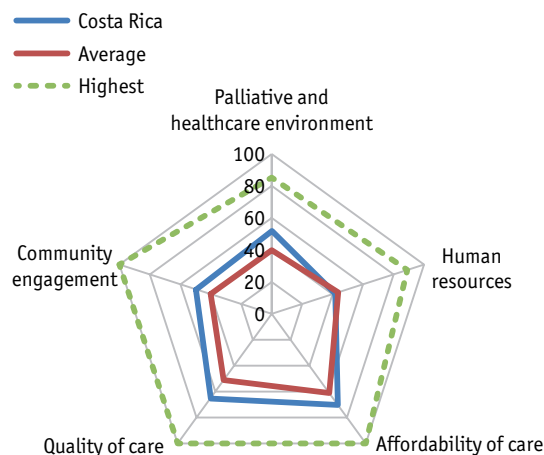
⁴ Ibid.

⁵ Ibid.

13. Costa Rica



	Rank/80	Score/100
Quality of Death overall score (supply)	29	57.3
Palliative and healthcare environment	22	52.1
Human resources	=41	41.6
Affordability of care	=30	70.0
Quality of care	30	65.0
Community engagement	=22	50.0



SNAPSHOT

Relative to its neighbours, Costa Rica provides affordable and quality palliative care. The government upgrades and enforces effective guidelines but the clinical environment still has considerable room for improvement.

IN DETAIL

The Ministry of Health recently established a National Council for Palliative Care to devise a national strategy.¹ To date, the lack of data and resources for research has meant that there are no evidence-based improvements to care.² The country established a strong accreditation system in 2007, but none of the seven medical faculties offer palliative care courses.³ Some educational opportunities occur outside the university system and the specialty is regulated by the Centre for Strategic Development and Information on Health and Social Security (a government body). The number of specialists falls short of the country's needs.⁴

Palliative care falls under the universal social insurance scheme. Hospitalisation, medication and specialist advice are provided for free,

and NGOs tend to support population who are uninsured.⁵ The Ministry of Health regularly audits palliative care units and upgrades guidelines on an annual basis.⁶ Existing infrastructure and regulations ensure an adequate range and supply of painkillers. Psycho-social support is also provided but underserved due to a lack of skilled professionals.⁷

Around half of doctors engage in transparent dialogue with patients on diagnosis and prognosis. Prevailing attitudes favour curative treatments and there is limited understanding in professional circles of what palliative care entails. The general public also has a minimal conceptual grasp of the subject. Teams of volunteers are engaged in fundraising and patient care but are rarely trained.⁸

¹ Pastrana, T., L. De Lima, R. Wenk, J. Eisenclas, C. Monti, J. Rocafort, C. Centeno, *Atlas de Cuidados Paliativos de Latinoamérica ALCP*, 2012.

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Ministry of Health, "Standard for Accreditation of Palliative Care and Pain Management," 2007; Pastrana et al.

⁷ Pastrana et al.

⁸ Ibid.

14. Cuba



SNAPSHOT

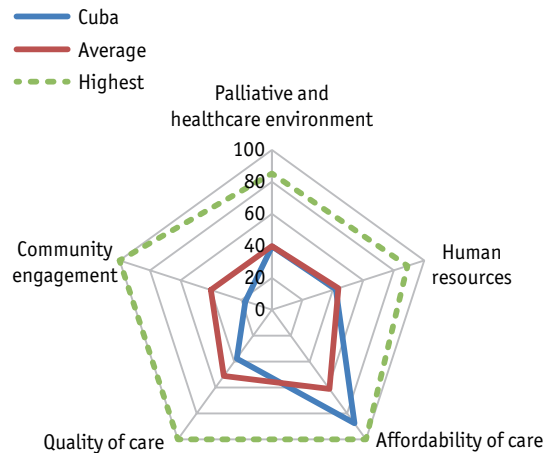
Affordability is the hallmark of Cuba’s public health model but shortages in skilled professionals and policy gaps limit the reach of its palliative care services.

IN DETAIL

Cuba administers palliative care as part of its National Strategy for Cancer Control,¹ and non-oncological patients are currently excluded. This policy gap has created a significant hurdle for the development of full-scale palliative care programmes, but the government is drafting a proposal to extend provision to all. Available data on care is presently drawn from independent academic studies funded by the government, but the authorities are proactively launching targeted research projects and allocating appropriate public funds.²

Palliative care education is limited in scope. The University of Medical Sciences in Havana has issued diploma certificates to trained non-specialist workers since 2010, but to date only 37 have been accredited. University training in palliative care is offered only intermittently and no register of specialists is kept. In 2011, the health authorities launched a nationwide training initiative to boost palliative care competence of medical workers. There is no indication as to the efficacy of this programme or an overall assessment of medical competency in the field.

	Rank/80	Score/100
Quality of Death overall score (supply)	36	46.8
Palliative and healthcare environment	34	39.7
Human resources	39	41.9
Affordability of care	=6	87.5
Quality of care	47	37.5
Community engagement	=66	17.5



The National Health System is free and fully covers palliative care in hospitals, but drugs and painkillers needed on an outpatient basis must be paid for by the patient. Monitoring and evaluation mechanisms are centrally directed from Havana and the National Institute of Oncology routinely audits cancer wards. Patient satisfaction surveys complement the feedback process.

The legal framework includes the right to access opiates. A wide range of painkillers are provided free of charge with a 24-hour dispensation programme available in accredited pharmacies and hospitals.

¹ Pastrana, T., L. De Lima, R. Wenk, J. Eisenchlas, C. Monti, J. Rocafort, C. Centeno, *Atlas de Cuidados Paliativos de Latinoamérica ALCP*, 2012.

² Ibid.

15. Czech Republic



SNAPSHOT

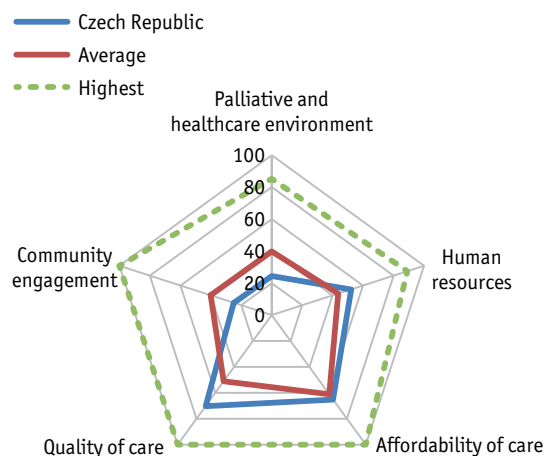
Efforts to formulate a national strategy are not yet complete, and the country's palliative care frontiers still have ample room for improvement. There is a shortage of both medical and psycho-social specialists.

IN DETAIL

A government-led initiative to forge a national strategy went adrift in 2012, contributing to the country's middling regional standing in quality of care provided.¹ Palliative care tends to be associated with end-of-life care, particularly for cancer, rather than a distinct treatment modality. Publicly funded research grants are available but data collection has not been substantial, and research findings are not contributing directly to policy improvements. Public universities offer optional courses for nurses and physicians, but palliative care has not been adopted as part of mandatory curricula.²

The state covers up to 80% of medical costs, placing a moderate financial burden on patients.³ Authorities routinely review guidelines but there are no enforcement mechanisms,⁴ and no national accreditation body. Trained professionals are in short supply, which hampers critical services like psycho-social support and bereavement care. Hospitals are better staffed, but shortages are common in hospices and rural areas.⁵

	Rank/80	Score/100
Quality of Death overall score (supply)	33	51.8
Palliative and healthcare environment	60	24.5
Human resources	26	52.2
Affordability of care	=36	65.0
Quality of care	28	70.0
Community engagement	=45	25.0



All WHO-recommended essential medications are freely available; physicians are liberal with prescriptions.⁶ Patients and families can voice feedback through systematic satisfaction surveys, but the level of government receptiveness to survey data is unclear.⁷ Doctors are generally reluctant to openly discuss diagnosis and prognosis with patients.⁸

The low level of public understanding reduces the number of volunteers. A 2013 survey found that almost four-fifths of respondents did not understand the term "palliative care." No information campaigns have been undertaken, and palliative care is not well-known outside the health care profession.⁹

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Czech Republic," *EAPC Atlas of Palliative Care in Europe 2013*.

² Ibid.

³ Slama, O., L. Kabelka, M. Spinkova, "Palliative care in the Czech Republic in 2013."

⁴ Ibid.

⁵ Jünger, S., S.A. Payne, A. Constantini, C. Kalus, J.L. Werth, "The EAPC Task Force on Education for Psychologists in Palliative Care," *European Journal of Palliative Care*, 2010.

⁶ Centeno et al.

⁷ eHospice, "Center for Palliative Care to build research and public awareness in the Czech Republic," October 16, 2014.

⁸ OECD, "Improving Value in Health Care: Measuring Quality," *OECD Health Policy Studies*, 2010.

⁹ Centeno et al.

16. Denmark



	Rank/80	Score/100
Quality of Death overall score (supply)	19	73.5
Palliative and healthcare environment	=26	50.5
Human resources	19	62.4
Affordability of care	=1	100.0
Quality of care	=16	83.8
Community engagement	=15	57.5

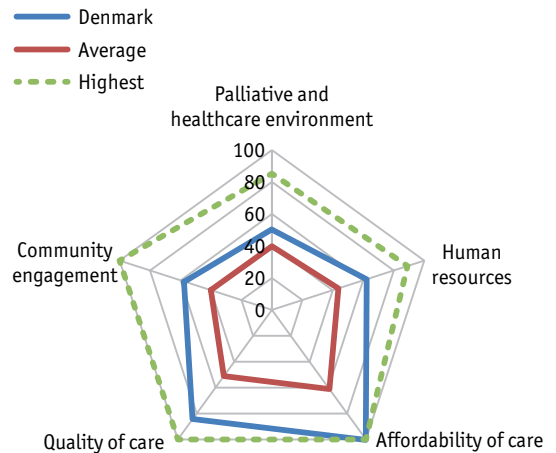
SNAPSHOT

Denmark firmly protects patients’ rights and access to palliative care. Excellent standards are in line with its Scandinavian neighbours with regards to research, facilities and overall responsiveness.

IN DETAIL

In 2011, the Danish government released new guidelines to strengthen operational capacity and educational requirements.¹ These guidelines do not formulate a national strategy but they provide a framework for systemic improvements. Publicly funded research informs policy decisions with routinely updated data.² There is no national accreditation system in place, but medical and nursing students have a wide range of training opportunities.

Public subsidies underpin affordable care. Families in financial distress can request a 100% cost reimbursement; otherwise, patients normally make a minimal contribution for medication.³ Monitoring and enforcement mechanisms are decentralised. Hospitals conduct regular evaluations to assess compliance with mandatory standards. Denmark has one of the world’s highest levels of legal opioid use, in line with the status of pain alleviation as a protected clinical



right.⁴ However, psychological care is less widely available.⁵

Transparency is ingrained in the medical culture; patients and physicians are partners in care and information related to diagnosis or prognosis is openly shared.⁶ Patients have a legal right to DNR. Regular surveys gather feedback from patients, who can also voice concerns via counsellors and group discussions.⁷ Readily accessible information has strengthened public understanding of the issue. Volunteers are present in all hospices, although the subsidised health model reduces the need for unpaid assistance.

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Denmark," *EAPC Atlas of Palliative Care in Europe 2013*.

² *Ibid.*

³ *Ibid.*

⁴ *Ibid.*

⁵ *Ibid.*

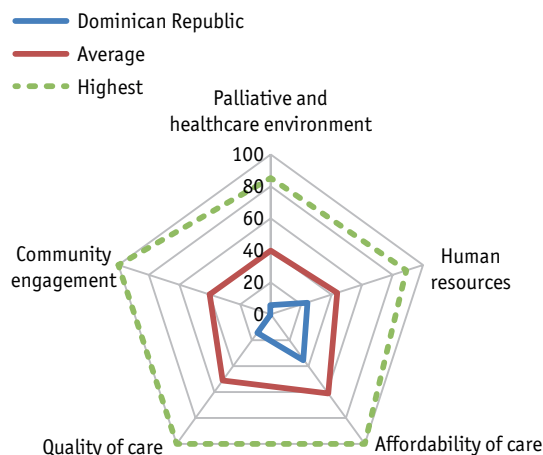
⁶ Health Consumer Powerhouse, "Euro Health Consumer Index 2014"; Olejaz M., A. Juul Nielsen, A. Rudkjøbing, H. Okkels Birk, A. Krasnik, C. Hernández-Quevedo, "Denmark: Health system review," *Health Systems in Transition 2012*

⁷ Olejaz et al.

17. Dominican Republic



	Rank/80	Score/100
Quality of Death overall score (supply)	75	17.2
Palliative and healthcare environment	78	6.1
Human resources	64	24.4
Affordability of care	=69	35.0
Quality of care	=71	13.8
Community engagement	=78	0.0



SNAPSHOT

The country's health system has critical shortcomings in the provision of palliative care. Many obstacles stand between patients and access to quality care.

IN DETAIL

The Dominican health model fails to ensure basic access to medical advice and facilities. There is no national strategy in place to set up palliative care units.¹ The scarcity of research or data makes it difficult to assess the extent of current gaps and what resources are needed. Our index ranks the Dominican Republic as having the poorest care in the Americas.

The near absence of qualified practitioners constitutes the biggest hurdle.² Monitoring mechanisms are non-existent.³ The few specialised professionals are foreign-trained, as there are no educational opportunities in palliative care available locally. Only one of the ten medical schools offers a module as part of its oncological training; no accreditation exists.

No government subsidies have been allocated to lower costs for poorer patients seeking palliative treatments. Patients can in some cases draw from

their retirement funds to pay medical bills, if an illness is terminal. Medicines are not subsidised. As a result, opioids are expensive and access is also complicated by bureaucratic rules imposed on medical staff. Psycho-social support and bereavement care are very hard to come by. Doctors tend to see their role as curative and rarely share information with patients, often at the request of the family.⁴

The system has no official feedback channels; satisfaction surveys are not conducted and do not feature in government guidelines.⁵ Public understanding of palliative care is very low; information activities are isolated and mainly at the provincial level.⁶ Volunteers are a rare sight, with only two teams operating in the whole country.

¹ Pastrana, T., L. De Lima, R. Wenk, J. Eisenchlas, C. Monti, J. Rocafort, C. Centeno, *Atlas de Cuidados Paliativos de Latinoamérica ALCP*, 2012.

² Ibid.

³ Ibid.

⁴ Ibid.

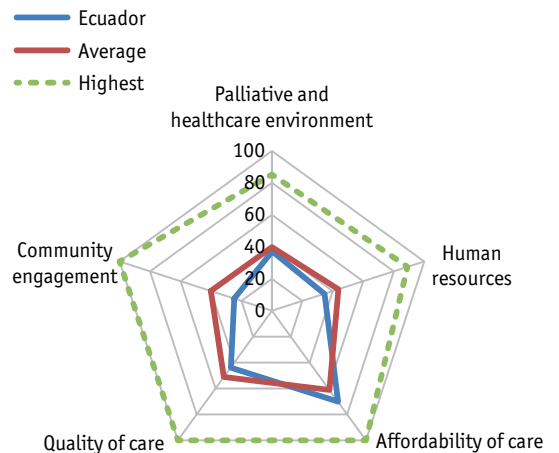
⁵ Ibid.

⁶ Ibid.

18. Ecuador



	Rank/80	Score/100
Quality of Death overall score (supply)	40	44.0
Palliative and healthcare environment	41	37.3
Human resources	51	34.4
Affordability of care	=30	70.0
Quality of care	41	43.8
Community engagement	=45	25.0



SNAPSHOT

A robust framework to regulate and expand palliative care services was adopted in 2013. The strategy is expected to yield tangible outcomes in the coming years.

IN DETAIL

Ecuador’s strategy, outlined in its “Plan Nacional de Cuidados Paliativos”, promises far-reaching change. Clear targets were set: to incorporate palliative care into the public health service; ensure availability of opiates; promote public understanding; and develop research support, as current data collection is patchy at best. The plan is reviewed every six months.

Implementation is underway but it will take time for the new strategy to achieve its goals. Notably, the shortage in professional workers persists. The Ministry of Education is developing a plan to accredit professionals, but only one of the twelve medical schools includes palliative care in its program. There is some availability of generic courses in three provinces.¹

There are very few facilities providing palliative assistance. Available services are covered

entirely by public subsidies, although semi-private institutions may request contributions in proportion to a patient’s ability to pay. Guidelines and monitoring mechanisms are being established across the country. Opioids are legally available but weak supply has caused persistent shortages. Most people die without access to pain alleviation.

The new framework encourages a fresh approach by medical professionals; training efforts are being directed at changing the physician’s role from purely curative to a nuanced one that includes palliative care. Targeted surveys are slowly becoming more common and are used to improve services. The government supports informational campaigns but public awareness is still limited. Volunteer numbers are low, but training is provided by the facilities that host them.

¹ Pastrana, T., L. De Lima, R. Wenk, J. Eisenchlas, C. Monti, J. Rocafort, C. Centeno, *Atlas de Cuidados Paliativos de Latinoamérica ALCP*, 2012.

19. Egypt



SNAPSHOT

Palliative care in Egypt is very limited and found only in Cairo. In the absence of government directives, improvements to care occur primarily through isolated and uncoordinated initiatives. Most people die without adequate pain relief.

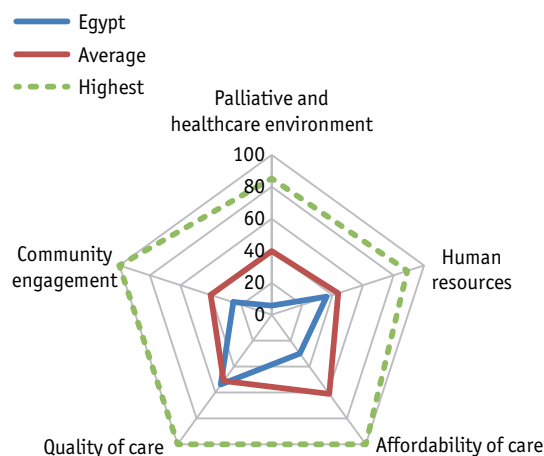
IN DETAIL

There is no normative framework in Egypt for palliative care.¹ The absence of national guidelines or research on palliative care leaves available services at a bare minimum. Educational opportunities are non-existent, along with accreditation. Specialised training is obtained abroad, and the number of specialised workers is far from meeting patients' needs.

There are no public subsidies for palliative care.² Private insurance may provide up to 70% of cost coverage, but the most important source of financial relief is NGOs who provide services free of charge. Hospital care is generally free, but there are no palliative care departments in public hospitals. The Health Ministry monitors standards, but without parameters in place to specifically evaluate palliative care wards.

Treatment options are limited by severe shortages of opioids and morphine. Legal restrictions apply

	Rank/80	Score/100
Quality of Death overall score (supply)	=56	32.9
Palliative and healthcare environment	79	5.5
Human resources	48	36.1
Affordability of care	=72	30.0
Quality of care	36	53.8
Community engagement	=45	25.0



and most general hospitals are not authorised to stock the full formulary of essential painkillers.³ Cancer patients can access cures more easily but must renew prescriptions on a monthly basis through a cumbersome process. Psycho-social support is generally offered only in hospices or private hospitals.

The law requires doctors to disclose diagnosis and prognosis; patients are legally empowered to choose DNR.⁴ Satisfaction surveys are infrequent and feedback channels largely informal. No awareness campaigns have been launched to mitigate the low public understanding of palliative care. Volunteers are few and typically untrained but they play an active role in patient care and are not relegated to fundraising.

¹ Silbermann, M., M. Arnaout, M. Daher, S. Nestoros, B. Pitsillides, H. Charalambous, A. Oberman, "Palliative cancer care in Middle Eastern countries: accomplishments and challenges," *Annals of Oncology*, 2012.

² Lancaster University International Observatory for End of Life Care, "Country Report—Egypt," 2005.

³ Alsirafy, S., "Palliative care in Egypt," Lebanese Society of Family Medicine 9th Annual Conference, November 5-7, 2010.

⁴ Knapp, C., V. Madden, S. Fowler-Kerry: "Pediatric Palliative Care: Global Perspectives," 2012.

20. Ethiopia



SNAPSHOT

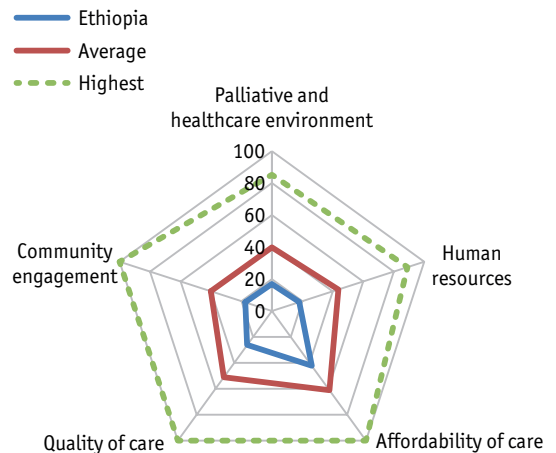
Structural factors limit the quality and scope of Ethiopia’s palliative care. Attempts are underway to extend public insurance coverage beyond HIV and cancer patients.

IN DETAIL

There is no overarching policy regulating palliative services.¹ The government is drafting a strategy to make pain-alleviating treatments accessible to patients currently excluded from the non-communicable disease (NCD) and HIV-AIDS programmes. Aside from an NGO-led survey in nine hospitals, limited research is conducted. The data collected is seldom used to inform policymaking.²

The number of specialists, including trained nurses, is very low; they have mostly received training abroad.³ Domestic education opportunities are limited; universities offer no accreditation or courses on palliative care. A partnership of local and international non-profit organisations delivers occasional five-day trainings in pain management.

	Rank/80	Score/100
Quality of Death overall score (supply)	70	25.1
Palliative and healthcare environment	72	16.8
Human resources	74	17.9
Affordability of care	=58	42.5
Quality of care	=59	26.3
Community engagement	=66	17.5



Government subsidies are reserved for NCD and HIV patients, and these programmes are easily accessible. HIV patients in terminal stages are treated for free, but the chronic scarcity of hospice and hospital beds means the vast majority of patients must seek costly private care.

Opiates and morphine are readily available.⁴ However, the prevailing medical ethos favours curative treatments and tends to leave patients uninformed of their condition; 83% of surveyed nurses report voluntarily lying to the terminally ill about diagnosis and prognosis.⁵ The government has not supported campaigns to enhance public awareness, and volunteers are limited in number and untrained.⁶

¹ Ddungu, H., “Palliative care: What approaches are suitable in developing countries?” *British Journal of Haematology*, 2011.

² Kassa, Hiwot et al., “Assessment of knowledge, attitude and practice and associated factors towards palliative care among nurses working in selected hospitals, Addis Ababa, Ethiopia,” *BMC Palliative Care*, 2014.

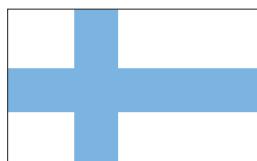
³ Ibid.

⁴ WHO Report, “A community health approach to palliative care for HIV/AIDS and cancer patients in sub-Saharan Africa,” 2004.

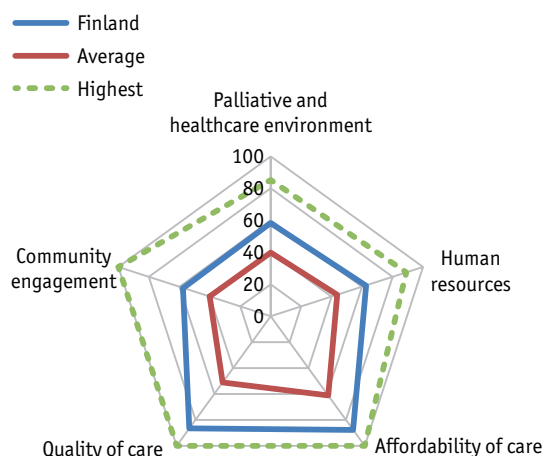
⁵ Kassa et al.

