

## Inclusion of end-of-life care in the global health agenda



Global development, strengthening of health systems, and an increase in access to treatments will improve health outcomes. However, the global need for palliative and end-of-life care will persist. As populations age and societies industrialise, the number of people who will need palliative care to manage the problems associated with chronic progressive illness, especially cancer, are predicted to increase in low-income and middle-income countries. This increase is compounded by late presentation to medical services and restricted access to potentially curative options.

The provision of palliative and end-of-life care, including access to pain relief, is a worldwide human right within existing covenants.<sup>1</sup> However, three documents have shown the woefully inadequate coverage in most regions. First, a worldwide classification of every country's level of palliative care provisions showed that only 58% of countries have a palliative care service, and provision ratios are as poor as one service per 90 million population.<sup>2</sup> Second, WHO's 2014 global atlas of palliative care reported that less than 10% of the 20 million people every year who need palliative care at the end of life actually receive it, and although most care is delivered in high-income countries, 80% of people who need palliative care are in low-income and middle-income countries.<sup>3</sup> Third, in 2012, the International Agency for Research on Cancer's GLOBOCAN published its first global cancer estimates for 4 years,<sup>4</sup> and reported 5.3 million deaths from cancer in less-developed regions during 2012.

Clearly, provision of appropriate end-of-life care is inadequate in low-income and middle-income countries. WHO's Public Health Strategy for Palliative Care has provided an important framework to assist countries to put into place the necessary actions to be able to provide their citizens with the palliative and end-of-life care that they need (ie, drug availability for pain and symptom relief, education of clinicians, and delivery of health-care policy that includes provision at the end of life).

The strategic approach at our Cicely Saunders Institute (King's College London, UK) towards global programmes and partnerships in palliative and end-of-life care has been led by a fundamental belief that, for this strategy to succeed, it needs to be underpinned by locally generated evidence. WHO's definition of palliative

care (ie, the assessment and control of physical, psychological, social, and spiritual problems in patients and their families from diagnosis, until the end of life, and into bereavement) is broadly accepted worldwide. However, strategic responses need to be based on evidence of local preferences and priorities at the end of life, to take account of local regulatory environments with respect to opioid use, and to be responsive to local cultural beliefs and health systems.

The evidence base for palliative care has been mostly generated in high-income countries; however, evidence specific to low-income and middle-income countries has started to be developed. For example, with respect to policy, health economic studies suggested that costs associated with palliative care were lower in high-income countries than in lower-income countries, and that this cost saving can be achieved by hospital-based palliative care services.<sup>5</sup> In terms of drug availability, although advocacy focuses largely on opioid availability, in east African pharmacies even non-opioid analgesics have interrupted supply.<sup>6</sup> With respect to education, in patients with advanced cancer in Cuba, fewer than half were aware of their diagnosis, and only 9% knew that they were dying,<sup>7</sup> and in Bangladesh futile active treatment is encouraged for those who can rarely afford it.<sup>8</sup> Evidence from high-income countries suggests that people prefer to die at home, yet this is not the case in Africa, which suggests that preferences are affected by resource availability.<sup>9</sup> The global health palliative care agenda needs to not only follow high-income countries' research agenda into other progressive conditions such as patients with heart failure, chronic obstructive pulmonary disease, and renal failure, but also to develop the evidence urgently needed to respond to locally prevalent disease, such as drug-resistant tuberculosis.<sup>10</sup>

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We declare no competing interests.

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For more on Cicely Saunders Institute see [www.csi.kcl.ac.uk](http://www.csi.kcl.ac.uk)

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