Palliative Care in Romania
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Abstract
HOSPICE Casa Sperantei has been pioneering palliative care development in Romania since 1992. They have developed specialist palliative care services in home-based settings, inpatient units, day care centers, and as hospital support teams. They have provided national and international education programs for professionals in the palliative care field, as well as promoting palliative care integration in the health care system. Legislative improvements were adopted, including funding mechanisms for the reimbursement of palliative care services through the health insurance funds, review of opioid policy, and quality standards of care. By the end of 2015, Romania had 115 specialist palliative care services (78 palliative care inpatient units, 24 home-based palliative care services, five outpatient palliative care clinics, four day care centers, and four hospital support teams). A palliative care subspecialty for doctors was recognized as early as 2000, and a multidisciplinary master’s degree program has been available at Transilvania University since 2010, when the first palliative care academic position was established. Nursing education includes mandatory palliative care modules in nursing schools. For coordinated development of palliative care at the national level, a national strategy was proposed defining three levels of palliative care provision, local, district, and national. The implementation of the palliative care strategy is partially funded through a World Bank loan.

Key Words
Palliative care, opioids, palliative care education, palliative care costing, World Bank, Romania

Background
Romanian Health Care System: Cultural and Societal Considerations
Worldwide, the number of deaths from cancer and other life-limiting illnesses is rising. In Romania, using an epidemiologically based estimation method, 150,000 persons are annually in need of palliative care. As a consequence, a growing number of people experience multiple and complex symptoms toward the end of life and require care over extended periods. According to a national survey, 18% patients identified with life-limiting illnesses were home-bound and relied on family members for care for up to six months, 18.4% for up to a year, 21.2% for up to three years, and 21.6% for over three years. Taking into account economic factors, population aging, and critical shortages in human resources, it is unlikely that the need for palliative and end-of-life care in the population can be born entirely by professional care. At the end of 2012, around 6% of Romanian patients in need did have access to palliative care specialized services. As a result, increasing demand is put on family caregivers of people at the end of life, as highlighted in the national survey, where 76.5% of families were left alone at home to deal with a patient in an advanced stage of disease.

Eighty two percent of people die in Romania at home and there is a prevailing wish among people to die at home. Patients’ ability to be cared for and to die at home, however, is heavily dependent on the family caregivers. Even when patients receive home care services, the likelihood of dying at home is dramatically reduced if family caregivers are unable to provide care. These data have been confirmed by a small study in Romania, where patients who preferred dying at home ended up in hospitals if the family was unable to provide care at home, because of fears concerning death or their inability to insure the daily physical care to a bedbound patient. Family caregivers have many functions...
including, but not limited to, domestic chores and household tasks, providing personal care and assisting the dying person with activities of daily living, managing symptoms such as pain and constipation, providing emotional and social support to the dying person, being a spokesperson, advocate and proxy decision maker, and coordinating all aspects of the dying person’s care.11

Although normally willingly undertaken,12 caregiving at the end of life entails considerable cost for family caregivers and the wider family, incurring emotional, social, physical, and financial costs.13,14 The toll of care extends even into bereavement; people who are at least somewhat distressed by care giving are 63% more likely to die within the four years following the patient’s death than those who were not distressed or those who were bereaved but did not provide care.15

The costing studies on palliative care performed in Romania have taken the perspective of the costs from the point of view of the health care system,16 and they have not looked at the financial impact of care for family members and the costs that the family members and patients have to pay at the end of life.

Health status in Romania is poor compared with the other European countries. Romania is spending only around 5.5% of Gross Domestic Product on health care (2008).17 Public health expenditure composes 81% of the total health expenditure, leaving 19% for private health expenses.

The Health Care System in Romania is a decentralized and pluralistic social health insurance system (administrated and regulated by the National Health Insurance Fund) with contractual relationships between purchasers, the health insurance funds, and health care providers. Public health funds are pooled from the compulsory health insurance payments paid in even shares by the insured and the employer, according to the Law of Social Health Insurance, introduced in 1998.18 Most primary care services are available free of charge, but there is a list of services provided by family doctors and/or general practitioners (GPs) that are to be paid for by patients. There are co-payments for medications prescribed by the family doctors and/or GPs. Regulations define the lists of medicines that are completely or partially subsidized by the government, with the established amount of the co-payment for the defined pharmaceuticals and medical interventions. More specifically, List A contains medicines with a 10% co-payment; List B presents medicines with 50% co-payment; and Lists C1 and C2 present medicines with 0% co-payment. The latter consists of drugs for cancers, diabetes, certain cardiac and liver diseases, HIV/AIDS, and drugs administered during organ transplantation. These lists are agreed by the Ministry of Health and the National House of Health Insurances.19,20