⁶ Ibid.

21. Finland



	Rank/80	Score/100
Quality of Death overall score (supply)	20	73.3
Palliative and healthcare environment	17	58.4
Human resources	18	62.6
Affordability of care	=6	87.5
Quality of care	15	86.3
Community engagement	=15	57.5



SNAPSHOT

Finland combines high standards and financially accessible care. Mandatory insurance schemes make the system universally affordable. Facilities are evenly distributed throughout the country.

IN DETAIL

A well-articulated national strategy supports the country's flexible care delivery system.¹ An organised network of academics and non-profit organisations conducts scientific research.² Specialised manpower is highly competent and present in all four of Finland's hospices.³ Targeted university courses were established in 2007 and produce qualified physicians and nurses. An independent body grants a nationally recognised accreditation.⁴

Palliative care is provided with minimal financial burden for patients. Finland's mandatory social insurance scheme covers all citizens. Subsidies are provided for medications as well as short- and long-term in-patient care. Partial payments are sometimes required.⁵ Most units rely on external

auditors for quality checks; ministerial guidelines are strictly enforced. Counselling and psycho-social support are widely available. Heavily subsidised morphine and other opioids are available with prescription. However, some health providers remain concerned about potential addiction.⁶

Satisfaction surveys are mandatory in all public health units,⁷ although the findings do not necessarily feed into system improvements. The visibility of palliative care has risen in the media thanks to government-supported information campaigns. Volunteers play an important role in the hospice care system and are assigned a mentor for training purposes.

¹ Poukka, P., T. Korhonen, L. Pyökkänen, and T. Saarto, "The Budapest Commitments," Finnish Association for Palliative Medicine, June 2010; Centeno, C., T. Lynch, O. Donea, J. Rocafort, and D. Clark, "Finland," *EAPC Atlas of Palliative Care in Europe 2013*.

² Centeno et al.

³ EAPC Task Force on the Development of Palliative Care in Europe, "Finland," 2006.

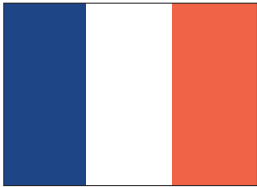
⁴ Centeno et al.

⁵ Ibid.

⁶ Ibid.

⁷ Raivio, R., J. Jääskeläinen, D. Holmberg-Marttila, K.J. Mattila, "Decreasing trends in patient satisfaction, accessibility and continuity of care in Finnish primary health care—a 14-year follow-up questionnaire study," *BioMed Central*, 2014.

22. France



SNAPSHOT

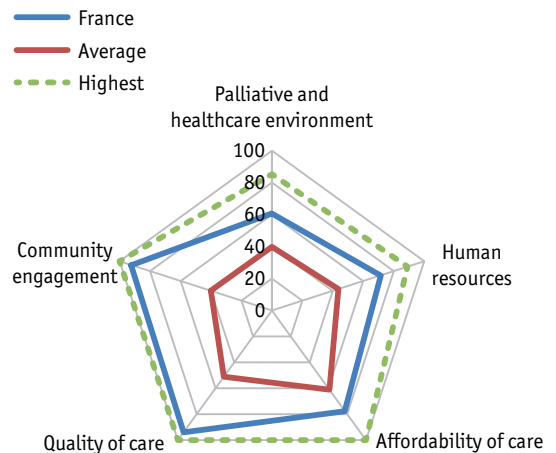
France combines a high standard of care with financial accessibility. The country's universal health system includes highly trained professionals operating in excellent facilities.

IN DETAIL

An ambitious 4-year palliative care programme of more than 200 million euros was funded by then-President Sarkozy's government in 2008.¹ The 2005 "Leonetti Law" regarding patient rights also creates a clear framework to guide treatment decisions.² Research on palliative care is mainly independently funded.³ Medical schools include limited compulsory training on palliative care. The number of specialised workers is generally sufficient but availability is uneven throughout the country.⁴

Palliative care services are offered free of charge thanks to substantial public funding. An allowance is also given to family caregivers who have to reduce their working hours.⁵ Public funds cover medication and treatment at home, but not the cost of a full-time nurse. The Ministry of Health regularly audits health providers and monitors service quality. Psychosocial support is an integral part of care services, along with access

	Rank/80	Score/100
Quality of Death overall score (supply)	10	79.4
Palliative and healthcare environment	16	60.9
Human resources	=10	71.6
Affordability of care	=22	77.5
Quality of care	5	93.8
Community engagement	=3	92.5



to a wide range of opiates and pain-alleviating treatments.⁶

In 2005, the patient's right to be fully informed was enshrined in the Code de la santé publique, although medical professionals may still be reticent when discussing the subject of death. Patients also have the right to limit or stop treatment, but DNR preferences are sometimes overlooked in favour of curative measures.⁷ Feedback is gathered through widespread satisfaction surveys. Patient associations have a voice in recommending changes. Volunteer levels are relatively low, but they receive adequate training; there are also volunteers behind many public awareness initiatives.⁸

¹ Ministry of Health of France, "Programme for the development of palliative care 2008-2012."

² Brieu, M.A., "Current conditions of the end-of-life care in France and Europe," Presentation at the International Longevity Centre-Japan, February 3, 2012.

³ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "France," *EAPC Atlas of Palliative Care in Europe 2013*.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

⁷ Baumann, A. et al., "Ethics review: End of Life legislation—the French model," *Critical Care*, 2009.

⁸ Centeno et al.

23. Germany



SNAPSHOT

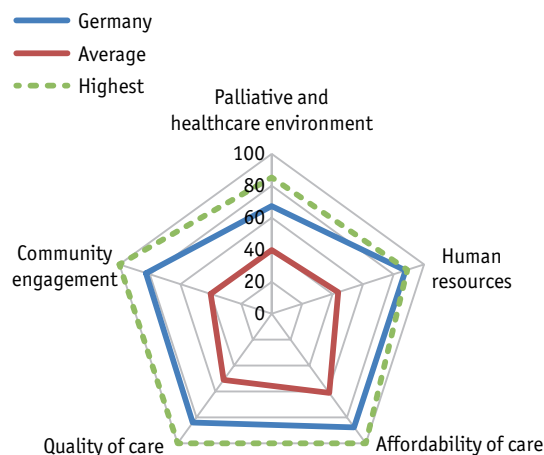
Germany is home to a well-regulated and efficient system of palliative care. Patients benefit from affordable high-quality care across its federated states.

IN DETAIL

Laws and regulations are in place to govern palliative care provision.¹ A National Charter released in 2010 spells out patients' rights and entitlements.² Several universities conduct independent scientific studies, and the government provides research grants. Palliative care training is a mandatory part of medical curricula but remains optional for nursing students.³ The German Palliative Care Association issues nationally recognised credentials, and over 6000 physicians have been accredited, creating a significant professional base.⁴

The mandatory public health system offers free palliative care, but partial payment is required for hospitalisation and medications provided at home.⁵ Legal restrictions on opioids and morphine have been lifted. Robust evaluation mechanisms provide regular quality assurance checks in all facilities.⁶ Non-cancer patients

	Rank/80	Score/100
Quality of Death overall score (supply)	7	82.0
Palliative and healthcare environment	11	67.6
Human resources	3	87.9
Affordability of care	=6	87.5
Quality of care	=16	83.8
Community engagement	=5	82.5



are often waitlisted for access to psychological treatment due to a shortage of trained professionals in public hospitals.

The health model is responsive to feedback, which is gathered through standardised surveys; however, these are general and not designed specifically for palliative care patients. DNR is a legal right, but physicians display a reluctance to engage in open dialogue with patients. Considerable progress has been made in raising awareness among the general public thanks to numerous information campaigns, including education in primary schools about palliative care.⁷ Patients benefit from the participation of more than 80,000 trained volunteer workers.⁸

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Germany," *EAPC Atlas of Palliative Care in Europe 2013*.

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.

24. Ghana



	Rank/80	Score/100
Quality of Death overall score (supply)	51	34.3
Palliative and healthcare environment	48	33.4
Human resources	47	36.3
Affordability of care	=54	50.0
Quality of care	58	28.8
Community engagement	=66	17.5

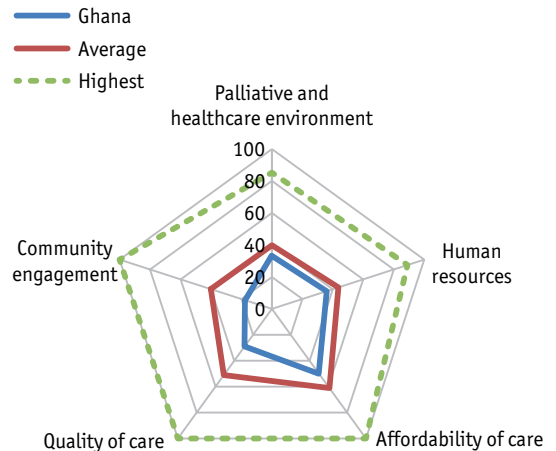
SNAPSHOT

A range of structural flaws hinders the accessibility and affordability of Ghana’s palliative care services. Existing policies are fragmented but a new national-level strategy is being drafted.

IN DETAIL

The concept of palliative care is relatively new in Ghana. Government policies remain fragmented, unenforced and weakly monitored.¹ Management of pain and symptoms has been partially developed as a treatment for HIV/AIDS and cancer patients, contributing to Ghana’s index performance. No public funds are deployed for research. Available data is collected via private efforts and international aid agencies. Overall, the system lacks a qualified workforce, which is limited to a handful of foreign-trained specialists who operate on a volunteer basis.²

Palliative care is offered as an elective course in some nurse training programmes but is not included in medical curricula. The limited training options for physicians occur outside of formal academic institutions, funded by international donors. The Ghana Medical & Dental Council offers a form of accreditation.³



Government funding is available in some cases, and the national insurance scheme subsidises the payments for certain cancer patients, but all others must purchase their own drugs. Due to the high costs, cumbersome bureaucracy and unreliable supply of opioids, most patients do not benefit from pain alleviation at the time of death.⁴ Psycho-social support is scant and cultural factors prevent a transparent doctor-patient dialogue. DNR has legal standing and satisfaction surveys are widely used, but the system has difficulties absorbing feedback. Public understanding is low and information at the community level limited. Likewise, the number of volunteers helping to care for patients falls short of needs.

¹ Lancaster University International Observatory for End of Life Care, “Country Report – Ghana,” 2005.

² Ddungu, H. and B. Basemera, “IAHPC Travelling Fellowship Report to Ghana May 2004,” International Association for Hospice & Palliative Care Newsletter.

³ Ajayi, I., O. Iken, R.A. Powell, O. Soyannwo, E. Namisango and F. Mwangi-Powell. “Palliative care research in western Africa,” *European Journal of Palliative Care*, 2014.

⁴ Ddungu and Basemera.

25. Greece



	Rank/80	Score/100
Quality of Death overall score (supply)	=56	32.9
Palliative and healthcare environment	58	26.7
Human resources	61	25.9
Affordability of care	=42	60.0
Quality of care	63	23.8
Community engagement	=38	32.5

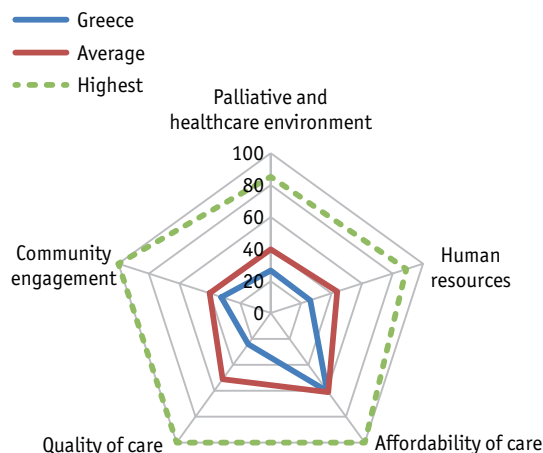
SNAPSHOT

With a lack of comprehensive policies and a shortage of facilities, dispersed pain treatment services and a strong volunteer system are at the core of Greece’s palliative care provision. Many provinces remain underserved.

IN DETAIL

Policymakers have largely overlooked palliative care. There is no overarching strategy or any trend of harmonising existing regulations.¹ The University of Athens offers elective courses and operates a small research unit.² Only one of Greece’s seven medical schools mandates palliative care studies; the rest offer it as an element of other courses. No accreditation is given and there is a shortage of specialists.³

As there are no specialised palliative care units, treatment is often provided within anaesthesia departments.⁴ The national insurance scheme covers consultation, hospitalisation and medication for cancer patients. Patients suffering from other illnesses have more difficulty in accessing subsidised care.⁵ Bureaucracy is a nuisance, delaying opioid administration and restricting prescriptions, and some strong opioids are banned. Guidelines and monitoring



mechanisms are absent.⁶ Churches and charitable societies provide assistance with home-care services and cost reduction but have limited geographical coverage.⁷

Shared decision-making is rare as physicians are not well versed in pain management and focus on curative treatments.⁸ DNR has no legal standing but the public has gained a better understanding of palliative care due to informational campaigns.⁹ Over 80 trained volunteer teams provide essential support to understaffed hospital units. Volunteers are often trained specialists who contribute additional time *pro bono* to guarantee service availability.¹⁰ Volunteers also assist with bereavement services.

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Greece," *EAPC Atlas of Palliative Care in Europe 2013*.

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

26. Guatemala



SNAPSHOT

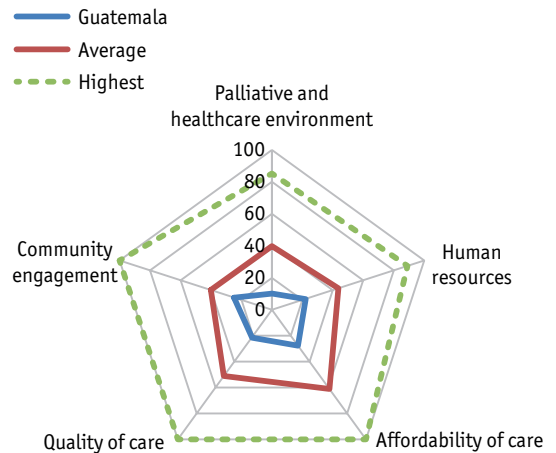
Palliative care services in Guatemala are understaffed and underfinanced. Poor infrastructure and restrictive opioid regulation result in inadequate pain management for most patients.

IN DETAIL

Palliative care in Guatemala is still at an early stage of development. The government has yet to formulate a strategy or implement any guidelines or regulations. Only one of the country's nine medical schools includes palliative care training in its undergraduate curriculum; there are no specialised courses or accreditation system. Shortages of professionalised manpower are widespread.¹

Palliative care is primarily considered to be a function of oncological care. The National Institute for Cancer receives financial support from the government and provides free consultations and medications in Guatemala City, but there is no evidence of similar programmes outside the capital. Bureaucracy and low supply

	Rank/80	Score/100
Quality of Death overall score (supply)	74	20.9
Palliative and healthcare environment	75	10.3
Human resources	68	22.1
Affordability of care	=74	27.5
Quality of care	=64	21.3
Community engagement	=45	25.0



limit access to pain-alleviating therapies even for patients in terminal stages of cancer, and opioids are off-limits for non-cancer patients. Psycho-social support is rarely available. Monitoring and enforcement mechanisms are not in place.

Communication barriers exist between doctors and patients, preventing them from being partners in care. Physicians tend to withhold discussing diagnosis and prognosis even with family members. There are no patient satisfaction surveys. The public is poorly informed despite isolated attempts to spread awareness at the community level on occasions like Palliative Care Day. Volunteers receive some training but their numbers are inadequate to meet the needs of the system.²

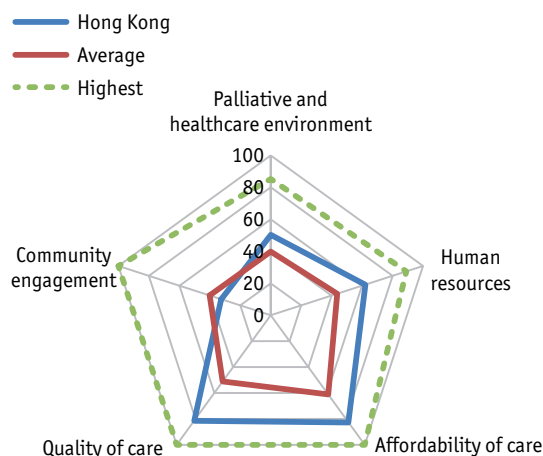
¹ Pastrana, T., L. De Lima, R. Wenk, J. Eisenclas, C. Monti, J. Rocafort, C. Centeno, *Atlas de Cuidados Paliativos de Latinoamérica ALCP*, 2012.

² Ibid.

27. Hong Kong



	Rank/80	Score/100
Quality of Death overall score (supply)	22	66.6
Palliative and healthcare environment	28	50.4
Human resources	20	62.1
Affordability of care	=18	82.5
Quality of care	=20	81.3
Community engagement	=38	32.5



SNAPSHOT

Palliative care in Hong Kong is moderately developed. Training institutions produce qualified specialists, and care is accessible and well-subsidised.

IN DETAIL

Palliative care services in Hong Kong are gradually improving. The government has backed a number of pilot projects with the objective of steadily expanding the range of available services.¹ The aim is to provide affordable and holistic care covering specialist and in-patient treatment as well as at-home and bereavement support. The number of residential and in-patient beds is gradually increasing. Universities can compete for public funding for research.

Palliative medicine is offered as a specialty in medical and nursing schools. The standard undergraduate medical curriculum exposes students to the subject, although courses are not compulsory. There is a general understanding of palliative care among physicians. Accreditation is given for physicians but not yet for nurses.

The public health service provides universal affordable care, which includes palliative care services. Psycho-social support is an integral part of care. DNR has no legal standing, but hospitals have internal policies to support patient decisions. Doctor-patient relations are typically open and transparent. Satisfaction surveys are rarely used and are not required in official guidelines.

There has been considerable progress in informing the public about palliative care but most people still have a limited understanding. Likewise, volunteerism is growing but varies considerably among facilities.

¹ Cheung, M., "HK promotes seniors' well-being," News.gov.hk.

28. Hungary



SNAPSHOT

Palliative care elements are unevenly developed across the health system. Shortages in funding and staffing place Hungary behind its European peers in quality and reliability of services.

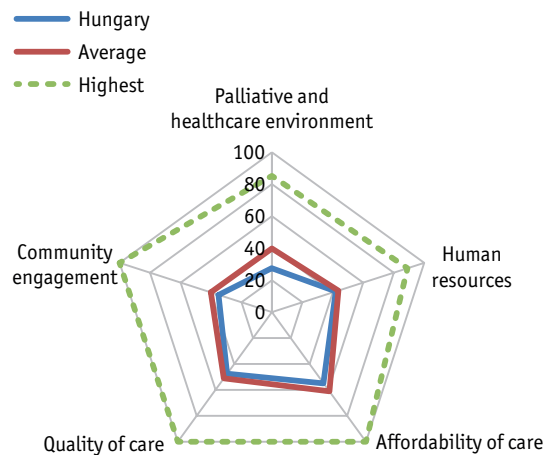
IN DETAIL

Hungary lacks coordination mechanisms to research, monitor and harmonise palliative care services.¹ The subject of palliative care is not recognised as a separate academic field in medical schools, where it is linked with oncological curricula.² Perceptions on specialised training are shifting, however, and accreditation was established in 2014.³

Doctors and nurses now complete mandatory courses lasting 20-30 hours, but shortages of professionals are pervasive.⁴

Under the National Cancer Control Programme, the few available facilities provide cancer patients with nearly free access to consultation, treatment and medication.⁵ Non-cancer patients are nominally excluded but are often able to access subsidised therapies, but with lower levels of reimbursement. The number of hospice beds is insufficient, and private clinics charge hefty fees. Overall, the sector is underfinanced. Terminally ill patients rarely receive the full range of services outlined by international standards for palliative care.

	Rank/80	Score/100
Quality of Death overall score (supply)	41	42.7
Palliative and healthcare environment	57	27.6
Human resources	38	42.1
Affordability of care	=47	55.0
Quality of care	=38	47.5
Community engagement	37	35.0



The National Health Insurance Service's quality control mechanisms are only loosely enforced.⁶ Though access to methadone is restricted, opioids are generally available and affordable. Psycho-social support is limited in availability. Doctors do not always disclose diagnosis and prognosis to patients, and tend to favour curative treatments.⁷ The system has limited response to feedback and satisfaction surveys are infrequent.⁸ Efforts have been made to improve public awareness, achieving modest results.⁹ Likewise, provisions to boost volunteer participation have been made but do not yet show tangible outcomes.¹⁰

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Hungary," *EAPC Atlas of Palliative Care in Europe 2013*.

² Centeno et al; Hungarian Hospice Palliative Association, "Palliative care of terminally ill cancer patients professional guidelines: 2nd and improved edition," 2002.

³ Centeno et al.

⁴ Komuves, A., "Hungary's doctor shortage," *Bloomberg Business Week*, 17 December 2008.

⁵ Hungarian Hospice Palliative Association website.

⁶ Centeno et al.

⁷ Ibid.

⁸ Balogh, Z., "Measuring the quality of long-term care in Hungary," *Eurohealth*, 2010.

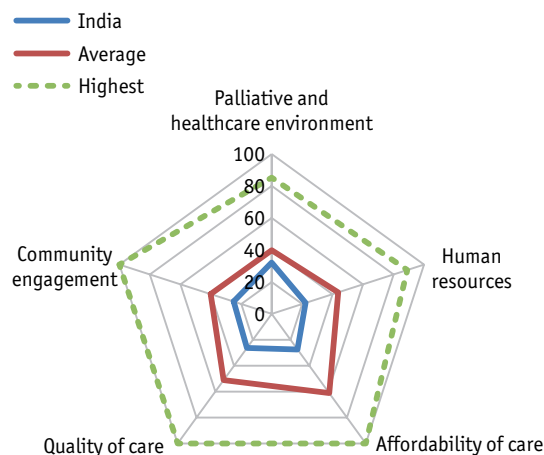
⁹ Centeno et al.

¹⁰ Ibid.

29. India



	Rank/80	Score/100
Quality of Death overall score (supply)	67	26.8
Palliative and healthcare environment	51	32.1
Human resources	67	22.3
Affordability of care	=74	27.5
Quality of care	=59	26.3
Community engagement	=45	25.0



SNAPSHOT

Provision of palliative care in India is poor, but the State of Kerala is a positive exception. Nationally, progress is slow but policy improvements are occurring.

IN DETAIL

Kerala's palliative care system stands out as a model for the region. Local authorities effectively harnessed centrally devolved power to set up clear state guidelines and adequate funding. However, at the national level India faces major shortages in specialists and facilities, and lacks coordination. NGOs work to fill gaps in public services. The National Cancer Control Programme mentions palliative care but development of services has been slow.¹ Other types of patients have even more limited options. A 5-year national strategy created in 2012 was weakened when Parliament withdrew its budget.² The Indian Association of Palliative Care conducts research and makes policy recommendations.

Palliative medicine is not compulsory for undergraduate medical students, and only one institution offers postgraduate studies.

Palliative care is recognised as a speciality but no accreditation is given. Subsidies vary across different states. Some, like Andhra Pradesh, include palliative care funding in public insurance, but most state budgets fall short of needs. Excessive bureaucracy limits access to pain medication, and opiates are under tight legal restrictions.³ Furthermore, doctors are not trained in dosage and use; thus most do not utilise effective pain management treatments. The need for psychosocial support exceeds available resources. With the exception of Kerala, public awareness of palliative care is very low, with limited attempts to increase public understanding.

On the whole, most terminally ill Indians are unaware of palliative care options and do not benefit from pain alleviation prior to death.⁴ Volunteers are present in some facilities but are under-utilised.

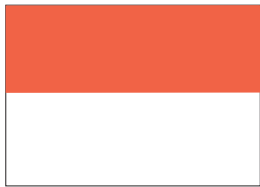
¹ Khosla, D., F.D. Patel and S.C. Sharma, "Palliative care in India: Current progress and future needs," *Indian Journal of Palliative Care*, 2012.

