

Editorial

Palliative Care in the Context of Public Health

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Global development and strengthening of primary access to sanitation and health treatments have facilitated world's ageing, providing both demographic and morbidity shift [1–3]. Life expectancy has increased globally, as well as the number of clinically complex patients with chronic progressive illness (cancer and non cancer), especially in low and middle income countries [4].

Although public health has traditionally been concerned with people's health at population level, focusing on the reduction of morbidity/mortality and on sanitary/ environmental reforms, the morbidity shift (from infectious diseases to chronic non transmissible illnesses) demands interventions to be conducted with people rather than on people [2].

The World Health Organization (WHO) estimates that about 20 million people annually need Palliative Care (PC) in the end of life; if people at an earlier stage of their illness are included, these estimates rises to at least 40 million [5]. Need for PC affects 377 adults out of 100.000 population over 15 years old [4]. In the end of life an enormous amount of health resources are consumed, especially in hospital setting [6]. Interestingly, economic studies suggested that these costs were lower in developed countries than in lower income countries [7].

After the 67th World Health Assembly (May 23, 2014), the debate on the impact and need for PC in public health became more evident. 1, [8]. After WHO approved a resolution recommending national health systems to provide full PC in conjunction with curative treatments, palliative care shifted from a limited medical specialty directed to terminal oncologic patients, to a more comprehensive approach, focusing generalist doctors and nurses and including patients with chronic non cancer conditions [2,4,8].

Palliative care is focused in optimizing the satisfaction, quality and meaning of life of patients (and their caregivers) that are facing life-threatening illnesses, through symptom control, psychosocial care and disease management [4,5,9].

Coverage of PC worldwide was found to be woefully inappropriate and insufficient in most regions [1,10]. Only 58% of countries are estimated to have minimum palliative care services, and less than 10% people who need PC actually receive this kind of care [5,10].

Although WHO provided a framework to assist countries in the actions required to implement national coverage and equitable PC

services across all levels of care, local difficulties and barriers may postpone the full establishment of these initiatives and related public policies [4]. One of the first steps should always be identifying barriers to and opportunities for palliative care in the community [4].

Finitude-related issues are still taboo in many African and Latin American countries. End of life in these cultures is enveloped by an aura of mysticism, faith, fear and guilt. In some of these countries, the decision on how to die and where to die can sound threatening; furthermore, advanced directives does not have legal effects in a lot of Asian, African and Latin American countries, and discuss them in early phases of life-threatening diseases may not be common for patients, families and health workers.

Societies whose culture barely discusses issues related to end of life will probably need active and joint efforts of national governments, health associations and media in order to be sensitised and invited to know and to start discussing PC issues within the community. In posterior phases, they may understand, introject, accept and apply the principles of palliative care.

Poverty and economic deprivation may also be barriers to a comprehensive and extensive discussion about the PC in some communities [4]. In low and middle-income countries, the availability of the main drugs used in PC in primary care usually is an obstacle; the resources needed to PC are often provisioned in conjunction with other public health programs, and they may not receive preferential allocation [4].

It is important to establish two different levels of services in a nationwide health system when considering a quality PC: the specialist care and the generalist palliative care approach [2,11]. Specialist PC applies to a team of trained professionals, with the expertise to deal with complex patients and situations. Generalist palliative care approach is used in settings and services that only occasionally treat PC patients. WHO has recommended a public health approach utilizing general palliative care that is delivered by primary care workers, who should be trained and counseled by palliative care specialists [4,11].

In order to strengthen general palliative care, education, training, counseling and interaction between the two previous levels of care is fundamental. Generalist palliative approach, developed by primary care workers, should focus on routine screening of symptom burden and discussing advance care planning in care trajectories [11].

Public health policies and primary care reorganization should be established in conjunction to promote universal PC coverage [8]. PC will only be accessible to all people in need when these all these steps are accomplished and available in the community [4,8].

Most evidence for PC has been produced in developed countries. There is a clear difference between effectiveness of expert PC services and individual interventions or approaches [2]. To the best of our knowledge, less evidence is available about the effectiveness of

training programs and services provided by generalists in improving care.

Recent research suggested that PC reduces emergency department demand and hospital admissions in the end of life [12], improved relationships and emotional attitudes toward death [13], and increased the rate of preference of dying at home [2,12,13]. There is good quality evidence for the impact of community engagement in end-of-life care [14].

PC interventions should be routinely subjected to economic evaluations, in order to enable comparisons between approaches and to determine the most efficient, and to better purvey the public health managers about the value for money used in PC, since PC will compete with other health care services for resources [2].

In the last 15 years a number of agendas and recommendations for priority research have been produced [1,15-17]. Although PC constitutes an expanding research field, lack of strong evidence for important topics in PC may be a direct result of insufficient research attention or methodological weaknesses in previous studies [1,17].

An interesting initiative proposed interviewing leading researchers in PC, aiming to systematically identify barriers impeding progress in PC research: [17] five barriers were identified: (1) public and professional misunderstanding of palliative care, (2) challenges related to the nature of the topic and population, (3) researcher workforce, (4) institutional capacity, and (5) funding. According to the same authors [17], combined efforts of funding agencies, policy makers and research institutions may be drawn to address the problem of limited funding, while difficulty of recruiting participants and cultural avoidance to end of life topics may not be suitable to planned interventions.

In conclusion, strategic responses in palliative care need to be based on good quality evidence and on local preferences and priorities, taking into account local regulatory environments. The unique aspects of public health care and social care provision of some countries, although perceived as barriers, should rely on the counterpart of mutual understanding by researchers teams. In the same way, economic evaluations based on cost reductions should be balanced with the reduction of futile interventions.

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