The following opioids are available in Romania for palliative care inpatient and patients at home: tramadol—tablets, parenteral form, oral solution, and suppositories; codeine—tablets; dihydrocodeine—long acting tablets; morphine—immediate and slow release tablets and parenteral forms; methadone—tablets; oxycodone—slow release tablets; fentanyl—patches, tablets, and parenteral form; and hydromorphone—parenteral form. They can be prescribed by all doctors and there is no maximum dose imposed by the law. A prescription can be written for the amount needed for maximum 30 days, and up to three opioids can be prescribed simultaneously.

HOSPICE Casa Sperantei—Reference Service for the Palliative Care Movement in Romania

Palliative care services started in the non-governmental sector in 1992 with the initiative of HOSPICE Casa Sperantei Foundation, a charitable organization founded in Brasov. At present, it is a large organization, with over 250 employees and over 350 volunteers. Its mission is to provide and promote palliative care services for patients with cancer and other chronic progressive diseases in Romania and in the region. The services offered are free of charge to eligible patients and their families and aim to ensure good quality of life by relieving suffering. The geographic area of clinical services provided by the HOSPICE Casa Sperantei covers the Brasov County and Bucharest; the coverage area for the education programs is Romania and Eastern Europe.

HOSPICE Casa Sperantei provides the following services:

Specialist Clinical Services

1. Home-based palliative care for adults with cancer and children with life-limiting diseases in the Braiov County and in Bucharest. The team provides control of pain and other symptoms, psychosocial emotional support, and counseling for patients and their families. The total number of referrals to the hospice services increased in 2015, in Brasov (87.5 average monthly number of new referrals) and Bucharest (average 48). The average number of current patients increased in 2015 by 8.75%. Most patients receive care in their homes, with an average number of current patients in Brasov of 140–150 adults and 90–100 children seen in the home-care services, 70–80 adults and children in the rural areas of the Brasov county (Fagaras and Zarnesti) and about 110 in Bucharest.

2. Inpatient unit for adults and children in Brasov, with four adult wards (13 beds) and two children’s wards (six beds). In 2015, the Bucharest Hospice Unit with 23 beds opened. Patients are admitted...
for limited periods (10–14 days) for symptom control, treatment, terminal, or respite care.

3. Outpatient clinics for palliative care in Brasov and Bucharest, currently the only such service in Romania. The clinic provides ambulatory treatment and monitoring consultations for patients with cancer and other life-limiting conditions.

4. Day centers for adults and children with incurable diseases who are in a stable phase of their diseases in Brasov and Bucharest. The centers offer occupational therapy, physiotherapy, psycho-emotional support, social support, and respite care for the families.

The interdisciplinary teams consist of professionals trained in palliative care: doctors, nurses, social workers, occupational therapists, psychologists, therapists, pharmacists, clergy, and administrative staff. Each year, the Hospice assists over 2000 new patients in Brasov and Bucharest.

**Education Programs in the Field of Palliative Care**

To promote and improve accessibility of palliative care services in Romania, HOSPICE Casa Sperantei has developed national post-graduate educational programs for professionals. The courses are accredited by the College of Physicians, Order of Nurses in Romania, and the 18 month palliative care subspecialty course is certified by the Ministry of Health. HOSPICE Casa Sperantei contributed to setting up the first master’s degree program in palliative care at the Transylvania University in Brasov. The same medical university established the first palliative care chair in Romania in cooperation with HCS. HOSPICE Casa Sperantei educated 131 national palliative care trainers and mentors and continues to work with them. Between 1997 and 2013, over 19,000 professionals attended the courses (doctors, nurses, social workers, psychologists, therapists, clergy, managers, etc.). Ten online courses on intermediate or advanced palliative care (Level B) are available for doctors who cannot attend face-to-face training. Organizational courses help new palliative care services in starting up their activity. A training platform with videos and brochures targeted to patients and families is available on the HCS Web site.