² Rajagopal, M.R., "The current status of palliative care in India," *Cancer Control* 2015.

³ Shariff, U., "An epidemic of pain in India," *The New Yorker*, 5 December 2013.

⁴ Nagarajan, R., "Palliative care is in need of a lifeline," *Times of India*, 3 March 2014.

30. Indonesia



	Rank/80	Score/100
Quality of Death overall score (supply)	53	33.6
Palliative and healthcare environment	54	30.9
Human resources	71	19.7
Affordability of care	=65	37.5
Quality of care	42	42.5
Community engagement	=38	32.5

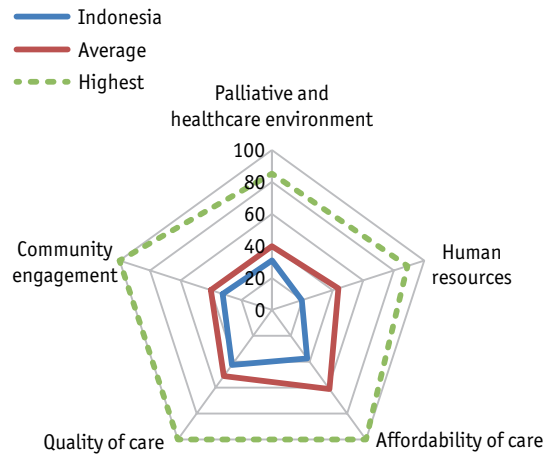
SNAPSHOT

Major improvements have been made to Indonesia’s palliative care framework, but implementation challenges remain. Difficulties in delivery mean that few patients receive care, and services are mostly absent outside of Java.

IN DETAIL

In an administrative breakthrough, palliative care has been integrated into the 2014-2019 National Cancer Control Programme.¹ Rigorous guidelines are now in place and public funds are available for cancer research, but weak monitoring and enforcement mechanisms result in variable outcomes.² The number of specialised workers is insufficient. Professionals are concentrated in Surabaya and Jakarta, leaving the rest of the country without basic palliative care services.³ Jakarta has the only fully equipped ward. A national postgraduate diploma provides unofficial certification, but no courses are offered at a university level.⁴

Health funding is limited and not focused on palliative care. In theory, low-income patients have access to free services but availability is limited. Standards vary across hospitals creating wide discrepancies. Many obstacles, including legal restrictions, reduce access to opioids; there are also difficulties in transporting medications throughout the country, which includes 17,000



islands.⁵ Isolated communities have limited stocks and clinical facilities. Psycho-social support is not included in official services. Significant improvements in the way doctors and patients interact were achieved over the last decade; prognosis and diagnosis are gradually becoming more transparent.⁶

Questionnaires are becoming more common and provide opportunities for feedback. The city of Surabaya actively supports local information campaigns and has established permanent services and volunteer networks, but is an exception. In most of the country, public awareness and community engagement are very low.⁷

¹ Witjaksono, M.A., N. Sutandiyo and D. Suardi, "Regional support for palliative care in Indonesia," *ehospice*, 1 August 2014.

² Ibid.

³ Ibid.

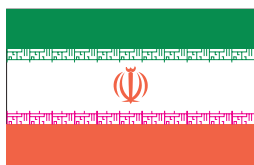
⁴ Ibid.

⁵ Ibid.

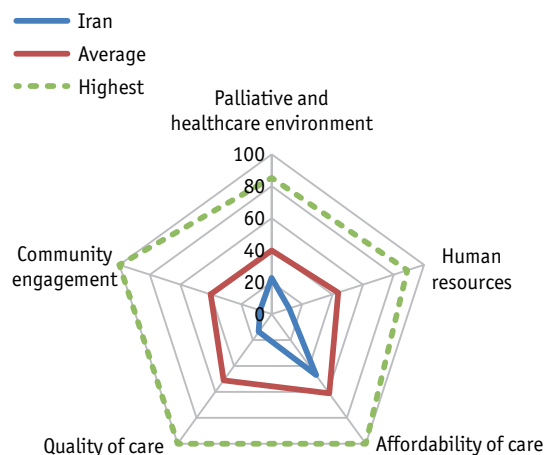
⁶ Ibid.

⁷ Ibid.

31. Iran



	Rank/80	Score/100
Quality of Death overall score (supply)	73	21.2
Palliative and healthcare environment	=63	22.5
Human resources	78	11.5
Affordability of care	56	47.5
Quality of care	=71	13.8
Community engagement	77	7.5



SNAPSHOT

A new strategy with sweeping changes is awaiting ministerial approval and implementation. It is designed to address the current limitations of care provision, which falls short of international standards and national needs.

IN DETAIL

The detailed policy draft currently under consideration by the Ministry of Health would provide a robust framework for enhancing palliative care services nationwide. The proposed strategy has ambitious targets and provisions related to narcotics, family support schemes, psycho-social support, and bereavement care, and would include substantial funding. The bill is expected to significantly upgrade Iran's palliative care services, which have crucial shortcomings.

Research is adequately funded. Data is regularly collected and informs policy.¹ Opportunities for training are scarce and no accreditation is available. Palliative care is not included in official curricula, and most doctors have a limited grasp of the subject.² The severe shortage of specialists constrains availability of care, which is confined to major urban centres.³ Where

available, care is adequately funded, with up to 97% of costs covered by state insurance. Monitoring mechanisms are enforced and will be strengthened if the new bill passes.

Opioids are widely available. However, morphine is hard to come by in rural areas and can only be administered by injection (oral intake is prohibited).⁴ Only a few independent facilities provide psycho-social support. Very clear legal provisions ban DNR on ethical and religious grounds. Doctors often do not fully inform patients of their prognosis, and mainly take a traditional, curative approach to treatment. Satisfaction surveys are not used to assess palliative services and are not yet embedded in official policy. Information at the community level is scarce. Volunteers provide support but are not trained.

¹ Abedi, M., "Palliative care within the Iranian context: Re-defining palliative care, deploying spirituality as a support measure and need for cultural sensitivity," *American Journal of Hospice and Palliative Medicine*, 9 December 2014.

² Asadi-Lari M., Z. Madjd and M.E. Akbari, "The need for palliative care services in Iran; an introductory commentary," *Iranian Journal of Cancer Prevention*, January 2008.

³ Asadi-Lari M, Z. Madjd., M.E. Afkari, A. Goushegir and H.R. Baradaran, "The concept of palliative care practice among Iranian General Practitioners," *Iranian Journal of Cancer Prevention*, 2009.

⁴ Human Rights Watch, "Global State of Pain Treatment," June 2011.

32. Iraq



SNAPSHOT

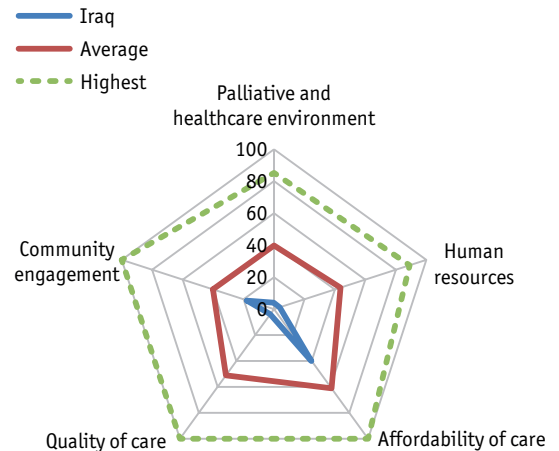
The challenges of health care provision in Iraq reflect the country’s overall predicament. Large regions offer virtually no medical assistance. Basic palliative care is almost completely absent.

IN DETAIL

There are no formal policies or guidelines relating to palliative care in Iraq.¹ Institutions are in a capacity-building phase but palliative care is not a priority for the government. No research is conducted, and no guidelines or accreditation are in place. The number of qualified doctors is very low as trained physicians flee the country’s political instability. There are no degree programmes in palliative medicine. Only a quarter of nurses are college graduates; most lack primary education.

Terminally ill patients face nearly insurmountable obstacles; most patients die without access to appropriate pain management.² The government provides no funding for palliative care. Post-embargo Iraq has not instituted a national insurance scheme.³ Hospitals are free of charge but lack many essentials and operate without

	Rank/80	Score/100
Quality of Death overall score (supply)	80	12.5
Palliative and healthcare environment	80	4.1
Human resources	79	4.0
Affordability of care	=60	40.0
Quality of care	80	3.8
Community engagement	=66	17.5



guidelines. Painkillers are dispensed for free when available. The country used to have the most restricted opioid inventory of the Middle East;⁴ family doctors are still restricted in their ability to prescribe morphine and strong painkillers. Authorised pharmacies are almost never accessible due to precarious security conditions.

Psycho-social support is non-existent.⁵ Physicians rarely share diagnosis and prognosis with patients, often at the request of families. There is no evidence of the topic being publicly debated or its awareness promoted by either government or civil society. There are no volunteers.

¹ Zeinah, G.F., S.G. Al-Kindi and A.A. Hassan, “Middle East experience in palliative care,” *American Journal of Hospice and Palliative Care*, February 2013.

² World Health Organization Country Health Profile, Iraq

³ Al-Hadad, S.A., M.F. Al-Jadiry and C. Lefko, “Palliative care in Iraq,” *Palliative Care to the Cancer Patient, The Middle East as a Model for Emerging Countries*, ed. M. Silbermann, May 2014.

⁴ Ibid.

⁵ Ibid.

33. Ireland



SNAPSHOT

Ireland provides some of the world's best palliative care services. Top-notch facilities are adequately staffed with qualified professionals. Information campaigns have successfully attracted broad public support.

IN DETAIL

Ireland adopted a clear strategy in 1994, which has since undergone regular review.¹ Guidelines are updated based on innovations in the sector. A specialised research and policy body acts in coordination with hospices and universities.² Regular data collection enables the formulation of responsive clinical strategies. The country has a clear accreditation process, with specialist education provided throughout four years of university training.³

Patients can rely on comprehensive support from public institutions. No payment is required for palliative care consultation, hospitalisation or medication.⁴ A strict monitoring system ensures consistent high quality across all hospital and hospice units. Patients have easy access to a wide range of opiates and affordable pain-alleviating

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Ireland," *EAPC Atlas of Palliative Care in Europe 2013*.

² Ibid.

³ Ibid.

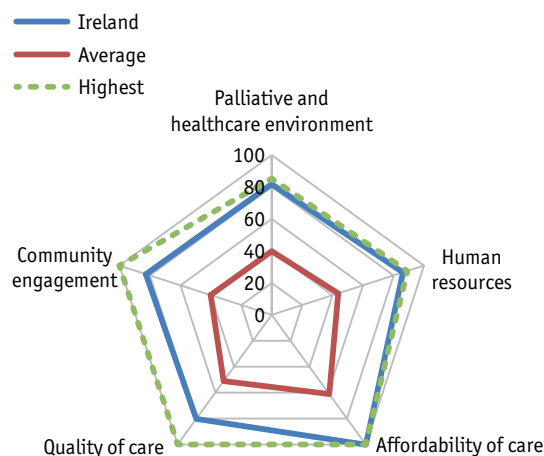
⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

	Rank/80	Score/100
Quality of Death overall score (supply)	4	85.8
Palliative and healthcare environment	4	81.7
Human resources	4	86.1
Affordability of care	=1	100.0
Quality of care	=22	80.0
Community engagement	=5	82.5



therapies. The psycho-social needs of patients are recognised and support is provided. There are no legal provisions for DNR.⁵

Surveys are widely used to collect patient feedback and are a key resource for monitoring and improving care. Public awareness is high, with increasing recognition of the role of palliative care at earlier stages of disease management in conjunction with other treatment strategies.⁶ The voluntary hospice movement has long been active in the development and provision of palliative care across the country.⁷

34. Israel



SNAPSHOT

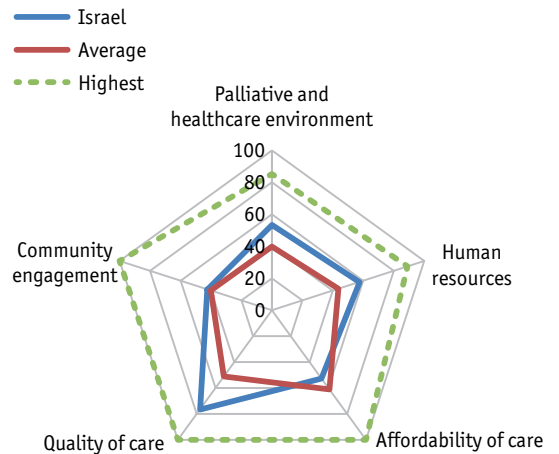
Concrete steps are being taken to ramp up and regulate palliative care services within Israel’s public health sector. The number of specialists is rising amid improvements in the overall standard of palliative care.

IN DETAIL

In 2009 the Ministry of Health integrated palliative care into its mandatory benefits package, with the objective of gradually ensuring universal access to palliative care. The current level of service does not meet public needs; palliative services are provided almost exclusively to oncological patients. Research informs public policy and is partly financed by the state, but regular data collection is not carried out.¹ Palliative medicine was recently recognised as a secondary speciality but the subject has yet to be included in mandatory curricula. Opportunities for continuing medical education abound for both physicians and nurses. A national body accredits specialised workers.

No specific funding for end-of-life care is earmarked in the national health budget. Public hospitals provide limited services and expansion is slow due to lack of financial incentives. Pension schemes do not cover palliative care. Quality

	Rank/80	Score/100
Quality of Death overall score (supply)	25	59.8
Palliative and healthcare environment	21	53.5
Human resources	23	57.5
Affordability of care	=49	52.5
Quality of care	25	76.3
Community engagement	=27	42.5



control mechanisms are only recently established and it is not known if guideline enforcement is effective or adequate. Opiates are widely available and most inpatient and community-based services offer psycho-social support.

The Dying Patient Act protects the patient’s right to forego treatments. Nonetheless, a cultural bias in favour of ‘aggressive’ therapies prevails among both the public and physicians. Doctors see themselves as decision-makers and tend to offer insufficient information to patients, but medical schools are beginning to shift attitudes towards greater transparency. Satisfaction surveys are not part of government policies but are widely used to improve care delivery. Public understanding is low; more than 80% of people report limited or no knowledge of palliative care.

¹ Bentur, N., L.L. Emanuel and N. Cherney, “Progress in palliative care in Israel: Comparative mapping and next steps,” *Israel Journal of Health Policy Research*, 2012.

35. Italy



	Rank/80	Score/100
Quality of Death overall score (supply)	21	71.1
Palliative and healthcare environment	19	56.7
Human resources	27	51.5
Affordability of care	=6	87.5
Quality of care	=13	87.5
Community engagement	=15	57.5

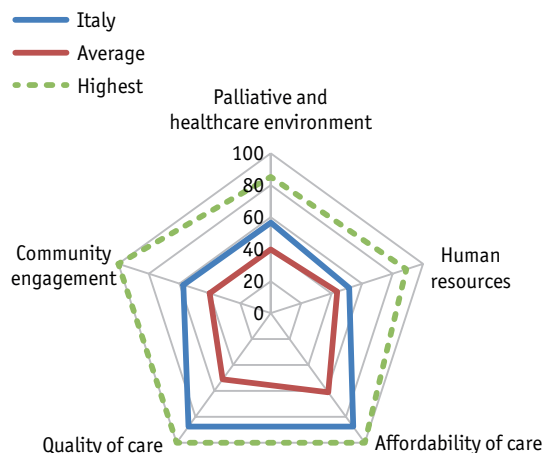
SNAPSHOT

A strong normative framework protects patients' rights and guarantees free, high-quality palliative care for all. Monitoring is decentralised, resulting in uneven implementation across the country.

IN DETAIL

The Italian Parliament ratified Law 38 in March 2010, providing a significant policy breakthrough in the expansion of structured palliative care services.¹ Targets, guidelines and monitoring mechanisms are in place.² Private foundations actively participate in and fund numerous research initiatives. Specialist courses are available but are not nationally coordinated. Recognised certifications do not amount to a full accreditation system.

In-patient and home care are entirely covered by the national insurance system.³ No payments are required for consultation, hospitalisation or medication.⁴ Pain alleviation is the cornerstone of the new health strategy; all opioids are dispensed free of charge and are widely available. Psycho-social support and bereavement services are easily accessible.⁵ Regional governments are responsible for monitoring services.⁶ Varying



degrees of quality achievement indicate that standards are not evenly enforced across all regions.⁷

The law is ambiguous in its endorsement of DNR but does obligate doctors to fully disclose prognosis and diagnosis to patients. Palliative care specialists follow this requirement, but a general reluctance to engage in transparent communications persists as a cultural norm among many physicians. Satisfaction surveys are increasingly used. The approval of Law 38 received wide media attention and contributed to public awareness, although this varies by region.⁸ The Health Ministry has sponsored robust national awareness campaigns.⁹ Large numbers of trained volunteers, organised in regional networks, support palliative care services.

¹ Law No. 38, "Provisions to ensure access to palliative care and pain therapy," Official Gazette no. 65, 19 March 2010.

² Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Italy," EAPC Atlas of Palliative Care in Europe 2013.

³ Centeno et al.; Zucco, F., ed., "Hospice in Italia," 2010.

⁴ Centeno et al.

⁵ Ibid.

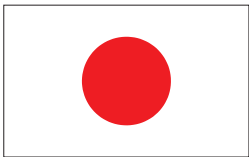
⁶ Ibid.

⁷ Ibid.

⁸ Law No. 38

⁹ Ibid.

36. Japan



SNAPSHOT

Top-notch facilities and skilled specialists support Japan’s high-quality healthcare system. However, palliative care is still primarily for cancer patients and is less accessible for those with other illnesses.

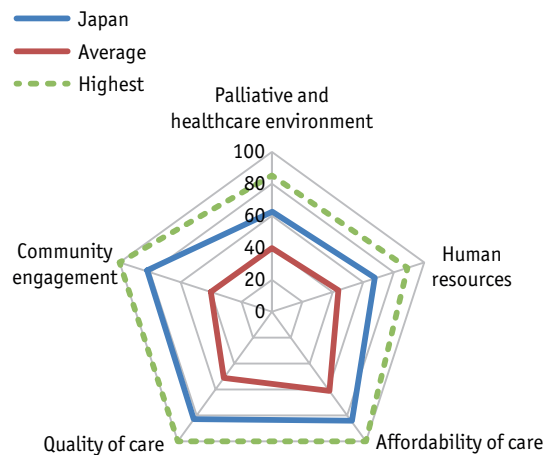
IN DETAIL

An ageing population has dramatically increased Japan’s need for palliative care. However, the existing framework is focused on cancer patients, making it difficult to expand treatment to others.¹ Although the number of specialised staff is adequate to meet oncological needs, it is insufficient to support patients with other illnesses. Substantial amounts of data are regularly collected and analysed by government agencies. Research informs public policy.

Educational programmes were boosted by the CLIC (Care for Life-threatening Illnesses) programme for paediatricians and cancer therapists, and undergraduate-level courses in palliative care are gradually being included in mandatory medical curricula.²

Cost-sharing allows for citizens below the age of 70 to pay 30% of costs, while those over 70 pay 10%. Above a certain threshold, only 1% of fees

	Rank/80	Score/100
Quality of Death overall score (supply)	14	76.3
Palliative and healthcare environment	14	62.2
Human resources	16	67.5
Affordability of care	17	85.0
Quality of care	=16	83.8
Community engagement	=5	82.5



are charged to patients. Low-income families are entitled to deductions. These schemes apply only to cancer patients; wider accessibility is hampered by lack of insurance and pension plan coverage for other terminal illnesses.

Japan has an acute shortage of trained psychologists; palliative care units do not include psychotherapy. The country has one of the world’s lowest rates of consumption of morphine per capita, despite wide availability. Recent medical graduates are reshaping traditional approaches to pain therapy. The communication between doctors, patients and families is usually informed by open disclosure of prognosis and diagnosis.

Advocacy and civil society groups have raised the profile of palliative care,³ and contributed to a more nuanced public understanding. Volunteers are a common sight and undergo basic training, and community-based networks are very active in rural areas.

¹ Tsuneto, S., “Past, present, and future of palliative care in Japan,” *Japanese Journal of Clinical Oncology*, November 2012.

² Ibid.

³ Eguchi, K., “Development of palliative medicine for cancer patients in Japan: From isolated voluntary effort to integrated multidisciplinary network,” *Japanese Journal of Clinical Oncology*, September 2010.

37. Jordan



	Rank/80	Score/100
Quality of Death overall score (supply)	37	46.7
Palliative and healthcare environment	35	39.3
Human resources	=30	49.4
Affordability of care	=36	65.0
Quality of care	=44	40.0
Community engagement	=33	40.0

SNAPSHOT

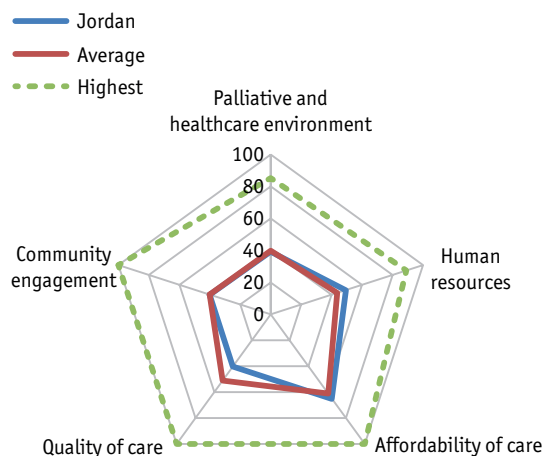
Palliative care in Jordan is only available to a minority of cancer patients. Public services surpass neighbouring Arab countries in quality and scope but severe shortcomings persist in manpower and facilities.

IN DETAIL

Jordan does not have an integrated palliative care policy. Available provisions and insurance cover cancer patients only. Plans are in place to extend coverage through the newly created community health care system but implementation lags. Research is limited and not publicly funded. Jordan has just five palliative care specialists, and fully equipped interdisciplinary teams are only available at the King Hussein Medical Center in Amman.

Doctors who wish to specialise in palliative medicine lack adequate training opportunities. NGOs offer limited continuing education workshops. No specialised university degrees are awarded. Academic training on palliative care as part of medical studies exists but only provides a brief introduction to the field.

The government does not specifically fund palliative care. Financial help is available for members of the military and those who are admitted to government hospitals. As public



infrastructure is limited, most patients do not have adequate access to end-of-life treatment. Private care requires out-of-pocket payment. Opioids are generally available, but psycho-social support is hard to find outside major cities.

DNR does not have legal status. Doctors see their role as more curative and typically offer only partial information to patients regarding their condition. Patient satisfaction surveys are used in a majority of cases, and feedback is taken to improve the system. The government does not invest in public information campaigns, and an estimated one-tenth of the population has a solid understanding of palliative care.

¹ Human Rights Watch, "Global State of Pain Treatment," June 2011.

² Ibid.

³ Ibid.

38. Kazakhstan



	Rank/80	Score/100
Quality of Death overall score (supply)	50	34.8
Palliative and healthcare environment	70	19.9
Human resources	60	27.0
Affordability of care	=25	75.0
Quality of care	=59	26.3
Community engagement	=45	25.0

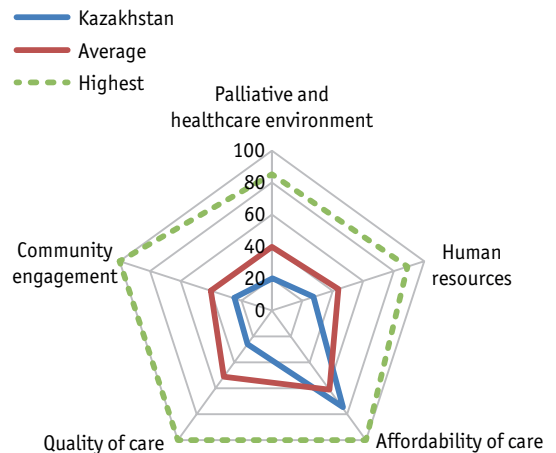
SNAPSHOT

Palliative care in Kazakhstan has significant room for improvement. Current policies narrow the scope of services, excluding non-oncological patients. The system is lacking overall strategy and relevant regulations.

