Barriers to the Development of Palliative Care in the Countries of Central and Eastern Europe and the Commonwealth of Independent States

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Abstract
During the years of communist rule in the countries of Central and Eastern Europe (CEE) and the Commonwealth of Independent States (CIS), there were few significant palliative care developments. Since the political changes of the 1990s, however, there has been a steady development of palliative care services in this region. In 2005, the European Association for Palliative Care Task Force for the Development of Palliative Care in Europe undertook a qualitative survey among boards of national associations to identify barriers to the development of palliative care in CEE and CIS. By July 2006, 44 of 52 (85%) European countries had responded to the survey, but we report here on the specific results from 22 of 27 (81%) countries in CEE and CIS. Data were analyzed thematically by geographic region and by the degree of development of palliative care in each country. Four significant barriers to the development of palliative care were identified: 1) financial and material resources; 2) problems relating to opioid availability; 3) lack of public awareness and government recognition of palliative care as a field of specialization; and 4) lack of palliative care education and training programs. Despite huge variations in the levels of provision across the countries of CEE and the CIS, data collected in the qualitative survey reveal that the development of palliative care in many countries continues to remain uneven, uncoordinated, and poorly integrated across wider health care systems, mainly as a result of...
inadequate investment and limited palliative care service capacity. J Pain Symptom Manage 2009;37:305–315. © 2009 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.

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Palliative care, barriers, Central/Eastern Europe, Commonwealth of Independent States

Introduction
During the years of communist rule in the countries of Central and Eastern Europe (CEE) and the Commonwealth of Independent States (CIS) of Central Asia, there were few significant palliative care developments. Since the political changes of the 1990s, however, there has been a steady development of palliative care services in this region, where now only a handful of countries have no known palliative care provision. This is attributed in part to initiatives, such as the Poznan Declaration in 1998;1 the Eastern and Central European Palliative Task Force, which commenced in 1999;2 and the European Association for Palliative Care (EAPC) Centre for Palliative Care in Eastern Europe,3 which began in 2000. A vital source of financial support to these initiatives and to the successful development of palliative care programs within CEE and CIS has come from the Open Society Institute Public Health Program.4 Palliative care development in the region has also been stimulated by the Council of Europe (2003) Report on Palliative Care (Recommendation Rec 24 of the Committee of Ministers to member states on the organization of palliative care).5

Emerging research evidence has begun to highlight the current state of development of palliative care in the region. In 2003, Clark and Wright reviewed the state of development of hospice and palliative care in 28 countries of Eastern Europe and Central Asia.6 The study covered matters of service development, levels of provision, policy implications, education and training, opioid availability, and local, national, and international partnerships. This project was the first step in providing the quantitative and qualitative data needed to frame palliative care as a serious public health issue for the countries of CEE and CIS. Since 2003, however, only two comparative studies of European palliative care development have emerged, both from Germany. The first study focused on 11 European countries and was undertaken on behalf of the German parliament;7 the only country reviewed from CEE was Poland, whereas no CIS countries were included in the study. The second study focused on 16 European countries and was carried out by a team of German sociologists at the University of Giessen;8 the CEE countries of the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, and Slovakia were reviewed, as was Ukraine from the CIS.

Against this backdrop, the EAPC Task Force for the Development of Palliative Care in Europe has produced a set of country reports that document the existence of palliative care services country by country, using a common template that facilitates cross-national and regional comparison, and they have been published as a European “atlas” of palliative care.9 The country reports also have been disseminated through the web pages of the EAPC10 and through links from the web pages of other participating organizations within the task force (International Observatory on End of Life Care, International Association for Hospice and Palliative Care, and Help the Hospices).

Methods
The overall methods of the task force have been documented in detail elsewhere.11 The work of the task force has been able to produce, for the first time, comparative data on the status of palliative care development across the whole of the World Health Organization (WHO) European region, covering 52 countries and a population of 879 million people. We report here in part from a quantitative survey of key experts within each country who gathered data on the availability, organization, and delivery of palliative care. In particular, we draw on the results from a qualitative survey of national associations
undertaken to provide expert opinions and legitimate assessments of the state of palliative care in each country, showing the achievements and breakthroughs that have been made, in addition to barriers to the development of the discipline. The qualitative survey included questions relating to opportunities, strengths, and weaknesses as well as to the viewpoint of the national associations on current and forthcoming challenges. Some specific questions were related to the national health policies and the influence of the Recommendations on Palliative Care from the Council of Europe and issues relating to the availability of opioids in each country.