HOSPICE Casa Sperantei has been one of the four educational centers in the European Palliative Care Academy since 2012. The academy’s goal is to develop future European palliative care leaders. HCS has also been recognized as a Center of Excellence in Nursing since 2014, with 1209 nurses trained in the first two years.

**Advancement of Palliative Care at the National and International Level**

HCS is actively advocating for the advancement of palliative care in Romania and internationally, with:

- organizational and professional support and technical assistance for those interested in setting up palliative care services;
- the development of pilot programs such as the basic palliative care for GPs in four counties;
- legislative improvements to integrate palliative care into national health care systems;
- cooperation with the national authorities (Ministry of Health, National House of Health Insurances, etc.) to develop a national program for palliative care;
- cooperation with authorities to improve funding mechanisms for palliative care;
- technical assistance and guidance on an international level for leadership and palliative care program development in Romania, Moldova, Ukraine, Serbia, Greece, Albania, Ukraine, Russia, Macedonia, Georgia, Armenia, Kyrgyzstan, Uzbekistan, and Kazakhstan.

In 2003, HOSPICE Casa Sperantei was described as a Beacon Centre of Excellence in Eastern Europe, following a study of 475 service providers in 28 countries in Eastern Europe and Central Asia. As mentioned, HCS is part of the European Palliative Care Academy and one of the seven models of palliative care development in countries with limited resources.

**Palliative Care Development in the Country**

**Palliative Care Services**

At the end of 2015, there were 115 specialized palliative care services in the governmental, NGO and for profit health care sectors, distributed as follows:

- 78 palliative care inpatient units (77 receiving funding through the National Insurance Fund),
- 24 palliative care home care services (four receiving funding through the National Insurance Fund),
- five palliative care outpatient services (funded through projects and private initiatives),
- four palliative care day centers (funded through projects and private initiatives),
- four palliative care mobile hospital teams (funded through projects and private initiatives).

Most providers have adults with cancer in their care, with few services focusing on dementia, heart failure, chronic obstructive pulmonary disease, or children. Distribution of services in the country is uneven, 15 counties have no palliative care services (as presented in Fig. 1), with the color of the county representing the estimated annual number of patients in need of palliative care. The yellow text box provides the number of inpatient units and the number of palliative care beds per county that are funded from public money. The white number illustrates home care services funded from public money.
Level C: Specialized Palliative Care. At present, palliative care is recognized as a subspecialty with 408 doctors who have successfully completed the 18 month national training in palliative care, delivered by HOSPICE Casa Sperantei under the umbrella of the Ministry of Health. Over 60% of the doctors who participated in the training work part-time or full-time in palliative care services. There are still counties who have no trained palliative care physician.

At the University of Transylvania—Faculty of Medicine in Brasov, a multi-professional Master’s Program in Clinical Care and Leadership in Palliative Care has been offered since 2010, with 21 students funded by the Ministry of Education and Research and up to 19 students paying for themselves. It is a two-year master’s program; and to graduate, the participants need to complete a research project in palliative care. Table 1 shows the number of students enrolled in each year.

Doctors wishing to work in specialized palliative care services must graduate from one of these two previously mentioned trainings.

Level B: Basic Palliative Care. After a three-year pilot project entitled “Overcoming disparities in the access to quality basic palliative care in the community,” HOSPICE Casa Sperantei developed in partnership with the Cantonal Hospital of St. Gallen, a model for basic palliative care for cancer patients in the community that includes a training program for basic palliative care. A total of 168 GPs completed the program and there is a proposal for a new curriculum to generate a certificate in basic palliative care waiting for approval at the Ministry of Health.

Fig. 2 shows the distribution of doctors trained in palliative care (yellow dots) versus the need of specialist palliative care doctors (red dots), the number of GPs in each county, and number of doctors from other specialties.

New initiatives are interested in developing a palliative care module for the specialty training of oncologists according to the ESMO recommendations as well as for the training of the future GPs.

Continuous medical education is available for doctors of all clinical specialties as face-to-face training or online courses.