IN DETAIL

There is no government strategy in place to sustain and promote palliative care in Kazakhstan. Reportedly, some administrative improvements have occurred, but a vision and clear targets are needed.¹ Data collection is minimal, with only occasional privately funded research conducted.² Underdeveloped services are unable to meet patient needs, and there is a shortage of staff.³ The limited training available is not coordinated at the national level. Some medical faculties offer optional courses. No accreditation is given.⁴

The palliative care system is primarily designed to assist oncological patients, and other types of patients have difficulty accessing coverage and services. In 2014, new standards and guidelines were created and are adequately enforced.⁵ Treatment and consultations have limited availability but what does exist is sufficiently funded. No overarching schemes are in place to financially assist more than a small minority of



patients requiring terminal care.⁶ Challenges in supplying appropriate amounts of opiates in the face of a heavily regulated market and widespread prejudices mean that most patients die without adequate pain relief.⁷

Families and volunteers provide essential support for care delivery. Services vary substantially in quality and scope; psycho-social support is not always available.⁸ Bereavement care is typically an option. There is a widespread hesitance to openly share diagnosis information, hindering transparent doctor-patient communication. DNR has no legal status and there is no evidence of surveys being used.⁹ The general public has a limited understanding of the topic.¹⁰ Volunteers tend to be few in number and untrained.¹¹

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Kazakhstan," *EAPC Atlas of Palliative Care in Europe 2013*.

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Shakenova, A., "Kazakhstan: National Palliative Care Standards approved," *ehospice News*, 8 February 2014.

⁶ Centeno et al.

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Ibid.

39. Kenya



SNAPSHOT

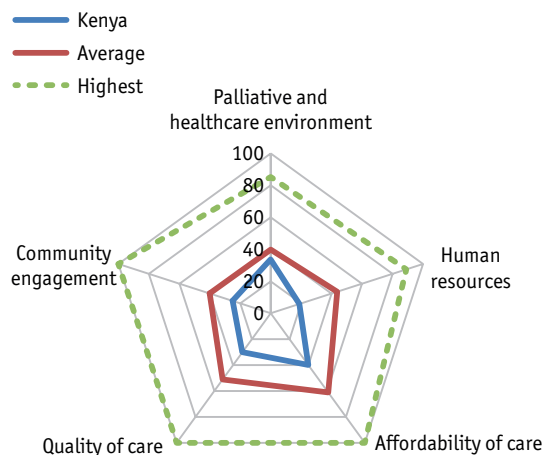
Palliative care services in Kenya are improving but availability is limited and the sector lacks funding, vertical integration and adequate professional training.

IN DETAIL

Kenya's cancer control strategy serves as the national framework for palliative care.¹ The government's goals are broad in scope and lack detail, but over 30 hospices and palliative care units have been established across the country.² Research is minimal and does not receive public funding.³ There are significant shortages of skilled palliative care professionals.⁴ Universities offer no formal courses; short-term trainings exist outside the academic system. No accreditation is given.

Participants in government insurance programmes have up to 70% of their costs covered, but only one in five people have coverage. A new collaborative insurance programme launched in April 2014 aims to assist an additional 35 million people, and includes palliative care.⁵ Monitoring standards are strict but clinical protocols are not always effectively

	Rank/80	Score/100
Quality of Death overall score (supply)	63	30.0
Palliative and healthcare environment	47	33.6
Human resources	73	18.8
Affordability of care	=60	40.0
Quality of care	=55	30.0
Community engagement	=45	25.0



enforced. Morphine is freely available, but unreliable supply and concerns over addiction limit access outside Nairobi.⁶ Psycho-social support is generally unavailable. DNR has no legal status.⁷

Information on palliative care is scarce, both in professional circles and at the community level. The public is mostly unaware of palliative therapies. Doctors are encouraged to share and discuss diagnosis and prognosis with patients, but often withhold clinical information and prefer curative treatments. There are some volunteers in public hospitals, but they are usually untrained.

¹ African Palliative Care Association website, "Introduction," 4 June 2015.

² Ibid.

³ Namisango, E., R.A. Powell, H. Kariuki, R. Harding, E. Luyirika and F. Mwangi-Powell, "Palliative care research in eastern Africa," *European Journal of Palliative Care*, 2013.

⁴ African Palliative Care Association website.

⁵ The World Bank, "Improving healthcare for Kenya's poor," *The World Bank News*, 28 October 2014.

⁶ Nyakundi, A., "Ministry of Health to purchase morphine," *ehospice*, 18 April 2013.

⁷ "Our patient's Requiem Mass was held long in advance," *Allnurses website*, 30 April 2012.

40. Lithuania



Vilnius

SNAPSHOT

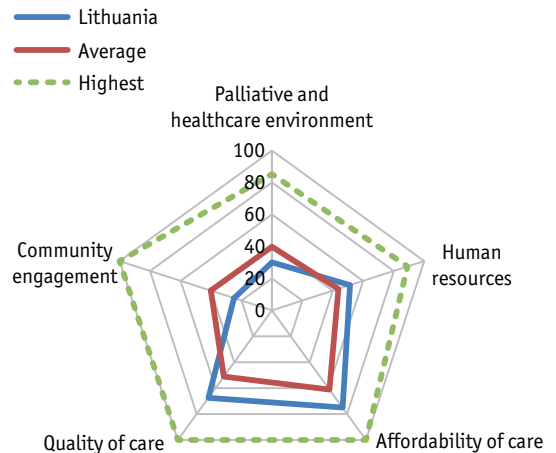
Palliative care in Lithuania is in transition. It is being developed as a distinct academic speciality, and community activists are lobbying for palliative care to be included in the national health framework.

IN DETAIL

Lithuania does not have a comprehensive national strategy.¹ Limited ministerial directives do not amount to a fully-fledged roadmap to integrate palliative care into the public health scheme.² Government funding is available for cancer-related research. Opportunities for professional development outside academia are scarce.³ Some medical schools offer mandatory courses at the undergraduate level. However, palliative care is still mainly considered a therapy for cancer patients. Nationally-recognised credentials exist but need strengthening.⁴

There is adequate funding for services within the current limited oncological scope. Patients only pay 20% of the cost of medicine.⁵ The government allocated separate financing for palliative care in 2008. Quality standards and guidelines have been instituted but it is unclear to what degree these are followed. There is scant evidence of appropriate monitoring and enforcement

	Rank/80	Score/100
Quality of Death overall score (supply)	30	54.0
Palliative and healthcare environment	55	30.1
Human resources	28	51.3
Affordability of care	=25	75.0
Quality of care	29	67.5
Community engagement	=45	25.0



mechanisms.⁶ Morphine and opioids are readily available. Psycho-social support is present and likely to expand.⁷

Available evidence suggests there are no legal provisions for DNR in Lithuania.⁸ The healthcare system regularly uses satisfaction surveys but it is not known to what extent they influence decision-making.⁹ The general public has a limited grasp of the subject. Mass media have rarely covered the issue. The number of volunteers is low, and they lack coordination by any regional or local network.¹⁰

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Lithuania," *EAPC Atlas of Palliative Care in Europe 2013*.

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

41. Malawi



	Rank/80	Score/100
Quality of Death overall score (supply)	66	27.0
Palliative and healthcare environment	=36	38.0
Human resources	50	35.1
Affordability of care	=60	40.0
Quality of care	=78	6.3
Community engagement	=45	25.0

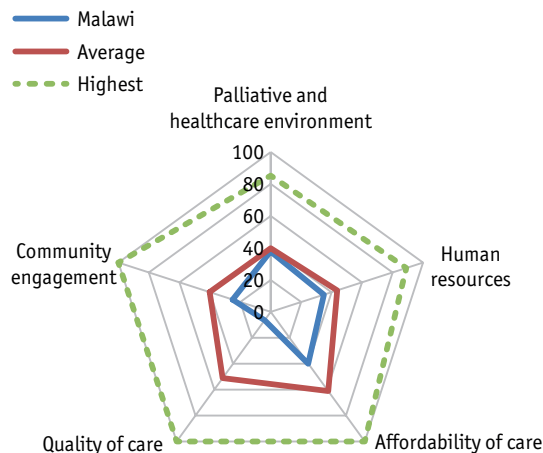
SNAPSHOT

Malawi's palliative care services are at a very early stage. Minimal public awareness and lack of government attention result in most patients dying without adequate pain relief due to a lack of facilities, trained specialists and opiates.

IN DETAIL

Malawi's palliative care strategy is a broad statement of intention,¹ which is not supported by integrative policies or robust implementation efforts. Palliative care has yet to become a priority for the government, which is focused on HIV and cancer. No data is collected and public funds are not directed towards research.² National accreditation is not available. Shortages of professional staff are endemic; there are only two oncologists in the whole country.³ Some districts have just one social worker per 45,000 inhabitants.⁴ Educational opportunities are poor in quality and scope, with most courses lasting less than one week. No university offers courses on palliative care.⁵

Malawi's economic predicament is evident in the lack of appropriate health facilities. There is no government funding for palliative care initiatives,⁶ and no national insurance.⁷ International charities function as health care providers for many patients outside the country's



capital. Public hospitals do not charge fees, but the range of their services is very limited and mostly reserved for cancer patients.⁸ Opioids are not legally restricted but supply is unreliable and costs are high. Psycho-social support is unavailable.

Hospices provide greater doctor-patient transparency than public hospitals in terms of communication on diagnosis and prognosis. In general, physicians see their role as being mainly curative. The system is not receptive to feedback, and satisfaction surveys are rare. NGOs are trying to stimulate a public discussion on palliative care through national media, but results so far have been modest. There are very few volunteers.

¹ Knapp, C., V. Madden and S. Fowler-Kerry, eds., *Pediatric Palliative Care: Global Perspectives*, 2012.

² Ibid.

³ Ibid.

⁴ Ibid.

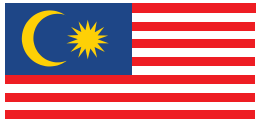
⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.

42. Malaysia



Kuala Lumpur

	Rank/80	Score/100
Quality of Death overall score (supply)	38	46.5
Palliative and healthcare environment	42	37.1
Human resources	40	41.7
Affordability of care	=30	70.0
Quality of care	=38	47.5
Community engagement	=45	25.0

SNAPSHOT

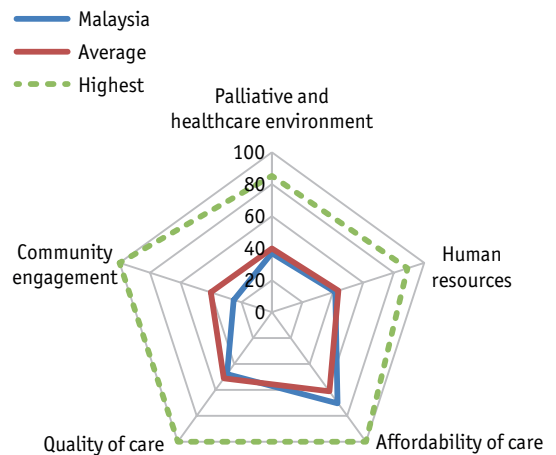
Malaysia has made inroads in terms of the quality, affordability and accessibility of palliative care. Training programmes are enlarging the specialised workforce and subsidies have increased.

IN DETAIL

Malaysia has a solid legal framework for the provision of palliative care nationwide.¹ Implementation falls short of targets as limited enforcement or monitoring mechanisms fail to ensure consistent quality across provinces. Funding for research remains insufficient to effectively inform policy decision-making.

Availability of specialised professionals is the most prominent issue; only 7 palliative care experts have completed the 2-year certification process and are listed in the national registry. Most medical schools do not offer compulsory courses, resulting in a limited understanding of the topic within the medical community. However, psycho-social support is common and affordable, often aided by part-time volunteers.

Inadequate public funding increases the importance of charitable institutions in delivering services. Public subsidies usually cover at least 90% of treatment costs; however there are only 5 public hospitals with palliative



care units. More funds are needed to expand public infrastructure to other hospitals and rural areas. Previous over-regulation of opioid access has been scaled back, and painkillers are available at public hospitals. Doctors tend to share information about diagnosis and prognosis with families, and only inform the patient if requested.

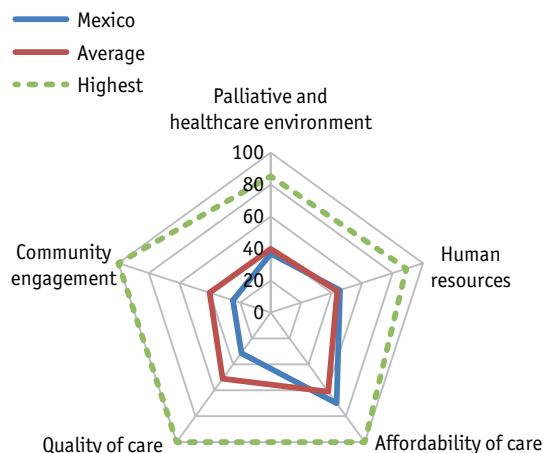
Use of patient satisfaction surveys is rare. Informal evaluations are conducted occasionally by NGOs but findings are not used consistently to improve the system. Public awareness has improved over the last decade but detailed understanding of palliative care is limited. NGOs rely on a robust network of voluntary support, although training is minimal.

¹ Ministry of Health Malaysia, "Palliative Care Services Operational Policy," 2010.

43. Mexico



	Rank/80	Score/100
Quality of Death overall score (supply)	43	42.3
Palliative and healthcare environment	=43	37.0
Human resources	34	45.4
Affordability of care	=30	70.0
Quality of care	54	31.3
Community engagement	=45	25.0



SNAPSHOT

Mexico has a robust theoretical and legal framework but quality of care is limited by the realities of the health care environment, including widespread shortages of specialised workers.

IN DETAIL

Mexico has adopted several national strategies aimed at incorporating palliative medicine into its public health model.¹ National and regional committees meet on a monthly basis.² Despite the robust legal structure, implementation has yet to achieve results. Some research is carried out, but without government support.³ Accreditation is given upon completion of specialised academic coursework, but less than one-tenth of medical schools offer palliative care courses.⁴ There are overall shortages of physicians, nurses and support staff.⁵

All Mexicans are nominally eligible to receive fully funded palliative care from the government, but services are not evenly developed to the same standard across the country.⁶ Clinical guidelines are updated every five years, but monitoring and enforcement mechanisms have

not been established. Although opioids are legally available, bureaucratic limitations and scarcity of supply severely limit access. Over 90% of terminally ill patients die without adequate pain relief.⁷ Psycho-social support is supported by legislation, but services are understaffed and underfunded.⁸

DNR is accepted as part of advance directives. Doctors are reluctant to share information with patients. Frank discussions on diagnosis are rare, and prognosis disclosure is often delayed until late stages of illness. Public understanding is low. A stigma is attached to palliative care, as public perception links it to the subject of death. Volunteers are mostly supporting cancer patients and not those with other terminal illnesses.⁹

¹ Government of Mexico, "Federal Law on Palliative Care Regulation," 2008.

² Pastrana, T., L. De Lima, R. Wenk, J. Eisenclas, C. Monti, J. Rocafort and C. Centeno, *Atlas de Cuidados Paliativos de Latinoamérica ALCP*, 2012.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Human Rights Watch, "Care When There is No Cure: Ensuring the Right to Palliative Care in Mexico," October 2014.

⁷ Pastrana et al.

⁸ Ibid.

⁹ Ibid.

44. Mongolia



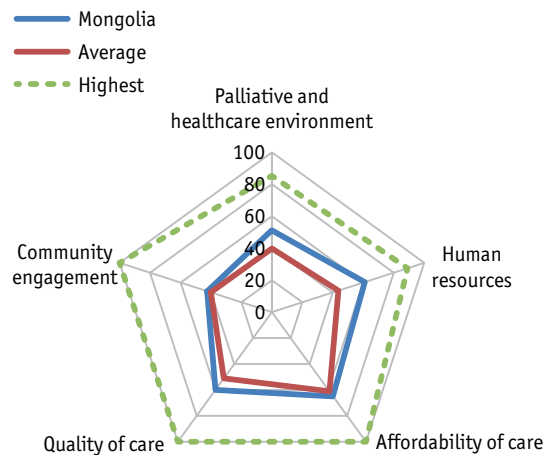
	Rank/80	Score/100
Quality of Death overall score (supply)	28	57.7
Palliative and healthcare environment	24	51.3
Human resources	21	61.1
Affordability of care	=36	65.0
Quality of care	32	60.0
Community engagement	=27	42.5

SNAPSHOT

There is a strong drive by Mongolia’s government to provide universal palliative care. An emphasis on training and facilities has led to significant improvements in the last decade.

IN DETAIL

Mongolia has adopted a far-sighted national strategy with clear guidelines and objectives. All districts are equipped with palliative care departments. The current plan emphasises home-based services and interdisciplinary teams, with the aim of complete palliative care integration into the health system by 2017.¹ Research is weak, with few resources allocated.² Mongolia is addressing widespread shortages of specialised workers by training more doctors and nurses. Accreditation is given following strict examinations.³



regulation. Morphine is free in principle, but demand outstrips supply, resulting in a black market for painkillers.⁶ There is also an unmet need with non-cancer patients who do not receive the preferential treatment provided for oncological care.

Hospitals have been given economic incentives to set up palliative care units and extend coverage to long-term terminally ill patients. All citizens are covered by the national insurance scheme and provided with free treatment.⁴ The Ministry of Health regularly monitors developments. Psycho-social support has been instituted in all care facilities. Spiritual and bereavement support are also widely available.⁵ Availability of opioids, morphine in particular, remains a challenge despite marked improvements in supply and

A traditional reluctance to speak about death with patients is being tackled by targeted communication trainings for physicians, with strong results over the past ten years.⁷ Surveys are regularly carried out. Information has been translated into Mongolian and made available to the public through advertising and television programmes. An Asian Development Bank programme established and trained networks of volunteers in each district.

¹ Mongolia Ministry of Health and World Health Organization, “National Cancer Control Program 2007-2017, Mongolia.”

² Ibid.

³ Tsillajav, T., E. Ser-Od, B. Baasai, G. Byambaa and O. Shagdarsuren, “Mongolia Health Systems Review,” *Health Systems in Transition*, 2013.

⁴ Ibid.

⁵ Ibid.

⁶ Bjørgaas, M.H., “Cancer and palliative care in Mongolia,” *Tidsskr Nor Laegeforen*, 6 March 2012.

⁷ Ibid.

45. Morocco



SNAPSHOT

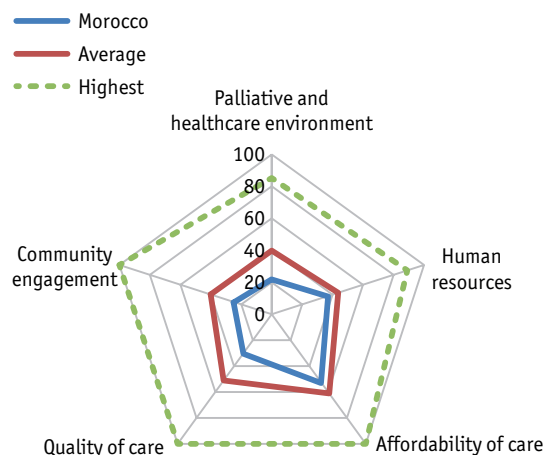
Morocco's palliative care services fall short of societal needs. Philanthropic programmes play an important role alongside the national health system in providing the public with access to affordable care.

IN DETAIL

There is no official government palliative care policy in Morocco. A non-profit organisation endorsed by the Queen of Morocco recently created a national anti-cancer programme that includes provisions for oncological palliative care. The Ministry of Health is considering incorporating these provisions into official guidelines. The lack of trained specialists hampers implementation. Research is limited. No accreditation is available.

Where available, university courses are compulsory and of a high standard. Continuing education programmes are also available outside of academia. International experts participate in annual conferences on the topic, sharing information with local practitioners. The national insurance scheme covers up to 80% of costs. Cancer patients receive additional support from the Queen's NGO facilities in Rabat and Casablanca, which cover 75% of oncological care, including palliative care.

	Rank/80	Score/100
Quality of Death overall score (supply)	52	33.8
Palliative and healthcare environment	65	22.2
Human resources	46	37.1
Affordability of care	=49	52.5
Quality of care	=55	30.0
Community engagement	=45	25.0



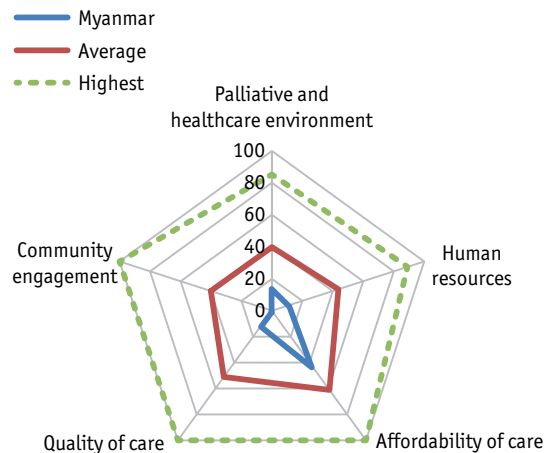
Systemic shortcomings include weak monitoring and enforcement mechanisms, which are implemented just once every two or three years and only in major hospitals. Psycho-social support is usually provided by NGOs and volunteer networks, as there is a shortage of full-time specialised personnel. Morphine is generally available but mainly found in oncological departments.

Doctors see their role as primarily curative but are encouraged to share information with patients. Although they are not part of government policy, surveys are common and often used to improve services. The government funds initiatives to increase public understanding but results have been modest. Volunteers are in short supply and rarely trained.

46. Myanmar



	Rank/80	Score/100
Quality of Death overall score (supply)	76	17.1
Palliative and healthcare environment	73	14.5
Human resources	=76	11.6
Affordability of care	=58	42.5
Quality of care	75	11.3
Community engagement	=78	0.0



SNAPSHOT

Myanmar’s recent capacity building efforts have only marginally affected provision of palliative care. Available evidence points to severe shortages in all areas pertaining to palliative care as defined by the WHO.

IN DETAIL

Myanmar’s ongoing political and economic transformation has not yet led to improvements in palliative care services. There is no government-led strategy or official documentation seeking to define or establish palliative care services. Charities and international organisations conduct advocacy campaigns and supply the few available services in the country.¹ The Asia-Pacific Health Network and Myanmar’s Ministry of Health are currently developing training programmes.²

There is no data available regarding Myanmar’s palliative care facilities and programmes. The absence of any government subsidies suggests severe shortages in skilled labour, specialised physicians and adequate infrastructure; however this assessment could not be verified beyond anecdotal evidence. There is no information available with regards to medicinal supply, doctor-patient relations and public awareness or the presence of volunteers.

¹ ehospice News, “Lien Collaborative for Palliative Care Launched,” 28 June 2013.

² Asia Pacific Hospice Palliative Care Network website, “Our faculty (Myanmar).”

47. Netherlands



Amsterdam

	Rank/80	Score/100
Quality of Death overall score (supply)	8	80.9
Palliative and healthcare environment	2	84.8
Human resources	22	59.6
Affordability of care	=6	87.5
Quality of care	=8	90.0
Community engagement	=9	75.0

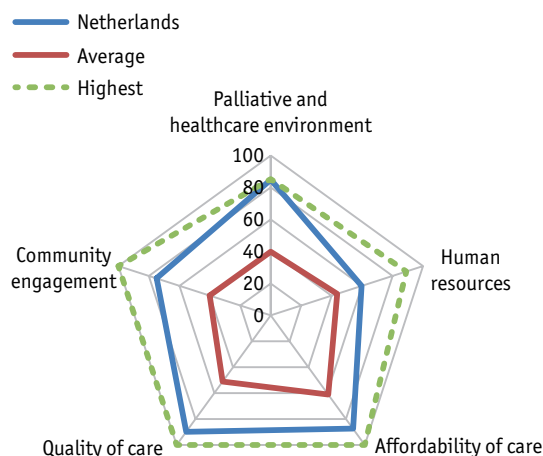
SNAPSHOT

The Netherlands is at the forefront of the palliative care movement. The country's system is open and transparent, and universal coverage is provided in state-of-the-art facilities.

