World Health Organization

WHY PALLIATIVE CARE IS AN ESSENTIAL FUNCTION OF PRIMARY HEALTH CARE

TECHNICAL SERIES
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Introduction

World Health Assembly Resolution 67.19 states that universal access to palliative care – the prevention and relief of suffering due to serious or life-threatening health problems or their treatment – is an ethical imperative: "it is the ethical duty of health care professionals to alleviate pain and suffering, whether physical, psychosocial or spiritual, irrespective of whether the disease or condition can be cured … ", and "palliative care is an ethical responsibility of health systems … " *(1)*. The Health Assembly also asserted that integration of palliative care into public health care systems is essential for achievement of Sustainable Development Goal (SDG) 3.8 (universal health coverage, UHC) and that this integration is especially important "at the primary care level". How can this ethically imperative integration be achieved? What changes are needed? And what will it cost?

What palliative care entails

WHO defines palliative care as the prevention and relief of suffering of adult and paediatric patients and their families facing the problems associated with life-threatening illness *(2)*. These problems include physical, psychological, social and spiritual suffering of patients, and psychological, social and spiritual suffering of family members. Palliative care (*3*):

- entails early identification and impeccable assessment and treatment of these problems;
- enhances quality of life, promotes dignity and comfort, and may also positively influence the course of illness;
- provides accompaniment for the patient and family throughout the course of illness;
- should be integrated with and complement prevention, early diagnosis and treatment of serious or life-limiting health problems;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life;
- provides an alternative to disease-modifying and life-sustaining treatment of questionable value near the end of life, and assists with decision-making about use of life-sustaining treatment;
- is applicable to those living with long-term physical, psychological, social or spiritual sequelae of serious or life-threatening illnesses or of their treatment;
- accompanies and supports bereaved family members after the patient's death, if needed;
- seeks to mitigate the pathogenic effects of poverty on patients and families, and seeks to protect them from suffering financial hardship due to illness or disability;
- does not intentionally hasten death, but provides whatever treatment is necessary to achieve an adequate level of comfort for the patient in the context of the patient's values;
- should be applied by health care workers at all levels of health care systems, including primary care providers, generalists and specialists in many disciplines and with various levels of palliative care training and skill, from basic to intermediate to specialist;
- encourages active involvement by communities and community members;
- should be accessible at all levels of health care systems and in patients' homes; and
- improves continuity of care and strengthens health systems.

The specific types and severity of suffering vary by geopolitical situation, socioeconomic conditions and culture. People in low- and middle-income countries (LMICs) often endure less healthy social conditions. They also typically have less access to prevention, diagnosis and treatment of health problems, to social supports and to specialized services of many kinds, than people in high-income countries. Palliative care should never be considered a substitute for prevention, diagnosis and treatment of common causes of suffering and death such as cancer, drug resistant tuberculosis (TB), cardiovascular disease or mental illness, and palliative care workers have a responsibility to advocate for these interventions wherever they are not yet accessible *(3)*. However, failure to integrate palliative care with disease prevention, diagnosis and treatment is indefensible. Planning and implementation of palliative care services must be based on assessment of the types and extent of inadequately prevented or relieved physical, psychological, social or spiritual suffering *(4,5)*.

Access to palliative care

Despite compelling evidence of a huge burden of remediable suffering, and of the effectiveness of palliative care to relieve suffering, palliative care is rarely accessible in LMICs *(6)*. Inequality of access to palliative care is one of the largest disparities in global health care *(4)*. Various barriers have impeded the development and accessibility of palliative care services. A major barrier is a misunderstanding of what constitutes palliative care; in particular, it is not always understood that palliative care is:

- not only for the dying, but for any patient suffering in association with serious or life-threatening health problems;
- not an *alternative* to disease prevention and treatment but should be integrated with them.

Additional barriers to the development and accessibility of palliative care include:

- lack of a national palliative care policy, a national palliative care strategic plan and national palliative care clinical guidelines in many countries;
- lack of basic, intermediate and specialist training programmes in palliative care;
- lack of staff positions in hospitals and primary care centres that include palliative care as an official responsibility, and that enable clinicians with appropriate training to be paid for practising palliative care;
- lack of insurance coverage for palliative home care; and
- excessive fear of opioid side-effects, addiction and diversion (opiophobia), resulting in excessively restrictive opioid prescribing regulations.

Throughout the world, but especially in LMICs, most people in need of palliative care are at home and cannot easily travel beyond their