Level A—Palliative Care Approach. Academic education is slowly developing with only two universities (Brasov and Iasi) having teaching faculty dedicated to palliative care since 2010.
Nurses. In Central and Eastern Europe, nursing is progressively shifting to an autonomous profession, with clear, independent interventions, and a distinct field of research. There are different palliative care nursing curricula for basic and advanced levels of education in different countries in Eastern Europe.32,33

As a reference educational center for palliative care in Central and Eastern Europe, HOSPICE Casa Sperantei developed the nursing team’s capacity to provide education nationally and internationally, and to have an ongoing influence in the field of palliative care and other disciplines, including oncology, neurology, psychiatry, geriatrics, pediatrics, etc., where palliative care interventions are needed. Nursing education in Romania has developed on three levels based on the European Association for Palliative Care recommendation:

**Level C—Specialist Palliative Care.** Nurses must have their unique contribution to the care of patients recognized. Performance evaluations should take place periodically to address continuing medical education needs, professional development, and career paths.34 The nurses working in specialist palliative care services need additional education in the following areas: patient and family communication, pain and symptom assessment and management, ethical aspects of end-of-life care,35 and managing difficult situations.36

There is no specialty training for nurses working in palliative care, but the Romanian Order of Nurses has proposed a list of specialties to the Ministry of Health, among them palliative care. This progress follows extensive advocacy with concrete policy amendments, including the integration of a palliative care nurse specialist program in the medium- and long-term national goals for educational programs by the professional national organization of nurses in 2015.37

**Level B—Intermediate/Advanced Palliative Care.** Over 200 nurses receive palliative care education in postgraduate programs annually. The training materials are adapted from the American College of Nursing’s End of Life Nursing Education Consortium.38

**Level A—Basic Palliative Care.** In the nursing technical schools in Romania, 24 theoretical hours and 96 clinical hours in a specialized palliative care service are mandatory.39 In the training of nursing students in universities, there is no general standard; each university has the autonomy to decide about the inclusion of palliative care either as a distinct module or some sessions or not at all.

To provide a unified curriculum with training materials, the “Trainers Manual in Palliative Care—a Guide for Nursing Teachers in Nursing Technical Schools or Medical Faculties,” was developed.40 The manual has been translated into Armenian, Georgian, Kazak, Russian, Tajik, and Ukrainian, and is available free of charge. In 2011, 2014, 2015, and 2016, four train-of-trainer courses were held for trainers in the nursing technical schools or medical faculties and certified nursing trainers to deliver continuing palliative care education for nurses.
Social Worker and Allied Professionals. The social worker is an important member of the multidisciplinary palliative care team, especially in countries where low income and changing demographics are important issues. To meet the learning and developmental needs of the specialists in the field of social work, Asociatia Lumina from Bacau41 has been implementing a project called “Palliative care—integrated measures for social inclusion.” The project was developed between April 2015 and November 2016, in partnership with General Directorate of Social Assistance and Child Protection Bacau. It aims to increase access to palliative care services for children and young people, vulnerable to social and economic exclusion and in need of palliative care.

The project has three components:

- Integrated training program (courses, job shadowing, and coaching) for 500 specialists: social workers, psychologists, kinetotherapists. There were more than 800 applications for the courses, which is a positive sign for the trend and the need for palliative care knowledge by social workers.
- Information campaign and “Open gates” events with the aim to increase information regarding palliative care for 500 students (nurses, social workers, physiotherapists, occupational therapists) and future specialists.
- A new work methodology is a tool that social workers and the staff in the social work field on the national level will use in their daily work. The methodology is the first of its kind in Romania. It has been tested in 12 General Directorate of Social Assistance and Child Protection programs and is intended to become a national tool for social workers.

Development of a National Program for Volunteering in Palliative Care Services. Volunteers have a unique position in palliative care, by offering informal and formal support (as members of the team). In Romania, volunteering is a new concept and the few volunteers in palliative care are mainly involved in administrative activities.

Between 2014 and 2016, HOSPICE Casa Sperantei and its partners Hospice Emanuel from Oradea and Lumina Association from Bacau, with support from a Polish expert, led a project to develop volunteering on the national level by creating a network of volunteer coordinators and by recruiting and training informal local leaders and clinical volunteers for palliative care services in 40 communities.

An expert group of seven members was set up to develop the curriculum for the volunteer coordinators (with 68 hours: 48 hours of face-to-face training and 20 hours of individual study) and to define the portrait of the volunteer in a palliative care service. As a result of the project, 45 volunteer coordinators were recruited and trained throughout the country, 306 citizens and 311 informal local leaders whose role it is to promote the principles of volunteering in palliative care in the community and to attract new volunteers were informed and trained, 345 new volunteers were recruited in 19 communities and a national network of palliative care volunteer coordinators was created.