IN DETAIL

The government effectively coordinates with long-standing grassroots movements to create a responsive public health model.¹ An alliance of private and public healthcare networks, often supported by trained volunteers, provides clinical and psycho-social assistance across the country.² Although palliative care is not recognised as a speciality, medical and nursing students have a wide range of training opportunities, as do other healthcare professionals. Eight university centres produce first-rate clinical and policy research.³

Care is affordable due to extensive public subsidies, and only limited costs are associated with inpatient services. National guidelines are in place but as monitoring and enforcement mechanisms are weak and decentralised, hospices and palliative care units rely on self-checks for quality assurance. Pain alleviation is



a protected right; there are no barriers beyond prescription to obtain opioid medication.⁴

Regular satisfaction surveys gather patient feedback to improve the system. Patients and physicians are partners in care and information relating to diagnosis or prognosis is openly shared. Ready access to information has strengthened public understanding of the issue, and over 10,000 volunteers provide assistance to professional teams.⁵

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "The Netherlands," *EAPC Atlas of Palliative Care in Europe 2013*.

² Agora, "Palliative care in the Netherlands," 2012.

³ Centeno et al.

⁴ Ibid.

⁵ Agora.

48. New Zealand



SNAPSHOT

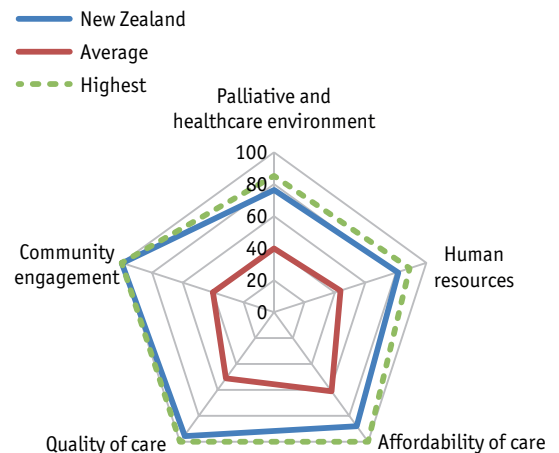
New Zealand has excellent facilities and a qualified workforce, and access to palliative care is free and universal. Inconsistent standards for research and quality monitoring make nationwide assessments difficult.

IN DETAIL

New Zealand adopted a comprehensive national strategy in 2001.¹ In 2013, more than 15,000 people received care from hospice services, with 20% of those under the age of 60.² With a growing and aging population, the government has pledged over NZ\$50m in funding to expand care for the terminally ill at hospices and in their homes.³ Research is overseen by the 20 individual district health boards, and the inconsistency in methodologies can lead to problems in broader analysis.

There is a lack of academic specialists in palliative medicine, but all doctors have undergone a basic level of training and have the capacity and obligation to administer palliative care when necessary. Specialists are found across the country although remote areas may be underserved.⁴ Around half of GPs have received a recognised accreditation and there are many opportunities for continuing education.

	Rank/80	Score/100
Quality of Death overall score (supply)	3	87.6
Palliative and healthcare environment	8	76.7
Human resources	5	81.4
Affordability of care	=6	87.5
Quality of care	4	95.0
Community engagement	=1	100.0



Patients are assisted by a generous welfare insurance system that covers all palliative care costs. A small contribution is required for visiting physicians delivering home care. Guidelines are widely followed but monitoring is decentralised and varies substantially across health districts. Access to painkillers and opioids is free and unobstructed, as is the availability of psychosocial, spiritual and bereavement care.

Transparency is part of the medical culture; patients and physicians are partners in care and information related to diagnosis or prognosis is openly shared. Satisfaction surveys are not consistently distributed. A national survey was proposed but did not receive government funding. Public awareness is improving steadily, bolstered by robust community engagement efforts. Teams of trained volunteers are a common sight.

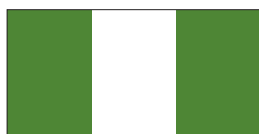
¹ New Zealand Ministry of Health, "The New Zealand Palliative Care Strategy," February 2001.

² Radio New Zealand News, "Budget Boost for Palliative Care," 21 May 2015.

³ Ibid.

⁴ Cancer Control New Zealand, "Annual report: For the year ended 30 June 2014," November 2014.

49. Nigeria



SNAPSHOT

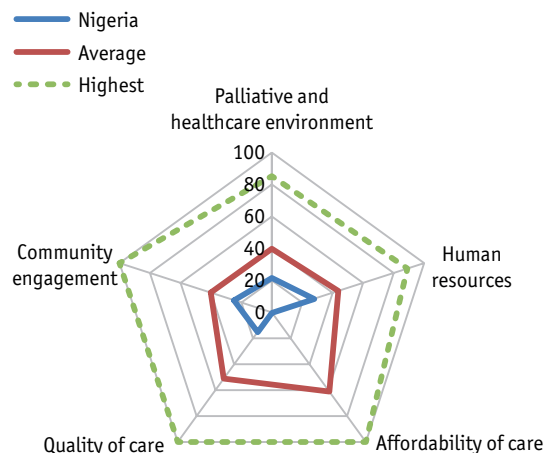
Palliative care patients in Nigeria face major obstacles to obtaining basic services. System failures and lack of adequate financial coverage leave most people unable to access pain-alleviating treatments.

IN DETAIL

Nigeria has not integrated palliative care into its public health system.¹ The Ministry of Health, with the help of international non-profit organisations, is working on developing a national strategy with guidelines and enforcement mechanisms, but acquiring the needed recognition and resources will be challenging. Research is minimal and not supported by government funds. Manpower is in short supply, with just one specialist for every 1.5 million people.² No accreditation is given. Palliative courses are mandatory in a handful of medical colleges. Course offerings are high-quality but are not harmonised across universities. Most specialists receive only minimal training.³

The financial burden for palliative care is entirely on patients and families. No insurance or pension schemes include palliative care.⁴ Morphine is

	Rank/80	Score/100
Quality of Death overall score (supply)	77	16.9
Palliative and healthcare environment	66	21.8
Human resources	58	27.9
Affordability of care	80	0.0
Quality of care	70	15.0
Community engagement	=45	25.0



available but limited by inefficient procurement and distribution. Access to opioids is especially difficult in areas with political instability. DNR has no legal status and doctor-patient communications are subject to cultural taboos relating to the subject of death. Doctors see their role as mainly curative.

The system affords very limited opportunities to provide feedback; satisfaction surveys are almost never used. The general public is not well informed on the subject of palliative care. There is no government promotion of the issue in media channels, but NGOs have made some efforts to raise public awareness. Volunteers are rare and mostly untrained.

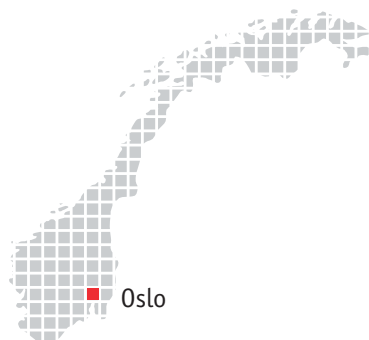
¹ Wright, M., J. Wood, T. Lynch and D. Clark, "Mapping levels of palliative care development: A global view," *Journal of Pain and Symptom Management*, May 2008.

² Lancaster University International Observatory for End of Life Care, "Country Report – Nigeria," 2005.

³ Ibid.

⁴ Ibid.

50. Norway



SNAPSHOT

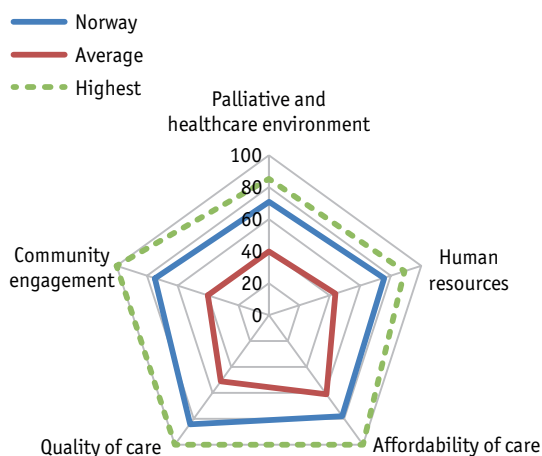
Norway has an excellent model for provision of palliative care. The system is open and transparent, and provides universal coverage for all citizens.

IN DETAIL

In 2010 Norway established a robust national strategy with clear targets and indicators, aiming to fully integrate palliative care into the public health system. As the strategy is relatively recent, many of the targets have yet to be fully achieved.¹ Norway's research credentials are strengthened by regular data collection and the presence of a national registry for palliative care. Findings inform policymaking.²

Additional specialised workers are needed to help meet the demand for palliative care;³ more doctors and nurses are being accredited to increase the specialised workforce. Palliative care is recognised as a sub-speciality.⁴ Medical curricula are being revised to include palliative care; courses are currently mandatory in only two of the four medical schools.⁵

	Rank/80	Score/100
Quality of Death overall score (supply)	13	77.4
Palliative and healthcare environment	9	71.0
Human resources	7	75.5
Affordability of care	=22	77.5
Quality of care	=16	83.8
Community engagement	=9	75.0



Norwegians enjoy free medication and inpatient access to palliative services.⁶ Outpatients pay a regular fee for consultations and visits, which can amount to a heavy financial burden. Outpatients are charged up to a threshold, after which the state insurance or pension funds cover the cost.⁷ Standards and guidelines are routinely monitored and enforced. Psycho-social support is widespread, although remote areas may be under-served.⁸

Clinical disclosure tends to be transparent, with doctors and patients acting as partners in care.⁹ Satisfaction surveys increase system responsiveness to feedback. The government is actively building awareness of palliative care among the general public.¹⁰

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Norway," *EAPC Atlas of Palliative Care in Europe 2013*.

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

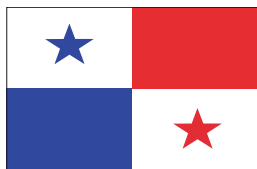
⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

51. Panama



	Rank/80	Score/100
Quality of Death overall score (supply)	31	53.6
Palliative and healthcare environment	25	51.2
Human resources	=41	41.6
Affordability of care	=6	87.5
Quality of care	=38	47.5
Community engagement	=38	32.5

SNAPSHOT

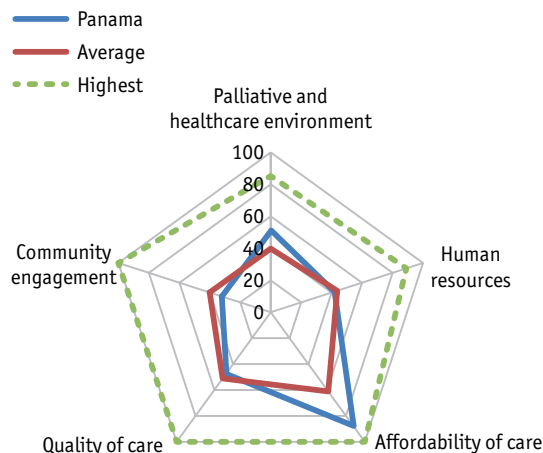
The government of Panama is radically overhauling its system for palliative care provision. Services are being expanded and staff trained. Improvements are tangible and widespread.

IN DETAIL

Policy improvements are revamping Panama's palliative care delivery system.¹ The National Strategy for Palliative Care, established in 2010, was one of the government's top priorities.² The framework is reviewed every six months. Critical shortcomings include the exclusion of the province of Darién and failure to loosen legal restrictions on opioids.³ The publicly funded University of Panama conducts regular and independent research. Data informs policymaking.⁴

An advanced course has been created to remedy the widespread shortage of specialised physicians.⁵ However, only a handful of doctors have taken the course and been awarded professional credentials for palliative care. Only one of the four medical schools offers a palliative care course.

Services for oncological patients are adequately subsidised. Additionally, the national insurance



covers between 80 and 100 percent of costs. The government is in the process of developing standards and guidelines. Palliative units have a multidisciplinary approach, and include a chaplain and psycho-social support. Doctors sometimes inform patients of diagnosis and prognosis. The general public has a limited understanding of the issue. Limited awareness campaigns have not altered widespread prejudices against palliative care. Volunteers support oncological and geriatric wards, but facilities catering to terminally ill patients affected by other illnesses lack volunteer support in most cases.⁶

¹ Pastrana, T., L. De Lima, R. Wenk, J. Eisenclas, C. Monti, J. Rocafort and C. Centeno, *Atlas de Cuidados Paliativos de Latinoamérica ALCP*, 2012

² Republic of Panama Ministry of Health, "National Programme for Palliative Care," *Gaceta Oficial Digital*, 6 July 2010.

³ Krakauer, E.L., R. Wenk, R. Buitrago, P. Jenkins and W. Scholten, "Opioid inaccessibility and Its human consequences: Reports from the field," *Journal of Pain & Palliative Care Pharmacotherapy*, September 2010.

⁴ Ibid.

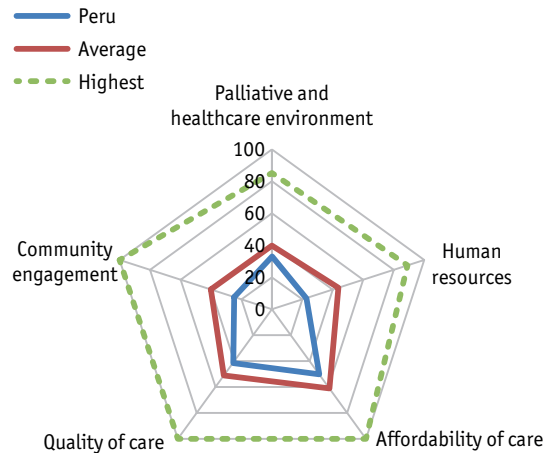
⁵ Pastrana et al.

⁶ Ibid.

52. Peru



	Rank/80	Score/100
Quality of Death overall score (supply)	49	36.0
Palliative and healthcare environment	49	33.2
Human resources	66	22.5
Affordability of care	=54	50.0
Quality of care	43	41.3
Community engagement	=45	25.0



SNAPSHOT

Peru has implemented a comprehensive strategy to provide pain alleviation treatment for the poor. Large margins for improvement remain, particularly with regards to overall accessibility and the availability of psycho-social support.

IN DETAIL

Peru launched the “Plan Esperanza” to extend coverage for treatment to the poorest strata of society; about half of the population signed up.¹ A decentralisation effort is expanding implementation outside major urban centres. There is limited research on the subject but the national plan is regularly evaluated. Palliative care professionals are in short supply throughout the country.²

None of the 21 medical schools offer mandatory or optional palliative care courses as part of their curricula.³ The Peruvian Society of Palliative Care offers occasional continuing educational programmes, mostly based in Lima. No national accreditation is provided.

Subscribers to “Plan Esperanza” receive free palliative care. Government subsidies are

adequate. Various insurance and pension programmes provide additional financial relief for patients. Monitoring and enforcement mechanisms are very weak. There are plans to streamline the cumbersome prescription process and extend prescriptions for painkillers for up to one month. Current access to opioids is partially restricted. Interdisciplinary integration of psycho-social support is minimal. DNR is not a legal right.

Medical doctors see their role as mainly curative and rarely share diagnosis and prognosis information with patients. The system is not receptive to feedback; satisfaction surveys are rarely used. Community understanding of palliative care is low. The government has yet to back any informational campaigns. The number of volunteers falls short of needs; volunteers are mostly involved in fundraising and receive little formal training.

¹ Republic of Peru Ministry of Health presentation, “National plan for comprehensive care of cancer and improving access to cancer services in Peru,” September 2012.

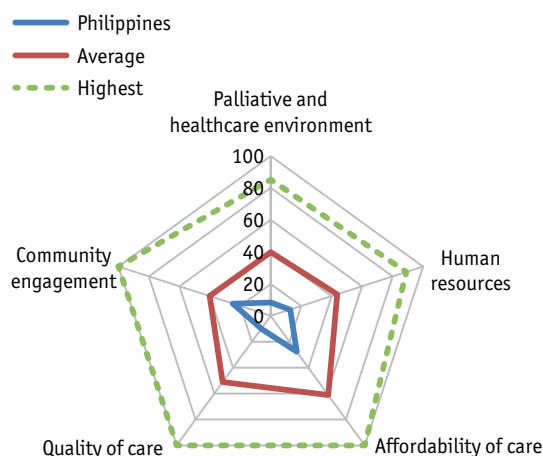
² Pastrana, T., L. De Lima, R. Wenk, J. Eisenchlas, C. Monti, J. Rocafort and C. Centeno, *Atlas de Cuidados Paliativos de Latinoamérica ALCP*, 2012.

³ Ibid.

53. Philippines



	Rank/80	Score/100
Quality of Death overall score (supply)	78	15.3
Palliative and healthcare environment	77	8.5
Human resources	75	12.8
Affordability of care	=74	27.5
Quality of care	76	10.0
Community engagement	=45	25.0



SNAPSHOT

Palliative care in the Philippines is not well-developed. Drugs are expensive and trained specialists scarce, and most patients die without adequate pain relief.

IN DETAIL

There is no government strategy in place to develop palliative care in the Philippines, and efforts at the national level have had limited support to date. Evidence points to an almost complete absence of palliative care services outside the capital, where just a handful of specialists are based. A training fellowship at the General Hospital in Manila began accepting 1 to 3 graduates per year in 2012, a rate which is insufficient to meet public needs. No accreditation is available. Research is limited in scope and primarily anecdotal.

A lack of funding underpins systemic problems in service delivery. Only one hospital can afford to set up multidisciplinary teams. A bill to extend compassionate leave and financial support for families was introduced in Parliament in 2012 but has failed to win approval. Meanwhile,

no tangible social assistance is offered. Pension and insurance schemes provide a 20 percent cost reduction for patients over the age of 60. However, basic painkillers are still expensive. Stringent restrictions apply to the commercialisation, import and prescription of morphine. Opioids are scarce outside of Manila.

Guidelines are seldom enforced. Psychological support is intermittently available. Cultural factors inhibit transparent doctor-patient communications; prejudices against palliative care are combined with a reluctance to speak openly about death. Patient satisfaction surveys are not used. Communities are not well-informed. Confusion about the implications of palliative care persists even among physicians. The number of volunteers is insufficient.

¹ Philippine Supportive Hospice & Palliative Medicine Network website, "About the SHPM."

² Ibid.

³ Philippine News Agency, "Senator seeks palliative care for terminally ill Filipinos," InterAksyon.com, 12 January 2013.

⁴ Palliative Care Nursing blog, "Long road ahead for palliative care: The U.S. and the Philippines," 4 January 2014.

⁵ Galanti, G.-A., "Filipino attitudes toward pain medication: A lesson in cross-cultural care," *Western Journal of Medicine*, October 2000.

⁶ Psychological Association of the Philippines website.

⁷ Manalo, M.F.C., "End-of-life decisions about withholding or withdrawing therapy: Medical, ethical, and religio-cultural considerations," *Palliative Care: Research and Treatment*, 10 March 2013.

54. Poland



	Rank/80	Score/100
Quality of Death overall score (supply)	26	58.7
Palliative and healthcare environment	31	42.2
Human resources	=30	49.4
Affordability of care	=40	62.5
Quality of care	27	73.8
Community engagement	=15	57.5

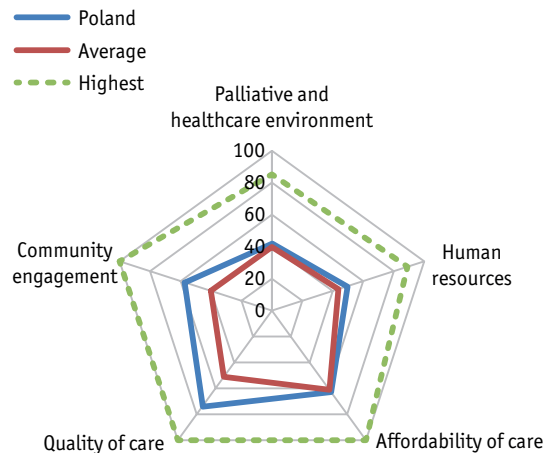
SNAPSHOT

Poland’s palliative care services are improving but without a national strategy, efforts vary across provinces. Subsidies fall short of needs. Meaningful integration into the public healthcare system is lacking.

IN DETAIL

Poland has no coherent national strategy for palliative care. The Ministry of Health, together with NGOs, has supported a number of programmes to extend provision of palliative care, but these policies lack guidelines and an implementation plan. Research is underdeveloped, but evidence points to a severe lack of specialists. All universities decide their curricula autonomously, which makes it challenging to harmonise training at the national level. Some medical faculties offer mandatory courses. Specialists obtain a national certification.

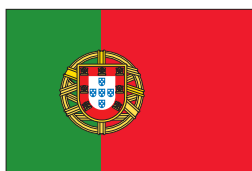
Government subsidies fall short of needs. Hospitals face limitations on the number of palliative care beds due to national insurance restrictions. The lack of funds erodes service effectiveness. Where available, treatment is free of charge. Each province employs a palliative care consultant to advise on policy measures and monitor implementation. Some facilities have instituted a system of self-checks but no nationwide quality standards are in place.



Access to opioids has drastically improved in the last decade. Strong painkillers are available upon prescription. Psycho-social support services are generally available, but inconsistent due to lack of funding for specialists. There is no legal order for DNR. Significant changes in doctor-patient relations in the last few years signal a shift towards a more holistic approach to medical care, with communications increasingly open and transparent.

Satisfaction surveys are rarely conducted. Media attention has generated substantial public debate. Government involvement in public awareness campaigns is negligible; the Society of Physicians and volunteers jointly carry out independent initiatives. Volunteers are active and increasingly numerous. Training of volunteers occurs before and during the time spent in palliative care units.

55. Portugal



Lisbon

	Rank/80	Score/100
Quality of Death overall score (supply)	24	60.8
Palliative and healthcare environment	33	41.4
Human resources	37	42.3
Affordability of care	=25	75.0
Quality of care	=22	80.0
Community engagement	=22	50.0

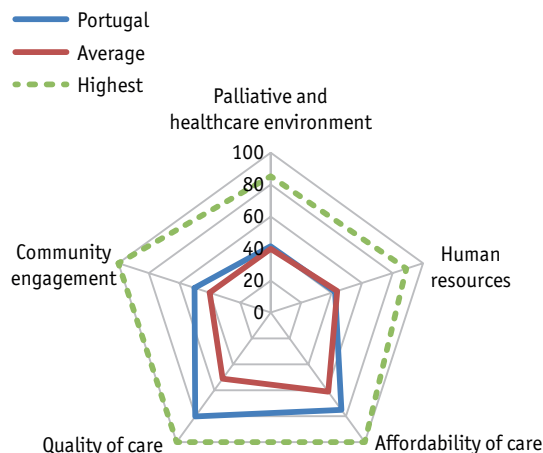
SNAPSHOT

Palliative care in Portugal is adequately developed. Supporting services have been enhanced, and disclosure of clinical information is progressively more transparent.

IN DETAIL

Portugal launched its first national palliative care plan in 2004,¹ which recommended a radical overhaul of services and the establishment of interdisciplinary teams.² The new directives have been ineffective in changing existing service models. Research is a core component of the government's strategy, but data collection remains modest and uncoordinated. The number of professionals is insufficient, but opportunities for training have increased. The universities of Porto, Lisbon and Coimbra offer masters' degrees. National accreditation is unavailable.

There are no specific budgetary provisions set by the government, but subsidies are adequate for the many oncological care units. Healthcare is provided free of charge. The state covers 95% of cancer treatment costs, including palliative care. Transportation and bereavement care are also covered. National guidelines are not enforced; hospitals rely on a system of self-checks for quality assurance. Opioids and painkillers are readily available upon prescription. Psychological



support is commonly provided and is free of charge. DNR is an accepted practice, although not legally validated.

