

A STUDY OF CANCER CARE MODELS FROM SOME DEVELOPED AND DEVELOPING COUNTRIES: AN EXPLORATORY STUDY

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Based on secondary sources and fieldwork, this paper tries to describe the processes and systems of palliative care in developed countries such as Australia, United States of America and United Kingdom and in developing countries like China and Uganda. These countries were selected from Clarke's (2020) levels of palliative care development. And accordingly, the developed countries mentioned above have advanced integration of palliative care while the developing countries are at preliminary integration stage. Based on their unique models, systems and coverage of palliative care and the availability of literature, these countries were specifically selected. Along with this, the scenario and provisions of palliative care in the context of cancer in India has been discussed, highlighting the necessity of palliative care and the barriers and challenges experienced in developing the palliative care services.

Keywords: Cancer, Care models, Developed and developing countries, Palliative care

Usually, cancer puts the patients and their family members under a lot of physical and mental duress. The concept of palliative care has been developed to take care of the various needs that arise due to cancer diagnosis and its subsequent treatment, which also includes psychosocial aspects of an individual's need. In a broad sense, palliative care is viewed as "the person-centred attention to symptoms, psychological, social and existential distress in patients with limited prognosis, in order to optimise the quality of life of patients and their families or close friends" (Ahmedzai et al. 2004). It is mostly delivered by a team of doctors (who assess and recommend therapy for managing uncomfortable symptoms), nurses (specialised in pain management and symptom control that

involve care provisions, assistance in assessing patients' needs and support to their families and significant others), social workers (providing emotional support, arranging access to supportive community resources including financial assistance when appropriate), pharmacists (who recommend and manage the drug therapies along with other team members) and spiritual specialists (who provide spiritual assistance) (Ahmedzai et al. 2004).

Palliative care was formally defined by World Health Organisation in 1986, which considered palliative care as the active total care of patients who are not responsive to curative treatment (WHO 1990). However, during the nineties, the improvement in anti-cancer treatments and technologies has enhanced survival expectancies and made palliative care more inclusive for many other illnesses and their onset at any stage and sometimes prior to treatment. Later, in 2002, acknowledging these, WHO redefined palliative care as an "approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (Sepulveda et al. 2002).

Following the World Health Organisation guidelines, concepts and definitions, different countries have developed various palliative care approaches, according to their demography, health and policy infrastructure for delivering palliative care services among their citizens. In the subsequent sections, I would be discussing the provisions of palliative care in the selected developed and developing countries in order to get a nuanced understanding of the services operating in different parts of the globe. This paper is based on existing literature and a fieldwork conducted at Karunashraya, Bangalore Hospice Trust, Karnataka, India. Clark et al. (2020) have classified 198 countries into six categories of development on the basis of the integration of palliative care in those countries. These categories are created based on 10 indicators that the authors derived through an online survey of experts from 198 countries for the year 2017. The categories are- Category 1, Category 2, Category 3a, Category 3b, Category 4a and Category 4b. The classification is based on provisions of palliative care services, service coverage, funding sources, education and training,

opioid availability, existence of national strategy or plan, legal provisions to support palliative care and vitality. Following Clark et al. (2020), I have reviewed palliative care provisions of six selected countries. Accordingly, Australia, United States of America, and United Kingdom were selected from category 4b and China and Uganda from 4a, whereas India has isolated palliative care provisions. This selection was done based on the differences in their approaches to palliative care and social development, their models, coverage of palliative care and the availability of literature.

PALLIATIVE CARE SERVICES IN DEVELOPED COUNTRIES

Palliative care in Australia

Australia has a population-based palliative care model, guided by network system. The care for the dying in Australia began with religious and charitable organisations at the end of nineteenth century. And in the late 1970s, modern palliative care emerged. The initiative was inspired by the works of Dame Cicely Saunders and was driven by the community's concern for people dying with cancer accompanied by suffering (Phillips, Ingham and MacLeod 2015). The Australian model of palliative care operates across all clinical settings, through a need-based referral system providing primary, secondary and tertiary care, where emphasis is given on the level and intensity of needs of the patients, primary carers and families rather than diagnosis (Mitchell and Currow 2009; Mitchell 2011; Phillips, Ingham and MacLeod 2015). This care is provided through hospital consultancy services and palliative care units with beds and community services, by primary and specialists care providers (Palliative Care Association [PCA] 2005a; Mitchell 2011).