Results

Key experts in 44 of 52 (85%) European countries responded to the quantitative survey, while national associations in 44 of 52 (85%) European countries responded to the qualitative survey. In total, 43 European countries responded to both the quantitative and qualitative survey; one country responded to the quantitative survey only (Slovakia) and one country responded to the qualitative survey only (Tajikistan). We report here on the specific results from 22 of 27 (81%) countries in CEE and CIS. The data have been analyzed thematically by geographical region and by the degree of development of palliative care. Each country has made a specific contribution to the findings of this paper (for a list of contributors, please see the Acknowledgments section).

Table 1 draws on the quantitative survey and presents data on the level of palliative care service provision in the region in 2005.

Although the majority of respondents in the qualitative survey suggested that there had been some improvement in the development of palliative care in their country (for example, Bosnia Herzegovina), from the varied data contained within the survey, we identified four significant barriers to the development of palliative care in CEE and CIS: 1) financial and material resources; 2) problems relating to opioid availability; 3) lack of public awareness and government recognition of palliative care as a field of specialization; and 4) lack of palliative care education and training programs.

Financial and Material Resources

The lack of financial and material resources were referred to as the most significant barrier...
to the development of palliative care in both CEE and CIS. This had various causes, and was often intertwined with other issues, such as organizational and administration difficulties owing to excessive bureaucracy:

The laws have not been favourable for investment into Croatia. In 1996, the German religious order of Allexianer wanted to invest in the Hospice in Zagreb. Because of the Croatian laws, they switched to Russia. In 2000, there was new interest from Canada, again very favorable, to build the hospice, but the interest got lost because of problems with the law. (Croatia)

Others suggested that the lack of palliative care funding arose from unstable governments. For example, the absence of financial resources in Tajikistan was reported to be partially as a result of political instability:

Following the disintegration of the USSR and civil war in Tajikistan, there was a disorder of the state system of rendering free-of-charge medical aid for patients, including rendering of palliative care to incurable patients. According to the World Bank, the state pays only 13% of charges on health care. (Tajikistan)

This related in turn to a succession of changes in personnel in relevant government departments:

The most important problem is the instability of leadership. We had in four years four ministers of health, every one making, more or less extensive, personal and program changes. (Croatia)

In some countries, a wide range of pressing social problems (relating to unemployment, poverty, homelessness, war, and the plight of refugees) meant that palliative care was a low priority for attention. For example, in Serbia and Montenegro:

Due to [a] large number of refugees, invalids and homeless people, we could not pay sufficient attention to palliative care development...The political and economic situation in the course of the past 15 years didn’t make it possible for us to calmly, as a society on the whole, recognize the problems of patients and make an effort to solve them in the best possible way. (Serbia and Montenegro)

A number of respondents reported that a lack of finance often made it impossible to either start or maintain palliative care programs (especially inpatient units). Financial restrictions in Kazakhstan resulted in the absence of a state program for palliative care development, whereas in the Russian Federation, state funding was limited, and there was little capacity to raise extra resources from other sources, such as philanthropy or development programs:

...insufficient funding, with the state budget as the only source merely covering only the very basic hospice needs and not allowing for many others, including computerisation, training for the staff, visits to conferences etc... The budget financing is insufficient and rigidly structured, providing for certain necessities and not providing at all for many others, whereas the status of a governmental organisation greatly impedes attracting any additional funding by the hospices themselves. (Russian Federation)

A number of respondents suggested that although palliative care was developing within their country, and had improved in recent times, there was still much work to be done, as services were often unevenly spread. The inability to provide comprehensive coverage was perceived as a barrier to the development of the discipline in Albania, while in the Czech Republic:

...quality care for the dying exists but it is available to a very small proportion of citizens only...Specialized, modern palliative care in hospices is available to only 1% of all the terminally ill and dying. (Czech Republic)

Similar problems in relation to the distribution of palliative care were being experienced in Poland, where it was reported that there were still many areas that did not have any access to services:

It may be assumed overall that on a national scale palliative/hospice care is being given to approximately 50% of all cases...in certain provinces, the distribution of palliative/hospice care is patchy. In 6 provinces
there are alarmingly large blank spots, administrative districts deprived of home care or with fewer residential hospices. (Poland)