The medical culture has undergone a cultural shift towards greater transparency in doctor-patient relations. Diagnosis is openly discussed, but there is still hesitation to disclose prognosis. Satisfaction surveys vary across hospitals but are generally available. The system is receptive to critical feedback. The government has supported informational campaigns. Information relating to palliative care services is readily available to the public. Medical interns are part of the large contingent of volunteers. Non-specialised volunteers are given basic training.

¹ Neto, I.G., "Palliative care development is well under way in Portugal," *European Journal of Palliative Care*, 2010.

² National Health Service of Portugal, "Development Strategy for the National Palliative Care Programme: National Network for Continuous Care 2011-2013," June 2011.

56. Puerto Rico



SNAPSHOT

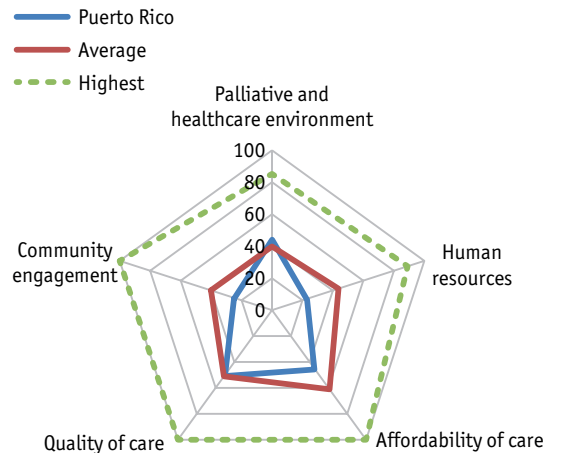
Palliative care in Puerto Rico is only partially developed. Large margins for improvement remain in the following areas: strategic coordination, education and specialised workforce.

IN DETAIL

The promotion and development of palliative care is managed by the country’s Hospice and Palliative Care Association. Efforts to monitor service quality and collect data are uncoordinated and lack adequate public funding. The number of specialised workers falls short of patient needs; the shortage of trained professionals is linked to the absence of opportunities for education and professional enhancement. None of the country’s four medical schools offer palliative care courses.¹ No formal accreditation is provided.

A system of private and government insurance schemes provides partial financial coverage, which ranges widely depending on eligibility and purchasing power of subscribers. Not all insurance programmes cover hospice care. Monitoring standards and guidelines are based on policies in the United States and reviewed every two years. Opioids are widely available, as is psycho-social support. DNR has no legal status.

	Rank/80	Score/100
Quality of Death overall score (supply)	46	40.0
Palliative and healthcare environment	30	44.6
Human resources	65	23.0
Affordability of care	57	45.0
Quality of care	37	50.0
Community engagement	=45	25.0



Doctors see their role as mainly curative; there is a reluctance to disclose prognosis to terminally ill patients. Satisfaction surveys are not mandatory but are regularly distributed and the results are used to improve the system. Public understanding of palliative care is mediocre and influenced by prejudices and cultural taboos on openly discussing the subject of death. There are some trained volunteer workers participating in both fundraising activities and patient care duties.

¹ Estudios de Medicina website, "Puerto Rico."

57. Romania



Bucharest

	Rank/80	Score/100
Quality of Death overall score (supply)	64	28.3
Palliative and healthcare environment	76	9.6
Human resources	54	31.3
Affordability of care	=65	37.5
Quality of care	=48	36.3
Community engagement	=66	17.5

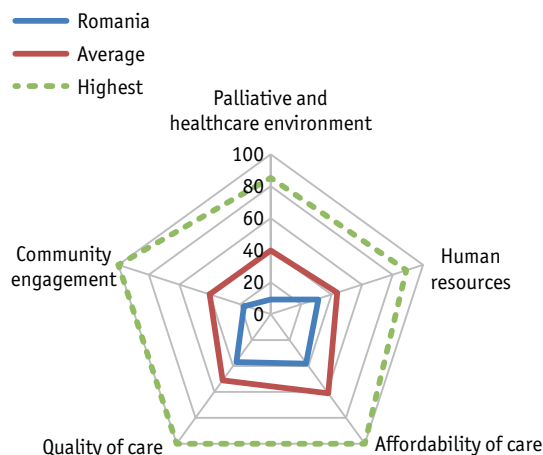
SNAPSHOT

Palliative care in Romania has many weak areas. Despite international assistance, the government has not actively developed the sector, and patients have difficulty accessing care.

IN DETAIL

Romania lags behind its European peers in development of palliative care. Lack of government effort to institute basic guidelines or financing slows progress.¹ Efforts by international non-profits and foreign donors have failed to build momentum for policy reform. Research is insufficient and lacking data. Specialised workers are too few and mainly concentrated in the capital; rural areas are underserved.

Medical curricula do not cover palliative care. Most GPs lack basic knowledge of pain therapy. Continuing education programmes are few, expensive and outside of academia. A national register for specialists is kept. Romania's palliative care shortcomings are worsened by lack of funding. Coverage is provided through a heavily bureaucratic process and patients must fulfil stringent criteria, which discourages the majority of potential applicants. Patients must pay for morphine and painkillers directly. Hence, services are either not available or not affordable for most people.



There is no system for quality control or national assessment. Interdisciplinary teams are very rare, as strict hierarchies govern professional relations in hospitals. Psycho-social support is seldom integrated. Competing ministries are in charge of different aspects of integrated care provision, creating unneeded complexity. Existing regulations are firmly against DNR policies. Informed consent is not a tradition in Romania. Patients are rarely informed of their condition or prognosis. The public at large does not have a good understanding of palliative care. In the absence of volunteers, most patients rely on the support of family members.

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Romania," *EAPC Atlas of Palliative Care in Europe 2013*.

58. Russia



	Rank/80	Score/100
Quality of Death overall score (supply)	48	37.2
Palliative and healthcare environment	40	37.4
Human resources	55	31.0
Affordability of care	=42	60.0
Quality of care	=55	30.0
Community engagement	=45	25.0

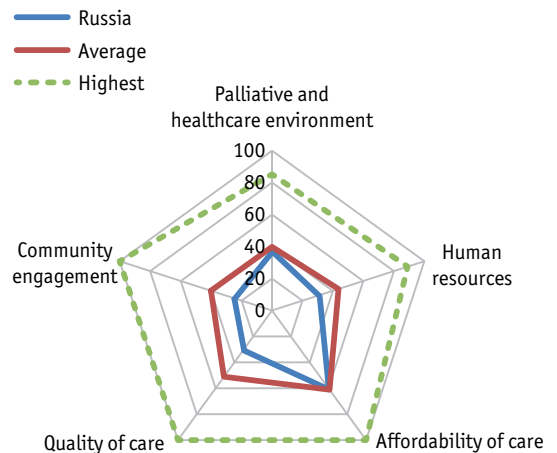
SNAPSHOT

Russia recently implemented a strategy to boost palliative care services. A significant gulf remains between stated goals and implementation results, but progress is gradual and ongoing.

IN DETAIL

Russia produced a milestone national ten-year health programme in 2011 which includes specific provisions for palliative care development (Article 36 of the Health Bill).¹ Services are to be strengthened by an increase in specialised workforce, which is still inadequate to meet basic needs.² A major drive to centralise research has faltered, leaving data collection to uncoordinated local initiatives. Russian medical schools are incorporating palliative care into their curricula through non-mandatory courses. Opportunities for continuing education are scarce and no accreditation is given.

Palliative care is provided nominally free of charge, but availability is limited and subject to an urban-rural divide. Funding depends on regional budgets, resulting in patchy progress and unequal access. There is a chronic lack of adequate facilities. At times, patients resort to bribes to secure a hospital bed. Severe obstacles in accessing pain medication are caused by clumsy bureaucracy and red tape. Russia's sharp



decline in opioid consumption since the 1990s is due to extensive supply shortages. Fast-acting morphine tablets for oral intake are not registered for use.³

Psycho-social support is the norm only in fully-equipped units, which are few. Regional health committees regularly monitor quality standards. DNR is a legal right for terminally ill cancer patients. The system is not consistently responsive to feedback. Doctor-patient communications are improving but a traditional reluctance to discuss death prevails. The number of volunteers is insufficient, although numerous charitable organisations are actively engaged in patient care.

¹ Chugaev, D.V., "Main Program Implementation of State of the Russian Federation," Presentation, 2013.

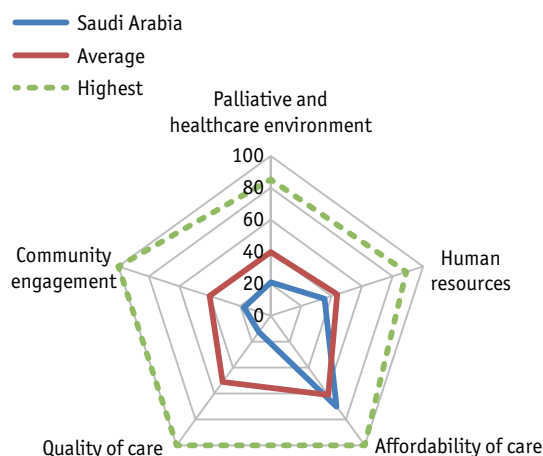
² Vvedenskaya, E., "Palliative care since now has been recognized one of four health care approaches in Russia," *Paliatia*, June 2013.

³ Usenko, O., "Russia: More pain – less opioids," European Association for Palliative Care blog, 22 November 2013.

59. Saudi Arabia



	Rank/80	Score/100
Quality of Death overall score (supply)	60	30.8
Palliative and healthcare environment	68	21.2
Human resources	49	35.4
Affordability of care	=30	70.0
Quality of care	74	12.5
Community engagement	=66	17.5



SNAPSHOT

Palliative care in Saudi Arabia is not well developed. The last decade has seen clear progress but legal restriction of access to opioids results in most patients dying without pain relief.

IN DETAIL

There are no national palliative care policies in Saudi Arabia, but local provisions exist mostly linked to individual initiatives. Palliative care is available in large hospitals, but the number of specialists falls short of needs.¹ There are less than 20 accredited specialists in the country.² The government indirectly supports some research on the topic; findings inform policymaking. State officials regularly monitor implementation.

Fellowship programmes are available in select universities, but palliative care has yet to be integrated into medical curricula.³ The Saudi Commission for Health Specialists provides professional accreditation.⁴ Government subsidies are inadequate. Partial coverage is rare outside of major medical centres like King Faisal Hospital in Riyadh.⁵ Legislation is a significant barrier, with highly restrictive policies on access

to pain medication. People are provided with much lower doses of pain relief than in most countries.⁶

Psycho-social support is not always available and there are no clear guidelines on DNR.⁷ There is a cultural reluctance to disclose information to patients, and family members are more likely to be consulted. Physicians display a preference for curative rather than palliative measures.⁸ The general public is concerned about terminal illnesses but awareness of pain relief methods is subject to misconceptions and social stigmas associated with use of opioids. There has been no effort by the government to improve public understanding.⁹

¹ Helen Ziegler and Associates website, "King Faisal Specialist Hospital & Research Centre, Riyadh."

² Alshammary, S.A., A. Abdullah, B.P. Duraisamy and M. Anbar, "Palliative care in Saudi Arabia: Two decades of progress and going strong," *Journal of Health Specialties*, April 2014.

³ Almobarak, F.K., "Exploring the perspectives of nurses, physicians, and healthcare administrators in Saudi Arabian hospitals on palliative care and palliative care nursing," *Journal of Health Specialties*, April 2014.

⁴ Gray, A.J., A. Ezzat and S. Volker, "Developing palliative care services for terminally ill patients in Saudi Arabia," *Annals of Saudi Medicine*, July 1995.

⁵ Balkhair, A., "Kingdom of Saudi Arabia: The National eHealth Program," Ministry of Health Presentation.

⁶ Alshammary et al.

⁷ Knapp, C., V. Madden and S. Fowler-Kerry, eds., *Pediatric Palliative Care: Global Perspectives*, 2012.

⁸ Gray et al.

⁹ Alshammary et al.

60. Singapore



SNAPSHOT

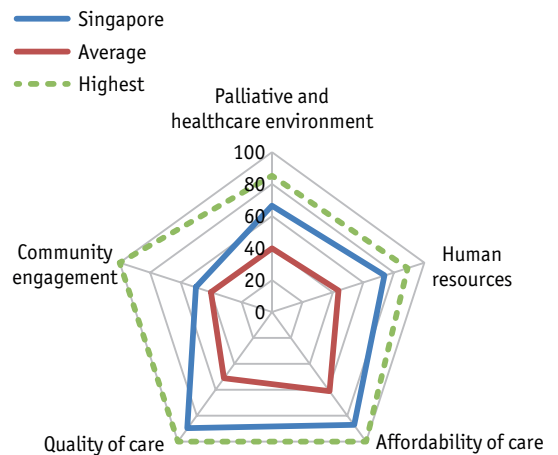
Singapore recently inaugurated a robust framework to expand the reach of its palliative care services. Trained professionals staff excellent facilities, making the country a regional leader in the provision of palliative care.

IN DETAIL

Singapore is at the front line of high-quality palliative care in Asia. The government plans to double the number of specialised inpatient beds, and also strengthen outpatient services.¹ Additional funding will be used to lower financial barriers and increase public awareness. New guidelines have been developed that define high-quality palliative care for inpatient and outpatient settings.² Research is in its infancy but there is a willingness to centralize data collection. Both generalist and specialist caregivers are adequate in number. A new post-graduate diploma has received interest from professionals leading to an expected increase in specialised manpower.³ Mid-career training options are also available.⁴

The government pledged to increase the lifetime withdrawal limit for public medical savings accounts, and raise the daily limit for in-patient care.⁵ However, these improvements will not cover all expenses. Painkillers are widely available upon prescription.⁶ Psycho-social support is generally available; interdisciplinary

	Rank/80	Score/100
Quality of Death overall score (supply)	12	77.6
Palliative and healthcare environment	12	66.4
Human resources	8	74.0
Affordability of care	=6	87.5
Quality of care	=8	90.0
Community engagement	=22	50.0



teams are the norm in palliative care units. DNR is legally recognised.

Transparency governs doctor-patient relations. While most cancer patients are involved in the therapeutic decision-making process in early stages, familial involvement is more prominent as the disease progresses.⁷ Service evaluation by patients is common practice. Public opinion surveys found that half of Singaporeans are aware of palliative care but only one in three people could define it correctly.⁸ Volunteer engagement is widespread.⁹

¹ Speech by Mr Gan Kim Yong, Minister for Health, Singapore Palliative Care Conference, 28 June 2014.

² Ibid.

³ Ibid.

⁴ "Report on the National Strategy for Palliative Care," coordinated by the Lien Centre for Palliative Care, Duke-NUS Graduate Medical School, submitted to the Ministry of Health on 4 October 2011.

⁵ Speech by Mr Gan Kim Yong.

⁶ Chong, A., "Singaporeans under-treated for pain," *The Straits Times*, 14 October 2010.

⁷ Chong, J.A., Y.L. Quah, G.M. Yang, S. Menon and L.K. Krishna, "Patient and family involvement in decision making for management of cancer patients at a centre in Singapore," *BMJ Supportive & Palliative Care*, January 2013.

⁸ Lien Foundation Survey on Death Attitudes, 2014.

⁹ "Report on the National Strategy for Palliative Care", 2011.

61. Slovakia



SNAPSHOT

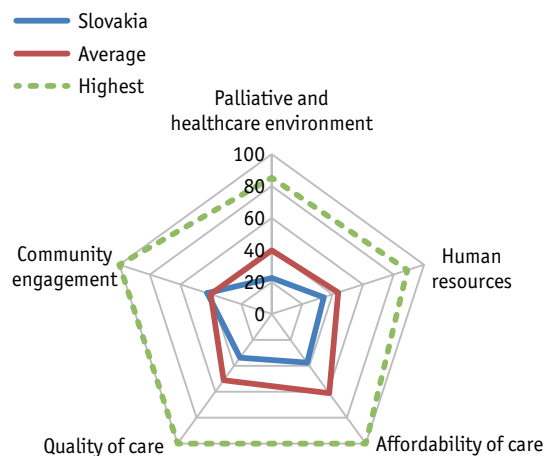
Palliative care in Slovakia is underdeveloped. The government has not addressed systemic weaknesses, leaving provision of care underfunded and understaffed.

IN DETAIL

Palliative care is a neglected branch of Slovakia's health system. The government took preliminary steps in issuing generic guidelines, but there is no overall vision or coherent rules. The health authorities have not made tangible implementation efforts. Research is lacking in funds and qualified personnel. The number of specialists is insufficient and facilities are understaffed. The few palliative care units in the country often compete against each other for limited public funds.

The University of Bratislava offers masters' courses and training for oncologists. However, these are not mandatory and medical professionals have a limited awareness of palliative care. Only ten physicians are nationally accredited. Funding streams for healthcare rarely include resources for palliative care. Economically troubled insurance providers have difficulty providing the stipulated 60% cost coverage for hospice patients. Charities alleviate some of the financial burden but ultimately patients must pay to access the full range of services. Monitoring mechanisms are weak and

	Rank/80	Score/100
Quality of Death overall score (supply)	55	33.2
Palliative and healthcare environment	=63	22.5
Human resources	52	34.0
Affordability of care	=65	37.5
Quality of care	=51	33.8
Community engagement	=27	42.5



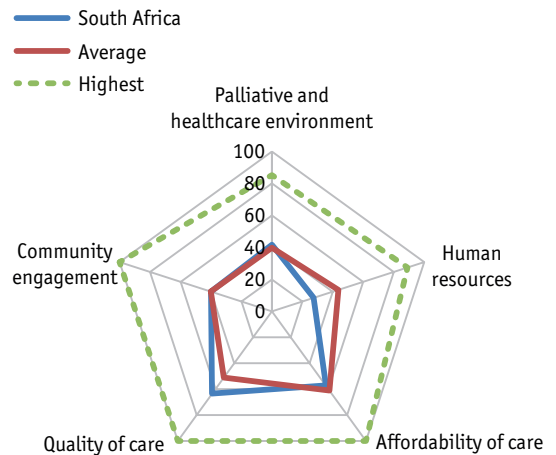
the system is unresponsive to requests for better funding and equipment.

Morphine and opioids are widely accessible, but social support is lacking. Psychologists are seldom available and must be paid by patients at additional cost. Physicians tend to have a paternalistic approach in communicating diagnosis to patients. Families often assume the role of decision-maker. The system is not receptive to feedback. Medical culture is changing, but patients still fear that voicing criticism will affect their quality of care. Palliative care has a positive image following modest media exposure. There are no volunteers, as nuclear families are the primary source of support for patients.

62. South Africa



	Rank/80	Score/100
Quality of Death overall score (supply)	34	48.5
Palliative and healthcare environment	32	41.7
Human resources	59	27.5
Affordability of care	=44	57.5
Quality of care	31	63.8
Community engagement	=33	40.0



SNAPSHOT

South Africa is home to a relatively advanced palliative care system. Funding is insufficient and provides for only a fraction of societal needs, but progress has been made in the last decade in terms of service quality and availability of painkillers.

IN DETAIL

South Africa has a broad strategy to develop palliative care services for HIV, TB and non-communicable diseases.¹ Implementation mechanisms have yet to be fully outlined, but changes are taking place. Research teams are well-staffed and supported by government funding.² Most caregivers have received some training in palliative care, although rural areas have a shortage of doctors and thus have limited access to basic palliative care.³ No accreditation is provided and support staff are unevenly deployed.⁴

Only four universities offer mandatory palliative care courses, which vary in scope and length. Mid-career training opportunities also exist. Financing is a crucial hurdle, barring most people from accessing specialised facilities. Services are offered for free, but institutions have to supplement limited government funds with

support from international donors and NGOs. This short-term solution hinders the growth of the sector. The national insurance schemes are not universal and cover only a minimal portion of costs. The Office of Health Services checks compliance with standards on a four-year basis.

Only doctors can prescribe opioids. There are plans to allow nurses to administer morphine in areas with few physicians.⁵ DNR has legal standing.⁶ Doctors are encouraged to share information with patients. However, physicians see their role as mainly curative. Most hospices use feedback forms, although these are not mandated by government policy. The general public has a limited awareness of palliative care despite the substantial community engagement demonstrated by large numbers of trained volunteers.

¹ HLSP, "DFID MSP Best Practices: Wits Palliative Care—Building the Foundations for a National Palliative Care Service."

² Gwyther, L., C. Blanchard, E. Namisango, F. Mwangi-Powell and R.A. Powell, "Palliative care research in southern and central Africa," *European Journal of Palliative Care*, 2013.

³ HLSP.

⁴ National Council for Health Service Accreditation of Southern Africa (COHSASA) newsletter, November 2006.

⁵ Lopez Gonzales, L., "Need to rethink palliative care in South Africa," *Health-e News Service*, September 2013.

⁶ Medical Protection Society website, "South Africa: Do Not Resuscitate (DNR) orders."

63. South Korea



SNAPSHOT

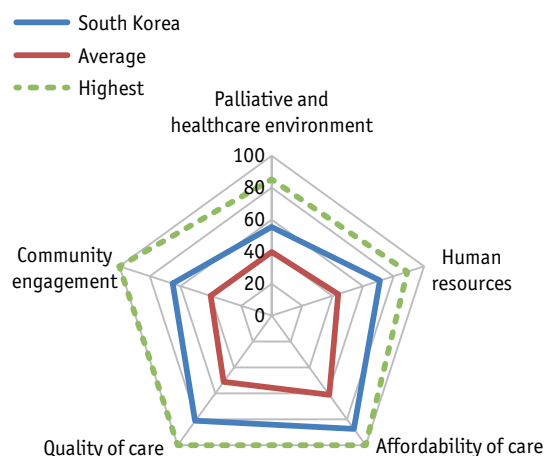
South Korea excels in the provision of quality palliative care. The system is open and transparent, receptive to feedback and accessible to all citizens.

IN DETAIL

The government instituted a comprehensive strategy more than a decade ago, and has continually updated its policies in light of new research. Several academic research centres conduct regular surveys and publish results in national scientific journals. The number of specialised professionals is adequate to meet current needs, although an increase would help to alleviate the work burden on staff.¹ Over 3,000 physicians and nurses have completed palliative care training. Multiple universities offer ad-hoc specialisations. Most medical schools include palliative care in their curricula, but these courses are seldom mandatory.²

Health services are mostly funded by a co-payment system involving private insurance, government subsidies and a minimal contribution from the patient of not more than 5% of total costs.³ The national insurance covers a range of palliative care services but excludes bereavement care. Monitoring mechanisms are locally implemented in the absence of national standards.⁴

	Rank/80	Score/100
Quality of Death overall score (supply)	18	73.7
Palliative and healthcare environment	20	55.5
Human resources	13	71.2
Affordability of care	=6	87.5
Quality of care	=20	81.3
Community engagement	14	65.0



There are no barriers to access strong painkillers. Psycho-social support is widely available but is not covered by national insurance;⁵ poor families can request a full reimbursement.⁶ The government plans to legalise DNR, but it is still pending in parliament.⁷ Patients are not always fully informed about their condition. Shared decision-making normally occurs between families and physicians.⁸ The system is receptive to criticism. Feedback forms are available in all hospice units.⁹ The public tends to be well informed on the subject. Volunteer training is available in all hospitals.

¹ Kwon, S-H., "End-of-Life care in Korea: Issues and trends," *Oita University Journal of Nursing and Health Science*, 2013.

² Ibid.

³ Ibid.

⁴ WHO and Ministry of Welfare of the Republic of Korea, "Health Service Delivery Profile: Republic of Korea," 2012.

⁵ Kim, S.H., B.Y. Chung and Y. Xu, "Evaluation of a home-based hospice and palliative care program in a community health center in Korea," *Asian Nursing Research*, March 2009.

⁶ Ibid.

⁷ Ibid.

⁸ Shin, D.W., J.E. Choi, M. Miyashita, J.Y. Choi, J. Kang, Y.J. Baij, H.N. Mo, Y.S. Kim, D.S. Heo and H.J. Shin, "Measuring the structure and process of end-of-life care in Korea: Validation of the Korean version of the Care Evaluation Scale (CES)," *Journal of Pain & Symptom Management*, October 2012.