Within this need-based model, care is provided and organised through numerous levels. These levels are- primary care, specialist palliative care level 1, specialist palliative care level 2, specialist palliative care level 3 (Mitchell and Currow 2009; Mitchell 2011). The primary care involves the basic clinical management and care coordination including assessment, triage and referral. It also has formal links with a specialist palliative care provider for the purpose of referral, consultation and access to specialist care from medical practitioners (National Palliative Care Strategy 2018; PCA 2005b). The primary care is, generally, provided by general medical

practitioners, nurse practitioners, registered nurses, generalist community nurses, aboriginal health workers and allied health staff. The level 1 specialist palliative care services usually exist in smaller population centres where palliative care is provided to the patients, primary carers and families whose needs exceed the capability of primary care providers (National Palliative Care Strategy 2018; PCA 2005b). It comprises a multidisciplinary team including a medical practitioner with experiences of palliative care, clinical nurse specialist, allied health staff, and volunteers, assessing the needs and care consistency as well as providing consultative support, information and advice to primary care providers. It has formal links with primary care providers and level 2 and /or 3 palliative care specialists (National Palliative Care Strategy 2018; PCA 2005b). The level 2 comprises large regional centres, providing formal education programmes to primary carers, level 1 providers and the community (National Palliative Care Strategy, 2018; PCA 2005b). It is composed of an interdisciplinary team of medical practitioners, clinical nurse specialists/ consultants and allied health and pastoral care staff. Level 3 specialist services are about providing comprehensive care to the patients, primary carers and families with complex needs, local support to primary care providers, regional level 1 and/or 2 services including education and creating/ establishing standards. These are given by an interdisciplinary team including a medical director, clinical nurse consultant, nurse practitioners and other health professionals with specialist qualification in palliative care (National Palliative Care Strategy 2018; PCA 2005b).

The Commonwealth Medicare Incentive Program, established in 1973, provides the facility of publicly financed health insurance system, including medical consultations, public hospital admission and access to subsidised drugs to all its permanent residents. Along with this, Australians also have the provisions in opting private health care coverage and ancillary healthcare (Phillips, Ingham and MacLeod 2015). In 2000, National Palliative Care Strategy was introduced to ensure best evidence-based quality palliative care to their citizens (Phillips, Ingham and MacLeod 2015). The strategy initiatives are focused on developing and enhancing support for patients, families, and carers in the community, access to palliative care medicines in the community, building capacity

through education, training and support and research and quality improvement (Phillips, Ingham and MacLeod 2015). Several communication campaigns, conferences and national programs are undertaken to promote and spread awareness about palliative care among the general population (Mitchell and Currow 2009; Walter et al. 2010; PCA 2005a; Mitchell 2011; National Palliative Care Strategy 2018; Murray and Sheikh 2008).

Palliative care in United States of America

The United States of America follows a community-based programme, where along with the multi-professional teams, volunteers, neighbourhoods and fraternity groups¹ play an important role in providing patient and family centred care in home, hospice and care units (Hughes and Smith 2014; Morrison 2013). However, in the United States, the health care system is driven by a business model where more than any central directive, it is the independent hospitals who have major say in any sort of innovations in the system.