The absence of state support in Armenia was reported to severely affect the ability to provide “necessary and appropriate” palliative care coverage, with the need for a wider range of program being of paramount importance:

Being a country with limited resources, Armenia is unable to organize a system of inpatient services for patients in need of pain management and palliative care, as well as to open hospices in all the regions of the country...At present, about 1,500 patients need daily palliative care and pain management services, but only 30 to 40% of them can obtain it. (Armenia)

In the Russian Federation, palliative care development was occurring spasmodically across the country, rather than according to any specific strategy, and this often resulted in large areas with little coverage; the absence of a strong national association for palliative care was seen as a related impediment:

Russia being a vast country, palliative care is developed very unevenly throughout its territory, greatly depending on the means of the region and the understanding and goodwill of its officials. The lack of a strong and effective co-ordination centre, uniting the hospices and palliative care providers in the country, giving necessary support and advocating for their needs with the authorities of all levels, is deeply felt by many. (Russian Federation)

A number of respondents mentioned the way in which lack of funding had affected specific palliative care services, such as home-based palliative care (Republic of Moldova, the Czech Republic, and Croatia). In Poland, the special problems of pediatric and geriatric palliative care were highlighted:

As regards home care, the criterion has been only partially fulfilled. In most provinces, it is present in between 70% and 80% of administrative districts, which means that in these provinces, 20% to 30% of districts do not have any home care team, which creates so called blank spots...[relating to children] a marked tendency has appeared in the Polish hospice-palliative movement to “hive off” care to paediatricians and to work on methods of treatment and care on the basis of paediatric departments or home care with the participation of a pediatrician...optimum conditions [need to be created] for the development of geriatric palliative care, conditions which at present we do not have...50% of terminally ill patients are over the age of 65. Too little attention is paid to this. (Poland)

Some respondents were more optimistic, however, about their ability to improve the accessibility of palliative care services in the future:

The main aim is to spread the hospice/palliative care in those regions of the country where there is no hospice team now. They should take care of about 50% of cancer patients in 10 years. (Hungary)

Problems Relating to Opioid Availability

A second set of problems identified by the survey related to the lack of availability and choice of opioids. Inadequate regulatory and government systems as an impediment to opioid availability were reported from a number of countries: a lack of state policy on drug availability in Georgia; a lack of normative documents on the use of drugs in palliative care in Belarus; and an absence of Ministry of Health rules relating to the registration and application of opioids in the Republic of Moldova. A vivid picture emerged from Bulgaria:

Strong opioids are supplied only by the Ministry of Health but some bureaucratic obstacles make the supplies irregular...The strict requirements from the police authorities for the pharmacies selling strong opioids, the high price for the license for selling such drugs and the risk from burglars are the reasons for the unwillingness of the biggest part of the local pharmacies not to sell such drugs. (Bulgaria)

In Belarus and Kazakhstan, there appear to be complicated procedures relating to the prescribing of opioids, and it was reported to be very difficult to obtain a license to prescribe such drugs. Further difficulties relating to the prescription of opioids were reported from
Croatia, Latvia, and Poland. Similarly, in the Russian Federation, there was:

...strict and rigid regulation on strong opioids, very close control of their use involving a lot of police requirements for their handling and much paperwork for those who prescribe them [along with] bureaucratic difficulties when introducing any new forms of opioids into palliative care practice. (Russian Federation)

Another barrier to the development of palliative care relating to opioids was the prohibitive cost and the lack of available funding streams (Serbia and Montenegro; Russian Federation). The cost of opioids was reported to be very high in Armenia and Kazakhstan as they are not produced in these countries, and it is difficult to import them owing to government restriction. The prohibitive cost of opioids in relation to the earning capacity of the patient was described by the respondent from Bulgaria:

The high price of the drugs compared with the incomes of the patients: for example, morphine SR 60 mg/60tabl costs 248.95lev (127.66 Euro). Officially, the minimal monthly income is 125lev (63 Euro per month). (Bulgaria)

A number of respondents also detailed the stigmatizing and taboo status of opioid use as a further barrier to the development of palliative care in their country. In Hungary and Slovenia, respondents referred to the fears expressed about tolerance and side effects of opioids by physicians, patients, and their families. False beliefs about opioids were said to be rife in Albania, where there is a long-standing perception that the use of morphine leads inevitably to the death of the patient. In Serbia and Montenegro, myths about the dangers of opioid addiction had been prevalent for many years:

Opiophobia of health care professionals and policy makers as well as patients and their families...is the result of earlier established strong prejudices towards opioids. (Serbia and Montenegro)

A barrier to the development of palliative care in Georgia was the "opioid mentality," both among health care professionals and in the wider community, where there were close associations between the use of opioids in palliative care and the psychological or physical problems of drug addiction. Similarly, in Belarus, there was a lack of information about the main effects of morphine, which fuels the negative stereotype that strong opioids result inevitably in dependence. In Latvia, lack of education about the use of opioids among medical staff and in society in general was a potential barrier to the development of palliative care, and in the Republic of Macedonia, there was a reported reluctance on the part of doctors to prescribe the necessary doses of opioids to terminally ill patients. In the Czech Republic, it was suggested that the main barrier is the lack of information available to general practitioners (GPs) about the use of opioids, combined with their fear of prescribing:

Large numbers of the dying suffer from inadequately controlled pain and from other physical symptoms, though modern medicine can effectively treat most such problems...
The only barrier is the hesitation and lack of information about using opioids in pain therapy among GPs. They are mostly very afraid about it and do not know how to use it in pain management. (Czech Republic)

A lack of choice among different opioids was reported from Albania, Georgia, the Republic of Macedonia, and Tajikistan. A similar story emerged from the Ukraine:

Immediate and slow release oral morphine and similar forms are not accessible in our country...Codeine and transdermal fentanyl are not available. (Ukraine)

**Lack of Public Awareness and Government Recognition of Palliative Care as a Field of Specialization**

Across the region, a number of respondents reported that the general public was not well informed about palliative care. For example, there was a lack of public awareness about issues of palliative care in Romania, and also in Georgia where:

...palliative care is a new sphere for our country. So, public awareness is rather at a low level. It is necessary to inform people
on the advantages that palliative care provides to incurable patients and their family members. (Georgia)

It was suggested that a lack of public awareness in the Russian Federation is connected to long-standing public prejudice about hospices in the country:

[There is] still poor information, understanding and support in the [wider] society. Even in St. Petersburg and Moscow, families and patients often are not aware that any terminal cancer patient is entitled to hospice care, which is free of charge...Still lots of prejudice exists, though hospices have long stopped being considered “houses of death” as it has been in the beginning. Very little voluntary work for hospices is done in communities, and this is mostly by members of religious sisterhoods. (Russian Federation)

Even in countries where the public had developed an awareness of palliative care, problems of public perception remained. A respondent from the Czech Republic reported on the results of a local study:

The public is unhappy with the current state of care for the dying. Even the best evaluated area of care (treatment of pain) was judged [in our survey] as “good” by 7% of respondents only, and as “rather good” by 29%. There is an alarming discrepancy between preferences of the public and the actual status of care provided for the terminally ill and dying in our country: approximately 75% of all deaths occur in health care or social care facilities (hospitals, nursing homes, retirement homes), yet 80% of those who responded to this question would not want to die in these institutions...The most critical in their evaluation of care for the dying are those who have most experience with it, i.e., health care providers and social workers. And especially those who provide care for the dying most frequently (oncologists, workers in nursing homes, retirement homes and hospices). (Czech Republic)

Another frequently reported problem was that lack of awareness resulted in a relatively small number of well-informed “activists” for palliative care in countries such as Croatia, and also Slovenia where there are:

...insufficient numbers of palliative care experts, willing to work in palliative care as care providers and as palliative care teachers. (Slovenia)

The lack of public awareness relating to palliative care and the failure on the part of government and the health professions to recognize the discipline as a medical or nursing specialty was summarized by the respondent from Ukraine:

...one of the biggest obstacles for developing the hospice system in Ukraine is the very low level of public...awareness of palliative care. Sources of information about hospices are limited. The general public simply knows nothing about it or does not believe that it could be implemented...The ongoing economic crisis is a big problem for developing hospice care in Ukraine, especially if it comprises implementation of a hospice network “from the top” that is only by government authorities...there is no certain government program for the development of palliative care in Ukraine...Government supports the idea of palliative care, but it is still not developed in our country and there is a lack of legal basis for successful implementation of hospice services...a few professionals know about the existence of hospices in other countries. Others easily admit hospice principles or have similar ideas...[yet] there is a considerable group of doctors, even among oncologists, who suppose the term “palliative care” means “non-radical treatment” and comprises only non-radical surgery and complex active supportive therapy. But they don’t know about established palliative care schemes of pain control and using oral forms of opioids, etc. (Ukraine)