⁹ Park, C.H., D.W. Shin, J.Y. Choi, J. Kang, H.N. Mo, Y.J. Baik, Y.H. Kim, M.J. Kang, J.I. Gwak and J.J. Lee, "Determinants of family satisfaction with inpatient palliative care in Korea," *Journal of Palliative Care*, 2013.

64. Spain



SNAPSHOT

The quality of palliative care in Spain is high and services are provided free of charge. Availability of specialists varies by region, but overall the system is transparent and responsive to patients' needs.

IN DETAIL

All the elements of a comprehensive plan are laid out in the 2010-2014 update on Spain's palliative care strategy.¹ Measurable targets support a commitment to promoting accessibility. Quality of care has improved along with the expansion of infrastructure and services. Data is gathered unevenly across health districts. Research receives government support, but is limited.

Opportunities for professional enhancement are widely available. Universities graduate large numbers of highly trained specialists. Nearly all nursing schools now offer palliative care courses.² Over half of Spain's medical schools provide mandatory or optional courses. Several masters' courses are also available for doctors.³ Advanced diplomas are awarded, but no nationwide accreditation has been established.

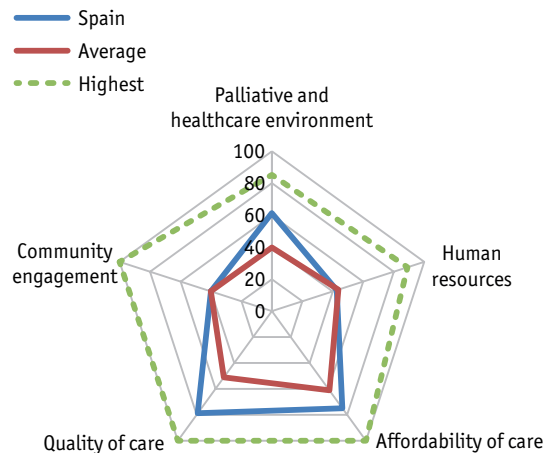
Spain's social security programme allows all citizens (including retirees) to access the healthcare system free of charge. Since 2007, the

¹ Ministry of Health, Social Services and Equality, "Palliative Care Strategy of the National Health System: 2010-2014 Update," 2012.

² Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Spain," *EAPC Atlas of Palliative Care in Europe 2013*.

³ Ibid.

	Rank/80	Score/100
Quality of Death overall score (supply)	23	63.4
Palliative and healthcare environment	15	61.2
Human resources	36	42.6
Affordability of care	=25	75.0
Quality of care	24	78.8
Community engagement	=33	40.0



Ministry of Health has set aside €7m annually to expand and enhance palliative care in Spain. The economic recession hampered the creation of new units, slowing down progress on provision of care. All prescribed medicines are partially or fully subsidised. Psycho-social support, bereavement and spiritual care are widely available.

Doctors share diagnosis and prognosis with patients, but not consistently; more work is needed to ensure open communication. The family plays an important role in communication. Satisfaction surveys are rare and the public is not well-informed. Trained volunteers are a common sight.

65. Sri Lanka



SNAPSHOT

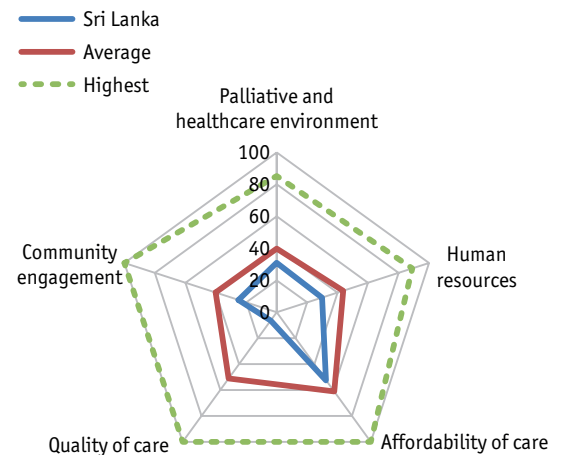
Palliative care in Sri Lanka is in its infancy. A new strategic framework should deliver sweeping improvements, but the system has not yet developed accordingly. Most people have inadequate access to basic pain relief.

IN DETAIL

The Sri Lankan government, in collaboration with the WHO, has issued a ground-breaking framework for the treatment of non-communicable diseases, including the development of palliative care. Guidelines are clear and implementation was slated to begin in December 2014. Research has improved; cancer control units collect standardised data which is shared with central authorities. NGO-run hospitals are not included in the programme.

Education and training are weak. Basic nursing curricula do not allocate sufficient time to teaching palliative care.¹ Palliative care courses were recently made mandatory for all undergraduate medical students and a new post-graduate programme was launched in Colombo;² accreditation will be given upon completion. The new government policies have yet to show

	Rank/80	Score/100
Quality of Death overall score (supply)	65	27.1
Palliative and healthcare environment	53	31.0
Human resources	56	30.0
Affordability of care	=49	52.5
Quality of care	=78	6.3
Community engagement	=45	25.0



meaningful results; there are only two trained specialists in the whole country. Capacity-building programmes are still led by international charities.

The government has allocated significant but still inadequate funding to develop end-of-life care across the country. Services are free but limited in scope, and mostly dependent on donations. There are no monitoring mechanisms in place. Access to analgesics and opioids is difficult outside of large cities. Health departments have quotas on the amount of morphine they can dispense, which limits supply. Psycho-social support is rarely available. Volunteers often fill gaps in hospital management, taking on roles that warrant specialised qualifications. Volunteers themselves are in short supply. The public has a very limited understanding of palliative care and no regular feedback informs the public system.

¹ Meegoda, L., "From Sri Lanka," *International Association for Hospice and Palliative Care Newsletter*, September 2012.

² Postgraduate Institute of Medicine of the University of Colombo, "Post-Graduate Diploma in Family Medicine – Prospectus," 2013.

66. Sweden



Stockholm

SNAPSHOT

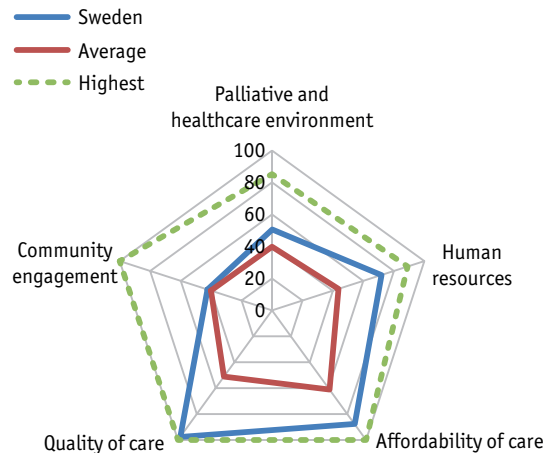
The palliative care movement is firmly established in Sweden. The system is transparent and accessible, with universal coverage and high-quality treatment.

IN DETAIL

There is no central strategy, but palliative care and pain therapy are fully integrated into the Swedish healthcare system.¹ A national board has issued clear guidelines on treatment and care. Research institutes usually operate within academia and produce high-quality research. The number of specialised physicians is adequate, although rural areas have more challenges with availability of care.² Three of the seven medical schools in Sweden offer optional palliative care courses,³ but more often the subject is included in traditional courses. Accreditation is available for certified specialists at the end of a two-year training programme.⁴

Regional governments manage service delivery. Palliative care is mostly covered by the national health insurance, but partial payment may be required for consultation and hospitalisation.⁵

	Rank/80	Score/100
Quality of Death overall score (supply)	16	75.4
Palliative and healthcare environment	=26	50.5
Human resources	=10	71.6
Affordability of care	=6	87.5
Quality of care	2	97.5
Community engagement	=27	42.5



Subsidies are provided for the poor. Advanced home-care services are available throughout the country, comprised of teams of experienced physicians, paramedics, psychologists and social workers. Horizontal integration across medical fields is the norm.

There is no standardised quality-control system, but a national register aims to collect information about care of dying patients.⁶ Individual hospitals gather data and independently apply internal protocols. DNR has legal standing. Communication between patients, physicians and families is transparent; prognosis and diagnosis are not concealed. The system is receptive to feedback, and satisfaction surveys are widely used to improve services. The public has a moderate awareness of palliative care. Community engagement is generally low, and volunteerism is not well developed.

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Sweden," *EAPC Atlas of Palliative Care in Europe 2013*.

² Axellsson, B., "Specialized palliative home care in Sweden with special respect to the development in sparsely populated areas," *Socialmedicinsk tidskrift*, January 2013.

³ Centeno et al.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

67. Switzerland



SNAPSHOT

Switzerland offers universal, high-quality palliative care coverage with adequate subsidies. The system is flexible and accessible, and relies on a system of shared responsibility among stakeholders.

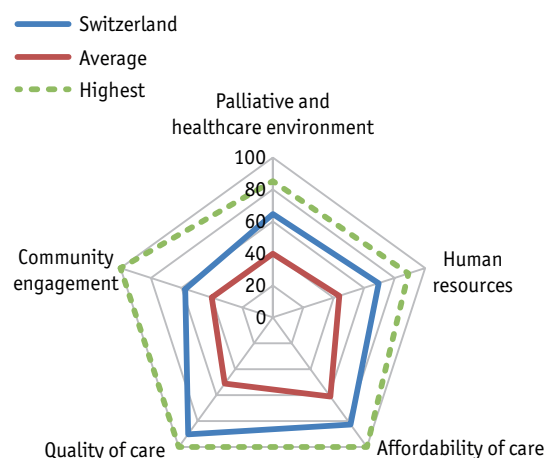
IN DETAIL

The national strategy adopted in 2010 fosters collaboration between the federal government, the Confederation of the Cantons and key local networks to integrate palliative care into the public health system.¹ Government-funded national research programmes were launched to provide uniform guidelines for all cantons and strengthen public policy.²

Uneven distribution of specialists and psychosocial support reflects an urban-rural divide, yet palliative care is widely available—GPs and nurses must pass mandatory courses in all five medical schools. However, opportunities for continuing education are limited and poorly coordinated. The Swiss Academy of Medical Science provides national accreditation and is working to harmonise training across the country and create an academic sub-speciality by 2016.

Community networks rely on donations. A 10% payment is required for consultation and

	Rank/80	Score/100
Quality of Death overall score (supply)	15	76.1
Palliative and healthcare environment	13	64.8
Human resources	15	69.4
Affordability of care	=18	82.5
Quality of care	=8	90.0
Community engagement	=15	57.5



hospitalisation, but remaining costs are typically shared by the hospital and the local canton government. Essential medication is free, but home care is only lightly subsidised and costly for patients.

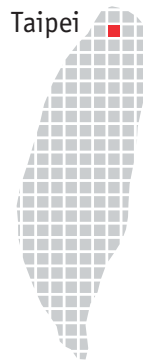
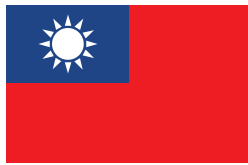
Transparency is ingrained in the medical culture; patients and physicians are partners in care, although certain ethnic or religious communities may request less openness. The system is receptive to patient feedback. Ease of access to information has strengthened public understanding and a growing number of volunteers are supporting specialist teams, particularly in provision of at-home care.³

¹ Federal Office of Public Health, "Palliative Care Strategy"; Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Switzerland," *EAPC Atlas of Palliative Care in Europe 2013*.

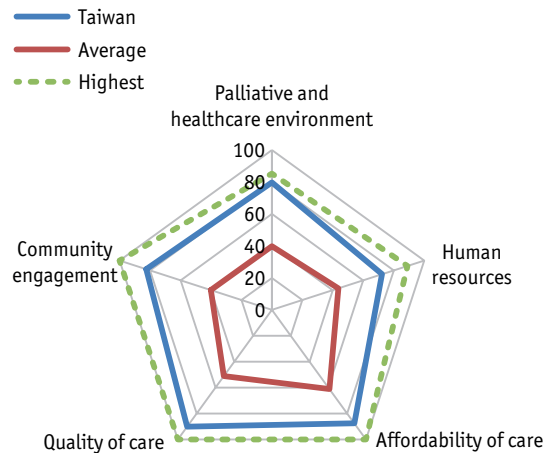
² Centeno et al.

³ Ibid.

68. Taiwan



	Rank/80	Score/100
Quality of Death overall score (supply)	6	83.1
Palliative and healthcare environment	5	79.6
Human resources	9	72.2
Affordability of care	=6	87.5
Quality of care	=8	90.0
Community engagement	=5	82.5



SNAPSHOT

Taiwan is home to one of the most transparent and efficient palliative care delivery systems. Top-notch facilities are adequately staffed with trained professionals who provide free comprehensive care for patients and their families.

IN DETAIL

Taiwan was the first country in Asia and one of the first in the world to institute a robust palliative care framework through the Hospice Palliative Care Act, passed in 2000 (also known as the Natural Death Act). Guidelines and policies have since been updated. The government pays for extensive research programmes to inform its policymaking process. This includes the “Good Death” index to track progress in palliative care provision in Taiwan and South-east Asia. Specialised manpower could be strengthened, but is adequate for existing needs.

Training opportunities are widely available. Over 600 physicians and 300 nurses have passed the rigorous national accreditation system. Government subsidies ensure that services are entirely free; all costs relating to inpatient and outpatient care are covered. Authorities

continually monitor quality standards. Medical teams are comprised of social workers and psychologists and tend to the spiritual needs of patients and families. Bereavement care is included. DNR is firmly established in the legal system.

A lingering reluctance to disclose clinical information to patients has been the target of widespread training courses. Cultural mores are slowly being replaced by more open and transparent communication. Satisfaction surveys are frequently used, and health providers take complaints seriously. The government is using creative social media strategies to promote palliative care. Volunteers are numerous, trained and support a wide range of essential services.

69. Tanzania



SNAPSHOT

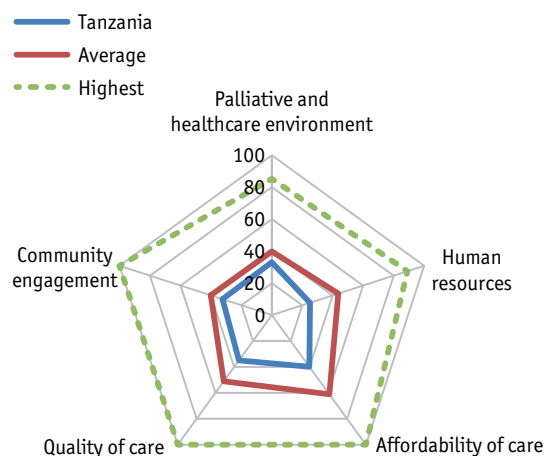
Tanzania is proactively integrating palliative care into its healthcare model. Scarcity of resources, human capital and infrastructure remain key hurdles to overcome.

IN DETAIL

The government aims to finalise its national palliative care strategy by 2015. This essential policy framework is expected to expand available services and enhance the quality of care by increasing facilities and support staff. Data collection is weak but has been included as an objective of the new strategy. Specialists are highly trained but in short supply.

Both of the country's medical universities offer short-term mandatory palliative care courses. However, there is no national accreditation body. There is no government funding available for basic services; existing units rely entirely on charitable support from international donors. Palliative care is not covered by insurance and pension schemes.

	Rank/80	Score/100
Quality of Death overall score (supply)	54	33.4
Palliative and healthcare environment	50	33.1
Human resources	63	25.1
Affordability of care	=60	40.0
Quality of care	50	35.0
Community engagement	=38	32.5

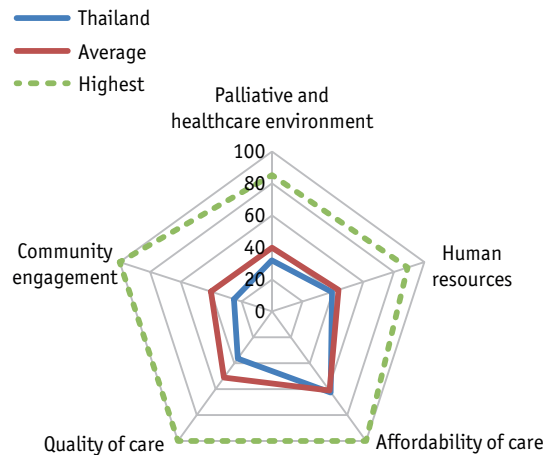


Hospitals are audited on a quarterly basis using generic guidelines for quality assessment. Morphine is widely available but prescriptions are only for one week. Psycho-social support is rarely provided and DNR is unregulated. Openness in doctor-patient communication depends on the type of training professionals have received. Medical information is generally disclosed, but a reluctance to openly discuss details is prevalent. Satisfaction surveys are seldom used. Volunteers are few but they do receive some training prior to participation.

70. Thailand



	Rank/80	Score/100
Quality of Death overall score (supply)	44	40.2
Palliative and healthcare environment	52	32.0
Human resources	45	39.5
Affordability of care	=40	62.5
Quality of care	=48	36.3
Community engagement	=45	25.0



SNAPSHOT

Palliative care in Thailand is in a development phase. Shortages of qualified workers hinder the integration of palliative care into the national health system.

IN DETAIL

The current transitional government has devised a national plan for palliative care to be implemented starting in 2015. Details of the plan are not publicly available, but independent sources confirm that it fulfils all WHO criteria for comprehensive care. Research is underfunded and does not use standardised data collection methods. A pioneering education programme was established in Bangkok in 2014.¹ There are less than a dozen specialists serving the entire country. Palliative care is not integrated into mainstream medical curricula and most physicians lack basic concepts and familiarity with international guidelines and pain management therapies.²

Underfinancing is a persistent challenge, and there are no specific subsidies for palliative care. Hospitals must provide palliative care by allocating funds from existing budgets. The most basic patient needs are met. National insurance fully covers all costs for public hospitals. A

council of hospital accreditation evaluates quality for all provinces every three years. Legal restrictions apply to the use of morphine, which is only available via oral intake and never for outpatient care. Strong prejudices influence attitudes towards the prescription of strong painkillers. Psychological support is limited in public facilities, but social and spiritual support for patients and families is abundant.³

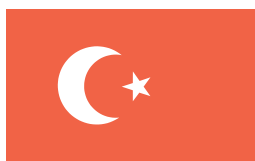
DNR has legal standing but a cultural reluctance to engage in transparent doctor-patient communication often results in less than full disclosure of prognosis and diagnosis. The feedback process is weak and inconsistent across provinces. There are no centrally-led efforts to collect and interpret satisfaction surveys. Public understanding of palliative care is inconsistent and subject to misconceptions. Volunteer workers are few and untrained.

¹ Mahidol University, "Introducing the Mahidol Hospice Research and Education Centre," *Spectrum*, May-August 2014.

² Government of Thailand, Ministry of Foreign Affairs website, "Thailand's information on the realization of the right to health of older persons."

³ Manasurakarn, J., A. Chaowalit, W. Suttharangsee, S. Isaramalai and E. Geden, "Values underlying end-of-life decisions of Thai Buddhist patients and their families," *Songklanagarind Medical Journal*, 2008.

71. Turkey



	Rank/80	Score/100
Quality of Death overall score (supply)	47	38.2
Palliative and healthcare environment	46	34.7
Human resources	57	28.8
Affordability of care	71	32.5
Quality of care	34	57.5
Community engagement	=66	17.5

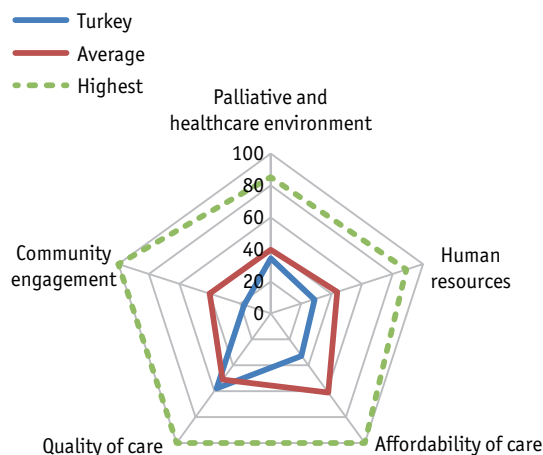
SNAPSHOT

Turkey is in the process of developing its palliative care services. Pilot projects have been launched but these do not provide adequate coverage outside urban areas. The number of specialists is increasing, as is the level of public awareness.

IN DETAIL

Turkey lacks a coherent framework for integrating palliative care services into its public health model.¹ Policy obstacles such as legal restrictions on opioids still hinder the provision of care. Doctors are encouraged to conduct research, but no central agency is tasked with collecting and analysing data on a national level. Half of Turkey's 80 medical schools offer palliative medicine as a mandatory course; optional courses are available in another 10.² However, specialists are not yet sufficient in number and are unevenly distributed across the country. No national accreditation is available.

A lack of funding slows progress. The national pension scheme does not cover palliative care services.³ Partial payment may be requested for home-based care, and hospitalisations mostly require payment by the patient. The availability



of essential painkillers is increasing and opioids are slowly being more widely prescribed, but significant bureaucratic hurdles keep supply low.⁴

The Ministry of Health is formulating national guidelines, but so far the lack of regulation has resulted in uneven monitoring of quality and enforcement of standards.⁵ Public discussion about DNR, sedation and pain therapy has been active due to media attention. Available evidence points to a lack of volunteer teams or community engagement networks mobilised in support of palliative care services.

¹ Elcigil, A., "The current status of palliative care in Turkey: A nurse's perspective," *Journal of Pediatric Hematology and Oncology*, April 2011.

² Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Turkey," EAPC Atlas of Palliative Care in Europe 2013.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

72. Uganda



SNAPSHOT

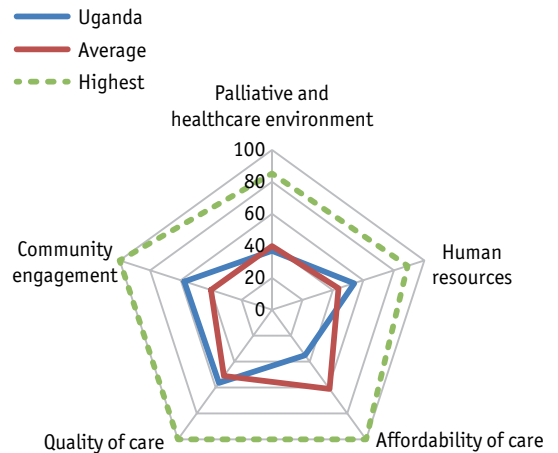
Targeted education programmes for palliative care specialists have produced an informed medical culture in Uganda. Problems remain, particularly regarding availability of professionals and inadequate public financing.

IN DETAIL

Palliative care is featured in the Ugandan national strategic health plan. The mainly aspirational document set unrealistic implementation targets, but established appropriate mechanisms for monitoring and reviewing services.¹ Implementation lags, with just over half of the country's 112 health districts providing basic palliative care.² The University of Makerere produces publicly funded research on the subject, but data collection and analysis are underdeveloped.³ Palliative care is a mandatory course in all undergraduate medical schools.⁴ There are plans to establish specialisation courses. Accreditation is given upon completion of specific trainings.⁵

Uganda is experiencing a brain drain of qualified physicians, leaving the country short of both specialists and GPs. The shortage has a direct impact on patients' lives, as only doctors are licensed to administer opioids, which were recently legalised.⁶ Public funding is insufficient,

	Rank/80	Score/100
Quality of Death overall score (supply)	35	47.8
Palliative and healthcare environment	=43	37.0
Human resources	24	54.0
Affordability of care	=69	35.0
Quality of care	35	56.3
Community engagement	=15	57.5



and health facilities rely on international donations. Patients must pay up to 70% of fees for medication. Psycho-social support is generally available. Satisfaction surveys are not in common use.

Communication between patients, families and doctors is generally open and transparent. Ethical guidelines require caregivers to disclose both diagnosis and prognosis. Public awareness of palliative care is very low.⁷ Rural areas are disconnected from advances in medical culture. Volunteers often include family members of former palliative care patients. Training for volunteers is available in all hospices.

¹ WHO, "Palliative care for HIV and cancer patients in Africa: Project description for a community health approach," 2001.