In USA, Hospice provisions began with the establishment of Connecticut Hospice in 1974. But it is in the 1990s that the modern palliative care, incorporating the core principles of hospice, started within the academic medical centres (Morrison 2013). The insufficient care for the seriously ill and growing demand for palliative care created an influx of funds for improvement of the care for the seriously ill which led to the expansion of palliative care teams in the institutional settings (Morrison 2013). According to Dumanvosky et al. (2016), about sixty-seven percent of hospitals in USA have palliative care programs. Since the opening of the first hospice in 1974, it has grown to 6100 in 2014 (Dumanvosky et al. 2016). In 1982, the Congress passed the Medicare Hospice Benefit in the United States, which became the major source of hospice payment and reimbursement in the country for its beneficiaries (MacLeod and Block 2019; National Hospice and Palliative Care Organisation 2018) and the Patient Protection and Affordable Care Act 2010 provided opportunities for the growth of palliative care in the nation (MacLeod and Block 2019; National Hospice and Palliative Care Organisation 2018). Like these, a combination of programmes and projects such as Education in Palliative and End-of-life Care (EPEC) Program, Project on Death

in America (PDIA), and Center to Advance Palliative Care (CAPC), that focused on capacity building through physician education and development of academic physician leaders, and the advancement of practices of palliative medicines in hospital and health systems, played a vital role in establishing palliative medicine and enhancing American health care. In 2006, palliative medicine was formally recognised by the American Board of Medical Specialities. Along with these, initiatives such as the establishment of certification program in 2002 by the American Board of Nursing Specialties in hospice and palliative nursing, and development of consensus quality guideline for standardised palliative care based on National Framework and Preferred Practices for Palliative Care and Hospice Care Quality by the National Quality Forum in 2006 helped in providing quality palliative care in the States (Morrison 2013).

In USA, palliative care services are delivered through home-care programs, free standing inpatient facilities, separate units within a hospital or skilled nursing facility and interdisciplinary teams which operate within a general hospital and see patients scattered within a given hospital facility (MacLeod and Block 2019; Cohen 1979). The home care programs provide a set of core services to the patients and their families. They provide medical and nursing care, guide family members in understanding the patient care techniques as well as emotional and bereavement counselling (Temel et al. 2010; Reiss 1982). This approach is cost-effective, since it uses volunteers and less expensive methods of treatment, enabling it to grow wider into the society (Temel et al. 2010; Mor and Kidder 1985; Cohen 1979). The free-standing inpatient hospice facility provides respite care². It is usually autonomous with its own administration or is affiliated with hospital or skilled nursing facilities (Temel et al. 2010; Reiss 1982). The separate hospice unit allows a certain degree of programme autonomy, although they operate within the existing healthcare facilities, providing compassionate environment associated with the hospice philosophy (Morrissett et al. 2019; Osterweis and Champagne 1979). In addition, the utilisation of interdisciplinary teams within the existing traditional facilities ensures enhanced palliative care to the dying patients (Morrissett et al. 2019; MacLeod and Block 2019; Reiss 1982). Although each type discussed here shares a basic conceptual

approach i.e. providing care, they differ in terms of physical setting, staffing and service arrangements (Morrissey et al. 2019; MacLeod and Block 2019; Osterweis and Champagne 1979).

Palliative care in United Kingdom

In United Kingdom, Saunders' end-of-life care strategy is implemented. It is rooted to the principle that end-of -life care is a right for everyone as a part of mainstream healthcare provision and is carried out through a "whole system and care pathway" approach (Finlay 2001; O'Neill and Fallon 1997). The first hospice for the dying – Our Lady's Hospice, in the British Isles was established in Dublin in 1879 by Mary Aikenhead and her Religious Sisters of Charity. Later, in the 1950s, St. Joseph's Hospice gave way to the pioneering works of Cicely Saunders for her pain research which played a significant role in recognising the needs of the dying (Finlay 2001; O'Neill and Fallon 1997). Several religious and charitable organisations, and hospitals started working on the needs and care for the severely ill utilising specialist in-patient units through home and day care services. In 1987, palliative medicine was recognised as a medical specialty in the United Kingdom. With the beginning of the twenty-first century, several policy initiatives and documents regarding the End of Life Care Strategy for England were introduced with an aim of integrating, enhancing and standardising palliative care services (Finlay 2001; O'Neill and Fallon 1997).