Palliative care lacks recognition among medical personnel in Estonia, whereas the negative attitudes of many health professionals in Russia continue to delay further development of hospice care, and compounds a sense of isolation from the international hospice movement. A lack of political commitment to the concept of palliative care was reported in Belarus:

...we will have a slow pace of hospice movement, until palliative care is recognized at
the governmental level. Without conceptual machinery we move from the bottom to the top. And in this case [our] palliative care service could not correspond to world standards. That is why we extremely need that government recognises palliative care as a branch of the public health service. (Belarus)

Lack of government recognition was also reported to exist in Georgia, where palliative care had still to be fully embraced into the health care system:

It is very important that the development of palliative care is supported by the governmental structures...Government support for the development of palliative care was really very important not only from the point of financing, but also recognition of palliative care as an integral part of the health care system. (Georgia)

There was a reported lack of government interest in the idea of palliative care in Lithuania and a failure to acknowledge the importance of the discipline as a medical specialty in Serbia and Montenegro:

Palliative care has not been recognized as a specific discipline by the health care professionals and policy makers. (Serbia and Montenegro)

A further barrier to the development of palliative care relates to its position within a biomedical worldview and the tendency of mainstream health services to focus on “curing” disease rather than “caring” for patients. This was highlighted in Hungary and in this extract from the Bulgarian respondent:

The medical society is still targeting their efforts towards disease treatment at any cost, still neglecting patients’ quality of life and thus palliative care. (Bulgaria)

The medical model was perceived as dominant according to most respondents in the survey, and was often seen to take priority over care for the dying patient, as emphasized in this quotation from Serbia and Montenegro:

...doctors are disease-oriented, focused on curing the disease, instead of being patient- and quality of life-oriented. (Serbia and Montenegro)

The lack of government recognition of palliative care as a medical specialty often coincided with a lack of national standards to regulate and determine palliative care planning and development. For example, there was reported to be a lack of palliative care legislation in Tajikistan and Lithuania, where there are no basic documents to regulate and determine the provision of palliative care; no classification of palliative care standards at the national level exist in Slovenia or Armenia; and there is no national policy or strategy concerning palliative care development in Serbia and Montenegro or the Republic of Macedonia. Policy and reform changes had a negative influence on the development of palliative care services in the Republic of Moldova, while in Russia there was an:

...absence of developed standards and federal norms regulating the work of hospices and palliative care practice. The regulations initially adopted have become outdated and need serious modification. It is however vital that the new standards are developed not by bureaucrats but by reputed hospice practitioners who know the needs of palliative care in Russia. (Russian Federation)

Lack of coordination was perceived to be a barrier to the development of palliative care in countries where the principle of team work and collaboration in multidisciplinary teams is not yet recognized as good practice. The inability to deliver an integrated palliative care service was reported in Slovenia and also in Serbia and Montenegro where:

...there is no cooperation between health care and social care sectors [that is] necessary for good palliative care. (Serbia and Montenegro)

Insufficient planning also made it difficult to deliver homogeneous standards of palliative care in the Czech Republic, largely owing to the fact that a number of different bodies are responsible for specific palliative care services:

Continuity and coordination of care for the dying are frequently poor. In the last weeks of their lives patients are frequently being
transferred between various health care facilities. (Czech Republic)

Finally, there was no monitoring and evaluation of palliative care services in many of the countries taking part in the survey:

No institution in the Czech Republic currently monitors the quality of care for the dying...No criteria for this (palliative) care have yet been developed. (Czech Republic)

Lack of Palliative Care Education and Training Programs

A further barrier to the development of palliative care in CEE and CIS relates to a lack of education and training opportunities. In the Czech Republic, specific concerns were expressed about the training of doctors in communication skills:

Communication between physicians and patients regarding diagnosis and prognosis varies and is generally inadequate...90% of young physicians interviewed feel that they are not trained to communicate with the terminally ill and their families. (Czech Republic)