² Opendi, S.A., "Uganda: Ministerial statement on palliative care," eHospice News, 28 August 2013.

³ Namisango, E., R.A. Powell, H. Kariuki, R. Harding, E. Luyirika and F. Mwangi-Powell, "Palliative care research in eastern Africa," *European Journal of Palliative Care*, 2013.

⁴ Hospice Africa, "Institute of Hospice Care and Palliative Care in Africa," 11 November 2011.

⁵ Palliative Care Association Uganda website, "Training and Mentorship."

⁶ Webb, M., "Uganda legalises morphine in Africa first," Al Jazeera video.

⁷ WHO.

73. UK



SNAPSHOT

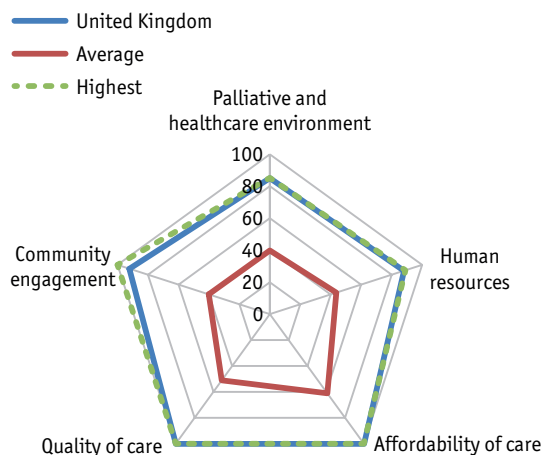
A pioneer in palliative care, the United Kingdom maintains cutting-edge services and is the world's best location to receive terminal care and pain-alleviating treatment.

IN DETAIL

Dame Cicely Saunders was an early advocate of palliative care in the United Kingdom, which is now integrated into the National Health Service. England,¹ Scotland,² Wales³ and Northern Ireland⁴ have all implemented country-level plans. Additional policies have strengthened services and enhanced access and quality.⁵ An extensive network of independent and government research centres is used to collect and interpret data, and provides recommendations.⁶

Education is a strong point. A wide range of publicly-funded generalist courses are available for students and mid-career trainees. Specialist courses are abundant and free, and palliative care is a stand-alone academic speciality. Consultation, hospitalisation and medications are free.⁷ Generous subsidies provide long-term funding for hospices and specialised units.

	Rank/80	Score/100
Quality of Death overall score (supply)	1	93.9
Palliative and healthcare environment	1	85.2
Human resources	2	88.2
Affordability of care	=1	100.0
Quality of care	1	100.0
Community engagement	=3	92.5



Patients may have to make partial contributions for home care. Guidelines are regularly reviewed and consistently enforced. Respect for patient rights is central to medical culture, from transparency in clinical disclosure to availability of psycho-social support.

Transparency is a hallmark of the UK system, which is receptive to constructive feedback and displays a commitment to understand grievances and improve services. The media has investigated cases of substandard care and raised general public awareness and palliative care is now seen as a national priority. Community engagement is central to the NHS model, and trained volunteers assist professional teams in everything from patient care to fundraising.

¹ NHS England, "Actions for End of Life Care: 2014-2016," 11 November 2014.

² The Scottish Government, "Living and Dying Well: A national action plan for palliative and end of life care in Scotland," 2 October 2008.

³ Palliative Care Planning Group Wales, "Report to the Minister for Health and Social Services," June 2008.

⁴ Department of Health, Social Services and Public Safety, "Palliative and End of Life Care Strategy: Promoting high quality care for Northern Ireland," December 2009.

⁵ For example: Department of Health, "End of Life Care Strategy: Promoting high quality care for all adults at the end of life," 16 July 2008.

⁶ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "United Kingdom," *EAPC Atlas of Palliative Care in Europe 2013*.

⁷ *Ibid.*

74. Ukraine



	Rank/80	Score/100
Quality of Death overall score (supply)	69	25.5
Palliative and healthcare environment	61	23.7
Human resources	=43	39.8
Affordability of care	79	12.5
Quality of care	66	20.0
Community engagement	=27	42.5

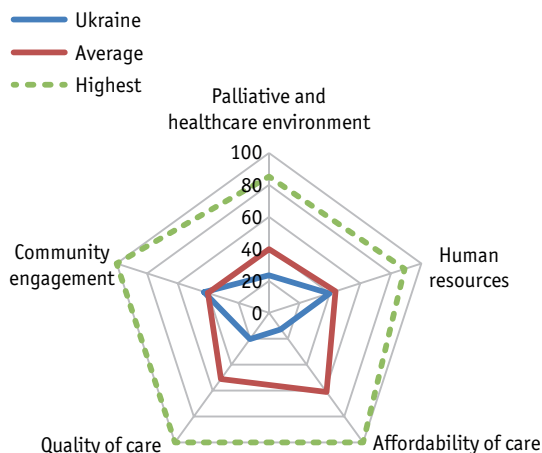
SNAPSHOT

Palliative care in Ukraine has significant room for improvement. Rules are loosely enforced amid widespread shortages of funding, specialised workers and educational opportunities.

IN DETAIL

The structure of Ukraine’s palliative care services is fragmented.¹ Following drawn-out negotiations between public and private stakeholders, only low-impact measures were undertaken by authorities. Policies are not centralised or comprehensive in scope. Research is minimal and relies on support from international donors. The number of specialists falls short of public needs. Trainings are usually limited to short courses on pain management, rather than being incorporated into academic curricula. Post-graduate training for nurses and doctors is available through some universities but costs are not covered by the state. Nationally recognised credentials are issued upon completion.²

The Constitution guarantees the right to universal healthcare, which includes palliative care.³ However, a significant gap remains between the legal framework and actual provision of care. With no targeted government spending, funding is scarce. Regional governments offer modest subsidies, but patients are required to contribute in most cases. The system is opaque,



and guidelines are not monitored or enforced. Bribes to access services are common. Doctors are not trained to disclose diagnosis and prognosis, thus infringing on patients’ rights to informed decision-making. Patients can rarely voice criticisms, as channels for institutional feedback are weak.

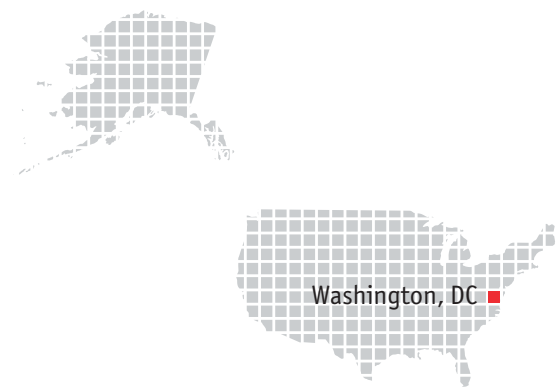
Legal limitations reduce the availability of morphine, and doctors are hesitant to prescribe strong painkillers. Fully equipped professional teams exist, but only include psycho-social support in 20% of cases. The last five years have seen growing public interest due to NGO promotion of media and awareness campaigns. Only well-established hospices enjoy support from volunteer workers, while most palliative care units lack community engagement.

¹ Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, "Ukraine," *EAPC Atlas of Palliative Care in Europe 2013*.

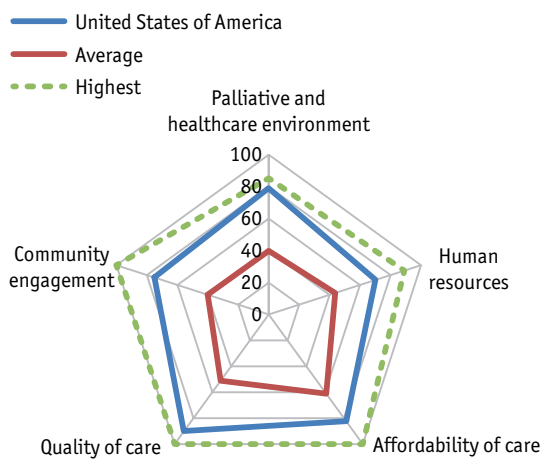
² Ibid.

³ Ibid.

75. US



	Rank/80	Score/100
Quality of Death overall score (supply)	9	80.8
Palliative and healthcare environment	6	78.9
Human resources	14	70.2
Affordability of care	=18	82.5
Quality of care	=8	90.0
Community engagement	=9	75.0



SNAPSHOT

Palliative care has been in development over a relatively long period in the United States. Services have expanded, providing high-quality coverage and legal protection of patients’ rights. The system is open and transparent, but not universally affordable.

¹ National Center for Care at the End of Life, “2013-2015 Strategic Plan.”

² Lupu, D., “Estimate of current hospice and palliative medicine physician workforce shortage,” *Journal of Pain and Symptom Management*, December 2010.

³ Centre to Advance Palliative Care and National Palliative Care Research Center, “Report Card: America’s Care of Serious Illness, A State-by-State Report Card on Access to Palliative Care in Our Nation’s Hospitals,” 2011.

⁴ Horowitz, R., R. Gramling and T. Quill, “Palliative care education in U.S. medical schools,” *Medical Education*, January 2014.

⁵ Bolognesi, D., C. Centeno, and G. Biasco, “Specialisation in Palliative Medicine for Physicians in Europe 2014,” *A supplement of the EAPC Atlas of Palliative Care in Europe*, 2014.

⁶ Centre to Advance Palliative Care.

⁷ National Hospice and Palliative Care Organization, *NHPCO Facts & Figures: Hospice Care in America*, 2012.

IN DETAIL

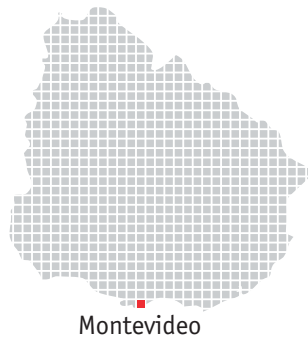
The national strategy is not government-led. Independent organisations have devised a plan to strengthen and expand services on a national level.¹ Public funding is available for research, although it is declining. Findings are used to inform policy. The number of specialists falls short of patient needs.² There is only one palliative medicine physician for every 1,200 terminally ill patients.³

Top-rated educational opportunities provide world-class training for students and mid-career professionals. All medical schools have offered palliative care content since 2000, although courses vary in intensity and duration.⁴ Accreditation was established in 1996.⁵ The old, the young and the poor can access free hospice care. Others rely on private insurance or must pay on their own. Pension and public/private insurance schemes usually do not cover

ancillary services such as psycho-social support and bereavement care; these services are widely available but may require additional payments which can be onerous.

Guidelines are well defined and carefully enforced. DNR is accepted but policies vary for each state Transparency is engrained in the system, and patients are fully informed about diagnosis and prognosis. Satisfaction surveys are common and the system is receptive to feedback. Public awareness is high, with polls finding that over 90% of Americans are likely to consider palliative care for themselves in the event of a terminal illness.⁶ Community engagement through volunteer programmes is widespread, in support of clinical, clerical and administrative services.⁷

76. Uruguay



Montevideo

SNAPSHOT

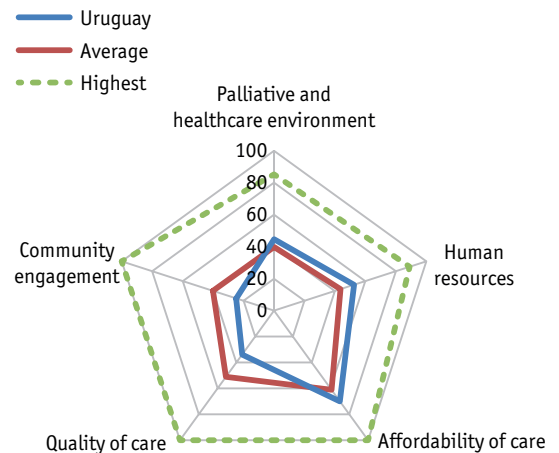
Palliative care in Uruguay has substantial room for improvement. Services are good where available but lack adequate financing. The low number of facilities results in many patients not having access to pain-alleviating therapies.

IN DETAIL

The National Programme for Palliative Care has been in place since 2012.¹ However, its non-binding nature reduces the impact of its recommendations. It contains a timeline, target milestones and a set of monitoring indicators. Resources devoted to research are insufficient.² A crucial barrier is the shortage of qualified specialists.³ Uruguay's two medical schools offer non-mandatory undergraduate courses but so far the number of graduates falls short of national needs. A national accreditation process has been set up.

Limited access is partly to blame on inadequate financing. Facilities are few and unevenly distributed across the country. In public hospitals, consultation and hospitalisation is free. Private institutions opt for either a co-payment system or charge patients for the full cost of care. The pension and social insurance

	Rank/80	Score/100
Quality of Death overall score (supply)	39	46.1
Palliative and healthcare environment	29	44.8
Human resources	25	52.6
Affordability of care	=30	70.0
Quality of care	=51	33.8
Community engagement	=45	25.0



system covers palliative care. Monitoring mechanisms are weak. Patients can rely on good access to opioids; however, many doctors have insufficient training in analgesia and are reluctant to prescribe strong painkillers.⁴ Psycho-social support is inconsistently available and DNR has no legal status, although patients' wishes must be respected.⁵

Physicians are not keen to discuss prognosis with patients, although the trend points towards greater transparency in doctor-patient communications. Satisfaction surveys are generally not available. The public has a limited grasp of the subject and efforts to improve awareness are not regularly carried out. Community engagement is low, with few volunteers supporting the system.

¹ Ministry of Public Health, "National Plan for Palliative Care," September 2013.

² Pastrana, T., L. De Lima, R. Wenk, J. Eisenclas, C. Monti, J. Rocafort and C. Centeno, *Atlas de Cuidados Paliativos de Latinoamérica ALCP*, 2012.

³ Ibid.

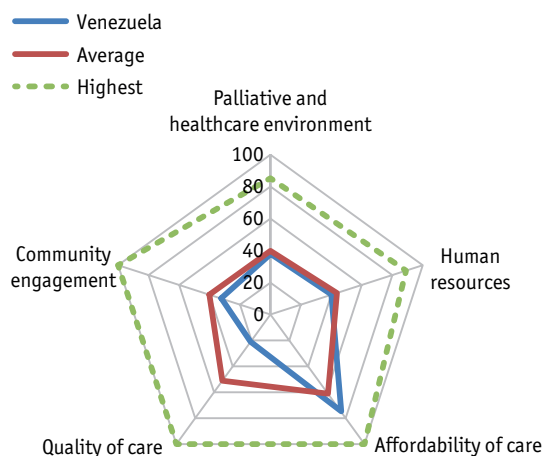
⁴ Ibid.

⁵ The Senate and House of Representatives of Uruguay, "Legislative Order no. 19.286," October 2014.

77. Venezuela



	Rank/80	Score/100
Quality of Death overall score (supply)	45	40.1
Palliative and healthcare environment	39	37.7
Human resources	=43	39.8
Affordability of care	=25	75.0
Quality of care	=64	21.3
Community engagement	=38	32.5



SNAPSHOT

Venezuela’s palliative care services score modestly as facilities are few, access to painkillers inadequate and training opportunities limited. The absence of guidelines negatively affects quality of care.

IN DETAIL

The policy framework for provision of palliative care in Venezuela contains significant gaps and omissions, such as a lack of guidelines and enforcement mechanisms, which constrain access and lower quality.¹ Palliative care is officially a sub-programme of the National Department of Oncology. Data is regularly collected on narcotic use and place of death, but only for cancer patients.² The number of specialists falls short of national need.

Opportunities for educational enhancement are limited. Only one of the eight medical schools in Venezuela offers courses on palliative medicine.³ However, the subject is recognised as an academic speciality and national accreditation procedures were established in 2009.⁴ Government hospitals are free, but medications and specialised workers are often in short supply.⁵ Some insurance companies cover hospitalisation in private clinics and

non-oncological patients also benefit from these schemes, where available.⁶

No guidelines have been issued. The system employs an insufficient number of psychologists and social workers.⁷ Palliative care concepts have not been absorbed into mainstream medical culture, and the reluctance to prescribe opioids remains the biggest obstacle to accessing pain-alleviating therapies.⁸ DNR has no legal status. Outside of a few trained palliative care teams, doctor-patient communication is opaque; doctors rarely disclose prognosis and diagnosis. There are no satisfaction surveys or plans to implement them. The public has a limited grasp of the subject despite efforts to set up informational campaigns. There is a widespread shortage of volunteers, who work in isolation and are rarely trained.

¹ Pastrana, T., L. De Lima, R. Wenk, J. Eisenchlas, C. Monti, J. Rocafort and C. Centeno, *Atlas de Cuidados Paliativos de Latinoamérica ALCP*, 2012.

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

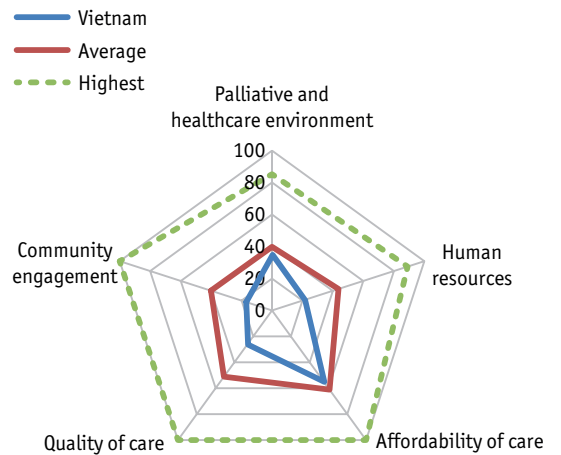
⁷ Ibid.

⁸ Ibid.

78. Vietnam



	Rank/80	Score/100
Quality of Death overall score (supply)	58	31.9
Palliative and healthcare environment	45	34.9
Human resources	69	21.3
Affordability of care	=47	55.0
Quality of care	=59	26.3
Community engagement	=66	17.5



SNAPSHOT

Vietnam has made progress towards establishing quality affordable palliative care for all. Availability of services and facilities are central issues along with the lack of adequate medical coverage for half of the population.

IN DETAIL

In 2005, the Ministry of Health and the WHO launched a range of palliative care initiatives. National guidelines were set up. Radically improved opioid regulations followed.¹ The aim is to integrate palliative care into the health system. Research is based on isolated efforts rather than coordinated data collection. Highly specialised doctors are few in number and concentrated in metropolitan areas.

International donors and non-profit initiatives, with approval from the government, have provided strong support for education. A Harvard University programme trained more than 700 physicians in palliative medicine. Other training curricula were developed in conjunction with the Ministry of Health. The medical establishment understands the importance of palliative care. However, only half of all Vietnamese citizens

are insured under a government or private plan and there are no specific subsidies for retirees to access palliative care. Poor patients may receive free treatment. No direct funding supports specialised units; hospitals have independent control over their budgets.

Hospitals are regularly audited but there are no separate mechanisms for monitoring palliative care. Access to opioids has dramatically improved since the new regulations were approved, although injectable morphine may be unavailable in remote regions. Psycho-social support is present in almost all trained palliative care units but may rely on community-based volunteers in rural areas. Patients are typically not well informed about their condition. Satisfaction surveys are rarely distributed. Public awareness remains low.

¹ Krakauer, E.L., N.T. Cham and L.N. Khue, "Vietnam's palliative care initiative: Successes and challenges in the first five years," *Journal of Pain and Symptom Management*, July 2010.

79. Zambia



SNAPSHOT

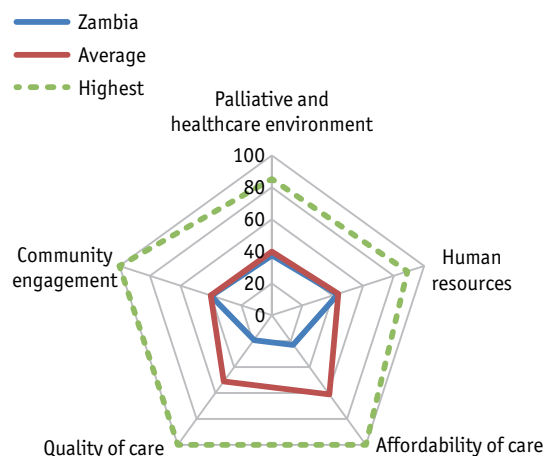
Palliative care in Zambia is only partially developed. Existing services are underfunded and understaffed and lack integration of palliative care into all medical departments.

IN DETAIL

Zambia's palliative care strategy is a broad statement of intent without an implementation framework, and has not led to transformational changes in the health system. A ministerial unit oversees research projects; it is well staffed but lacks adequate funding. Research findings inform policymaking. Specialists are few and unevenly distributed across the country.

Palliative care is a mandatory course in undergraduate medical faculties. The quality of training is high and formal accreditation is given upon successful completion of courses. Support staff such as nurses, psychologists and social workers are few in number and lack training opportunities. Most hospitals cannot afford these essential services. Palliative care is not directly subsidised. Cancer and HIV therapies include palliative care provision covered by the state but patients affected by other terminal conditions are poorly covered.

	Rank/80	Score/100
Quality of Death overall score (supply)	61	30.3
Palliative and healthcare environment	38	37.8
Human resources	35	43.2
Affordability of care	77	22.5
Quality of care	=67	18.8
Community engagement	=33	40.0



Authorities audit hospital standards on a quarterly basis but no specific mechanisms are in place to monitor palliative care. Legal restrictions on morphine have been lifted, but physicians underutilise opiates due to lack of adequate training in analgesics. A longstanding shortage of doctors limits access in underserved regions. Physicians usually disclose diagnosis and prognosis to patients and families. Feedback channels are unavailable and surveys rarely conducted. Several government-backed campaigns have helped to increase public awareness but overall understanding is still low. A large number of trained volunteers provide support.

80. Zimbabwe



Harare

	Rank/80	Score/100
Quality of Death overall score (supply)	59	31.3
Palliative and healthcare environment	56	28.1
Human resources	62	25.8
Affordability of care	78	17.5
Quality of care	=44	40.0
Community engagement	=22	50.0

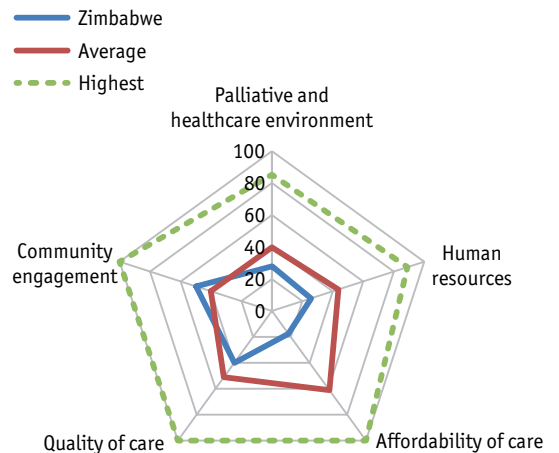
SNAPSHOT

Palliative care in Zimbabwe is poorly developed. The effectiveness of top-down initiatives has been limited by a lack of resources to build facilities and train an adequate number of specialists. Few patients have access to pain-alleviating treatment.

IN DETAIL

The government is developing a strategy for palliative care. The policy is expected to include essential features including clear goals, regular reviews and implementation mechanisms. But realities of the healthcare system are far from ideal: services are severely underfinanced and understaffed, and palliative care is poorly integrated into the wider healthcare framework. The government does not support research on the topic. No accreditation has been set up.

Educational opportunities are scarce. All medical students have mandatory courses in palliative care, although faculties have not harmonised content or testing. The few available services are regularly monitored. Lack of adequate subsidies means that most patients must pay for medications and all services, both public and private. Elderly patients have free access to



services where available. Low stocks of morphine in public facilities and limited consumption can be linked to financial barriers.

Psycho-social support is common but workers are not always adequately trained. There are no provisions for DNR. Physicians are encouraged to share diagnosis and prognosis with patients according to national ethical protocols but disclosure occurs only in a minority of cases. The public appears to be well informed thanks to a robust government campaign to spread awareness.

While every effort has been taken to verify the accuracy of this information, The Economist Intelligence Unit Ltd. cannot accept any responsibility or liability for reliance by any person on this report or any of the information, opinions or conclusions set out in this report.

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