Palliative care services in United Kingdom is carried out through a "whole system and care pathway" approach directed at a specific population (Finlay 2001; O'Neill and Fallon 1997). Through pathways monitoring, maintenance, and continuous efficiency and quality improvement of care is achieved. This approach includes a combination of initiatives in a planned and integrated way. It first identifies people approaching the end of life and initiates conversations about preferences for end of life care. This is followed by care planning, where the needs, wishes and preferences are assessed and recorded in a care plan, which is then reviewed by a multidisciplinary team, the patient and the carers. According to the care plan, the care is provided in the required time and setting. Care continues, even after the death of the patient. The needs of family members, friends and other

informal carers are assessed, and accordingly practical, emotional and bereavement support are provided (Finlay 2001; O'Neill and Fallon 1997; Hall et al. 2011). The country has three nationally coordinated initiatives- the Gold Standards Framework, the Preferred Place of Care Document and the Liverpool Care Pathway, that play an important role towards palliative care approaches and services in the country (Seymour and Clark 2018; Storey 2003; Thomas 2018). The Gold Standards Framework (GSF), an initiative by a GP Macmillan Facilitators³ in Huddersfield, is an evidence-based programme of assessment and care. Originally, it involved 12 GP (general practitioner) practices and was developed for the use of the primary healthcare teams to assess the patients, utilising pain assessment and other symptom assessment tools. Emphasis is given on improving and optimising the quality of life for patients, their families and friends in the last year of life, by providing equal opportunity, good quality and end-of-life care irrespective of location and diagnosis. In this initiative, each practice nominates a key nurse and GP for each patient, for monitoring, managing and improving symptoms, care continuity, coordination, communication, support and continued learning (Thomas 2003, 2018).

The Preferred Place of Care or the Preferred Priorities of Care (PPC) is an initiative of the Lancashire and Cumbria Cancer Network, where importance is given to the patient's autonomy and the patient is put at the centre of the care planning (Storey 2003). The PPC documentation comprises details of the family, records of discussions of the patients and their families regarding the understanding of the diagnosis and possible outcomes, information about the comprehensive assessment of health and social services available to the patients, and a variance sheet for documenting the changes, which can be utilised while delivering care (Storey 2003). The Liverpool Care Pathway (LCP) was developed as a joint initiative between the Marie Curie Hospice in Liverpool and the Royal Liverpool Hospital in the 1990s. It was designed as a central organising tool for all clinical care, which can be used in the last days of life. The care pathway includes expert opinion, guidelines, protocols, evidence-based practice and research and development (Ellershaw and Wilkison 2003). It is estimated that around 25 percent of hospices in UK are utilising

the LCP (Murtagh, Preston and Higgson 2004; Mirando 2005). However in 2014, the LCP was phased out and it was replaced by Leadership Alliance for the Care of Dying People (LACDP) for delivering care (Seymour and Clark 2018).

The purpose of the alliance (LACDP) was “...to take collective action to secure improvements in the consistency of care given in England to everyone in the last few hours or days of life and their families” (BBC 2013). The LACDP developed five strategies in terms of priorities of care for the dying person. Priority one was about recognising the possibility that a person may die within next few days or hours and communicating it clearly in order to take decisions and actions in accordance with the person’s needs and wishes. Priority two emphasises on a sensitive communication between the professional carers and those identified as important to them. Priority three talks about involving the dying person and those identified as important to them in the decisions about treatment and care to the extent that the dying individual wants. Priority four focuses on exploring, respecting and meeting the needs of families and the significant others as far as possible. And the fifth priority stresses on an individualised plan of care which includes agreed food and drink, symptom control and psychological, social and spiritual support, delivered with compassion (Skyles 2015; Seymour and Clark 2018).

PALLIATIVE CARE SERVICES IN DEVELOPING COUNTRIES

The necessity of palliative care is utmost in developing countries. Out of 58 million people dying every year globally, 45 million people are from the developing countries, and it is estimated that 60 percent of them are from poor countries and would be benefitted from palliative care (Shetty 2010). Yet, palliative care is still unavailable in most of the developing countries (Shetty 2010).