Besides the “Management of Volunteers in Palliative Care Services” Handbook,42 the first of this type in Romania, 15 other types of booklets were printed, designed to help the volunteers who choose to be directly involved in patients care (clinical, counseling, information for patients and families). Also, a video was created to raise awareness of the importance of volunteering in palliative care.43

Funding of Palliative Care Services

There are funding mechanisms in place for palliative care in inpatient units and home-based palliative care services. In 2010, the cost for care in an inpatient unit was 325 Ron per day (approximately $82 USD) and 101 Ron (approximately $25 USD) for a specialist home-care visit.16 The insurance system is partially reimbursing these costs—235 Ron per day for each admission day and 60 Ron per home visit. The funding system for home-based palliative care services is very cumbersome; patients need to request palliative care and get approval at the district level; therefore, few providers are offering such services, although these are the most sought after services by patients.

There is some funding provided for the day care centers through the Ministry of Labor, at 125 Ron per month (approximately $32 USD),43,44 and no funding for outpatient or mobile hospital teams.

For basic palliative care provided by GPs for cancer patients, the average cost is 70 Ron per visit (approximately $18 USD).

Romanian Palliative Care Strategy

In 2010, the National Palliative Care Association together with the Ministry of Health and international experts developed the Romanian Palliative Care Strategy. According to the strategy, the provision of palliative care services can be thought of on three geographically defined levels: local, regional, and national. The types of services that can be provided at these levels—basic, specialized, and developmental (including education and research) are presented in Table 2 and are detailed below.

A range of basic palliative care services should be provided at the local level to those people who have relatively simple, straightforward palliative care
The first aim is to provide as much palliative care as possible in the person’s home locality (when this is appropriate), whether this is in their home or a community location, be it one of the 6000+ dispensaries, GPs’ offices, or hospital outpatient departments, considering the person’s preferences and those of their family caregivers. To the greatest extent possible, basic palliative care services should be provided through existing professional and lay resources which have been trained in the provision of palliative care.

The range of basic services that should be provided locally is:

- Assessment
- Assessment of the patient’s condition and service needs
- Assessment of available competent services
- Care planning
- Symptom and pain control using recognized tools for assessing and measuring symptoms and pain
- Medication within agreed protocols
- Counseling
- Monitoring
- Terminal care: skilled nursing and medical care and support at the end of life
- Education for patients and families.

People who can receive palliative care at the local level are expected to be those who have relatively straightforward needs, few if any co-morbidities and are in a stable condition. Protocols that define when a referral should be made to specialized palliative care services should be established and followed. Protocols are likely to include such considerations as persistence, severity, and complexity of problems.

Specialist palliative care services should be provided at a regional level to those people who have complex needs. These patients could be expected to have one or more of the following characteristics:

- Complex physical and/or emotional needs;
- Symptoms that are difficult to alleviate or control or that fluctuate;
- Multiple pathology—co-morbidities that could be either related to or not associated with their primary cancer;
- A poor social support network or the need for respite care.

Specialist palliative care services include:

- Control—control of physical and emotional symptoms;
- Medical services—input from specialist palliative care physicians in relation to care planning performed jointly with the care recipient, their family, and health care professionals; they include assessment of physical, psychological, social, and spiritual needs, developing and/or implementing the care plan, and monitoring and evaluating care;
- Symptom assessment and symptom management with appropriate medical interventions and medications;
- Nursing care—help and support with activities of daily living, effective communication, and nursing interventions;
- Therapy services—physiotherapy, occupational therapy, and creative (music and/or art and/or drama) therapy;
- Pharmacy services—prescription advice, preparing and dispensing medication;
- Psychological services—counseling, support with pain management and bereavement services;
- Social services—help with legal and financial issues, obtaining specialized equipment, respite care and/or holiday breaks;
- Chaplaincy services—spiritual and religious support;
- Information service—covers a range of information from clinical information (e.g., conditions, symptom control) to social care information (e.g., benefits and resources).