There were reports of insufficient palliative care education programs in Latvia and a lack of education about palliative care for patients and their families in the Republic of Macedonia. In Croatia, the need for public education at all levels relating to palliative care was emphasized, while in some of the countries in the survey, there was no palliative care education of any kind:

There exists no education in the field and this subject has not become a part of medical schools’ curricula. (Serbia and Montenegro)

Shortages of skilled palliative care staff owing to lack of education and training were reported to be affecting the delivery of palliative care in a number of countries. For example, insufficient funding resulted in a lack of skilled/qualified palliative care staff in Belarus, Georgia, Hungary, and the Republic of Moldova. This was also the case in Latvia where difficulties were reported in recruiting doctors, nurses, and allied health care professionals with specialist palliative care training:

Complicated work conditions, lack of experience, and inadequate salaries make medical people avoid this field of care. (Latvia)

Palliative care services without professional certification for physicians and nurses were often perceived by respondents as not being able to guarantee the best quality of care for patients. Inadequate training of doctors in standards of palliative care was reported from Albania and Bulgaria, while inconsistencies in the training of health professionals were also reported in Poland:

The training of postgraduate students in the faculties, which train doctors and nurses, follows very varied patterns in different teaching establishments and depends on decisions taken autonomously by the authorities of each institution. (Poland)

In Ukraine, it was reported that there was too little focus on palliative care within general medical education; palliative care was not integrated into the obligatory syllabus for medical or nursing students, or other allied professions:

...there are no special courses on palliative care for nurses, physicians and social workers on a regular basis...The existing under- and post-graduate nurse and doctor education doesn’t include a palliative care course. That is why, unfortunately, there are no specialists in palliative care and other health professionals that can provide elements of palliative care in their departments. (Ukraine)

Insufficient funding in Croatia had caused a number of postgraduate studies to be cancelled, with similar problems relating to the funding of palliative care education and training occurring in Poland:

Since 2003, when financial difficulties in our country started, postgraduate training is [only] possible through the support of private sponsors and pharmaceutical companies. The Ministry of Health is only partially financing training for physicians specializing in palliative medicine. (Poland)

Lack of finance for palliative care training and education at medical colleges and universities was also reported from Kazakhstan:

Currently we as Pavlodar hospice representatives and our Almaty colleagues...developed and introduced a palliative training program for medical students. We are developing a similar program, but due to the lack
of financing, its development and introduction have been very much prolonged... At the moment we are planning a seminar for doctors, hospice managers, and Public Health Ministry officers. It will include common issues of hospice organizing and palliative psychotherapy. A.V. Gnezdilov, a leading Russian specialist in the palliative sphere, has agreed to carry out the seminar, but currently we are concerned with the problem of financing it. (Kazakhstan)

Discussion

Despite huge variations in the levels of provision across many countries, data collected in the qualitative survey reveal many common barriers to development in CEE and CIS. A lack of financial and material resources resulting from bureaucratic government systems or political instability was referred to as the most significant barrier to the development of palliative care across the region. Many respondents highlighted organizational and administration difficulties owing to excessive bureaucracy, and a number of them saw the lack of funding in palliative care as a product of unstable governments within the context of wider social transitions from communism to free market democracies. Inadequate investment in palliative care services had a number of different implications in the countries concerned, including what were seen as constant changes to health ministry personnel, an inability to initiate and to maintain palliative care programs, and an uneven spread of palliative care services that often resulted in a lack of comprehensive coverage.

Another major barrier to the development of palliative care in CEE and CIS was the lack of opioid availability, seen as a product of restrictive procedures and practices, prohibitive cost, and negative cultural stereotypes held by health care professionals and members of the community in relation to the stigmatizing and taboo status of “drug addiction.” A lack of awareness about palliative care on the part of the general public and other health professionals was perceived to be a further barrier to the development of the field, as was the failure to recognize palliative care as a field of specialization, or to downplay its value in relation to a more overtly disease-oriented model of “cure” rather than patient-oriented “care.” Other reported barriers to development included a lack of coordination and integration of palliative care across health care settings and services owing to poor national standards to regulate and determine palliative care planning and development, and a shortage of qualified palliative care staff resulting from a lack of education and training programs. In sum, the findings from the qualitative survey suggest that the development of palliative care in many countries within CEE and the CIS continues to remain uneven, uncoordinated, and poorly integrated across wider health care systems, mainly as a result of inadequate investment and limited palliative care service capacity.

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References