<table>
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<tr>
<th>Level</th>
<th>Ambulatory</th>
<th>Palliative Care</th>
<th>Hospitals (In Patients)</th>
<th>Governance</th>
<th>Financing</th>
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<tr>
<td>Local</td>
<td>Dispensaries</td>
<td>Basic services</td>
<td>Rural (internal medicine, pediatrics) 120 beds</td>
<td>Local town halls</td>
<td>Local community</td>
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<td></td>
<td>Primary care physicians</td>
<td></td>
<td>Town/municipal (general) 250—400 beds</td>
<td>Local network</td>
<td>District Health</td>
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<td>District Public Health Directors</td>
<td>Insurance Funds</td>
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<tr>
<td>District</td>
<td>Diagnosis &amp; treatment centers</td>
<td>Specialized services</td>
<td>District (first level specialization)</td>
<td>District Public Health Directors</td>
<td>District Health</td>
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<td></td>
<td>Outpatient departments</td>
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<td></td>
<td>Insurance Funds</td>
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<tr>
<td>National</td>
<td>Developmental education research</td>
<td>Specialty (Tertiary)</td>
<td>Ministry of Health</td>
<td>National Health Insurance Fund</td>
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A number of services should be provided at the national level through a consortium of palliative care providers. With a non-hierarchical approach of providing palliative care, there will be benefits for the palliative care providers working together to address areas of mutual interest that are more efficiently performed at a national level. These include promulgating and disseminating standards of care and care protocols, gathering statistics on needs, utilization, cost, surveying the opinions of patients, caregivers, fundraisers, volunteers, the general public about palliative care, national campaigns to raise awareness of palliative care services, provide input to education and research programs.

The Way Ahead

The political will to integrate palliative care into the national health care system was clearly stated when Romania applied to the World Bank for a loan to reform the Health Care System and included palliative care as a subcomponent. During this five-year project, palliative care services will be developed on a national level as follows: 29 inpatient units will be opened by reallocation of acute care beds to palliative care beds, 90 home care teams, and 90 outpatient clinics will be set up, alongside an adjustment of the legal framework to allow the smooth functioning and coordination of these services. Training for GPs and community nurses to deliver basic palliative care is included in the project.45

A better understanding of the barriers that need to be removed is illustrated in the SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis presented in Table 3. The SWOT analysis was performed during the development of the palliative care chapter for the National Cancer Program in spring 2016.

There is a particular concern for quality in health care services and the National Agency for Standardization in Health Care (ANMCS) has reviewed the national standards and has also included specific standards for palliative care in inpatient units. The reviewed edition of the hospital accreditation standards has been recently published in the Official Gazette.46 The process is ongoing and work will start in 2017 for developing standards in palliative care also in outpatient and home care settings.

Table 3

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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<tr>
<td>• Leadership and model services recognized at national and international level offered by HOSPICE Casa Sperantei</td>
<td>• Insufficient palliative care specialized services</td>
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<td>• Undergraduate and postgraduate education programs</td>
<td>• Services labeled as palliative care services without fulfilling the necessary quality criteria</td>
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<td>• National network of palliative care trainers and mentors</td>
<td>• Unequal distribution of services across the country</td>
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<td>• Two palliative care chairs in medical universities</td>
<td>• Lack of approved protocols at national level</td>
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<td>• Pilot projects that</td>
<td>• Insufficient health care providers involved in palliative care</td>
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<td>• develop and test new educational projects</td>
<td>• Lack of applying basic palliative care in oncology and family medicine centers</td>
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<tr>
<td>• explore development models of palliative care in different settings: oncology, general practice, community</td>
<td>• Lack of basic medication for palliative care in oncology centers and general hospitals</td>
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<td>• develop professional accreditation mechanisms for quality services</td>
<td>• Prescribing problems of opiates and drugs for symptom control</td>
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<tr>
<td>• Financing mechanisms for palliative care in home care and inpatients units</td>
<td>• Lack of palliative care education for residents in oncology, family medicine</td>
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<tr>
<td>• Increasing number of PC providers both in the public and non-governmental sector</td>
<td>• Difficult financing mechanisms for home care services in palliative care.</td>
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<tr>
<td>• Professional standards in palliative care</td>
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<td>• Palliative care protocols developed by the professional association.</td>
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Opportunities

• International recommendations urging member states to develop palliative care services
• Inclusion of palliative component in project reform of the health system in Romania financed by World Bank
• Standardization through ANMCS of basic palliative care in hospital and for compartments and/or wards and/or units specialized in palliative care
• The new Cancer National Plan that is intended to be comprehensive from prevention to palliative care.

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