Palliative care in Uganda

Palliative care provision in Uganda is at the preliminary stage of integration (Clarke et. al. 2020). In Uganda, nearly 80 percent of the patients affected with cancer and HIV/AIDS require palliative care (Nabudere et al. 2014). Community-based palliative care provisions are delivered via government’s strategic health plan through civil society organisations involving paid staff and volunteers in the form

of home-based care (Kamonyo 2018). One of the most prominent organisations in the field of delivering palliative care services in the country is Hospice Africa Uganda (HAU). Since 1993, HAU is providing affordable, accessible, culturally appropriate, and holistic care through hospital, home, outpatient and day care services to the patient and family in need. Along with the care services, HAU is engaged with creating awareness and educating the health care professionals to enable smooth access and availability of pain medication and integration of palliative care into the public health system (Kamonyo 2018). Later, in 1999, a non-governmental membership organisation of professionals, volunteers and other organisations– Palliative Care Association of Uganda (PCAU) was formed to support the growth and development of palliative care provisions and professionals in Uganda through capacity building, advocacy, awareness creation, palliative care research and resource mobilisation. PCAU is also actively involved in incorporating the perspectives of human rights in the context of palliative care into their care facilities and services (Kamonyo 2018). The legal system of the country has also taken several initiatives to integrate palliative care in Uganda, especially since many palliative care patients lose their decision making rights related to properties and health options. To ensure efficient legal guidance for the patients and professional development from the lawyers, Uganda Law Council and Uganda Law Society adopted a palliative care training curriculum (Kamonyo 2018). Amongst all African countries, Uganda is the first country to include palliative care as an essential service in their five-year strategic health plans (Gwyther, Boucher and Harding 2016) and has integrated it in The Health Sector Development Plan 2015-2020 (THSDP 2015), National Pain Control Guidelines for the Use of Narcotic Drugs 2016, National Drug Policy and Authority Act 2016, Nursing Prescribing Authority 2015 and Draft National Palliative Care Policy, pending approval from Ministry of Health (Ministry of Health Uganda 2002, 2012; Kamonyo 2018). Based on the public health model and these initiatives, Uganda is delivering palliative care services to its citizens and is heading towards advanced integration of palliative care.

Palliative care in China

The increasing ageing population and the number of cases of cancer

patients in China led to the establishment of palliative care in the country in the late 1980s (National Bureau of Statistics of China 2017; IARC 2015; Chen et al. 2016). China delivers palliative care (mostly private) through inpatient specialised units, inpatient specialised beds, outpatient, units and home care to those in need of palliative care, especially to cancer patients and the elderly, through an interdisciplinary team, though limited to the areas around the palliative care units (Li, Davis and Gamier 2011). The National Health and Family Planning Commission of the People's Republic of China has initiated a national program in 2011 to establish pilot units to address pain and managing symptoms of cancer patients in generalised and specialised hospitals (Lu, Youhui and Wenhua 2018). In order to ensure sufficient availability and accessibility of opioids for the patients, the State Council of China issued regulations on Narcotic Drugs and Psychotropic Substance in 2005. Through this regulation, essential pain relief and palliative medicines are covered through the medical insurance (Xiaox 2015; Lu, Youhui and Wenhua 2018). Along with these initiatives, China also promotes integration of palliative care into Chinese society through public advocacy by various non-profit organisations of the country (Li, Davis and Gamier 2011; Lu, Youhui and Wenhua 2018).

However, a few studies (Hu and Feng, 2016; Wu, et al. 2016) portray a contrasting scenario of palliative care in China, which show that China has insufficient palliative care provisions for their citizens. According to The Economist Intelligence Unit (2015), China ranked 71st in the Quality of Death Index amongst 80 countries and it also reported that the end-of life care provisions in the country is low and palliative care is inaccessible to majority of the population. It has low scores for other parameters such as palliative and health care environment, affordability of care and quality of care as well (The Economist Intelligence Unit 2015). Several barriers have been identified in this context, one of the most prominent being the slow adoption or less acceptance of the concept of palliative care and its provisions by the general population, which is due to its perceptions about palliative care, death and dying, associated mostly with the cultural and social values (Hu and Feng 2016). Often in the Chinese society, palliative care is perceived as a bad omen and the facilities providing

palliative care are considered as hospitals for the dying. Other barriers such as opioid availability, financial costs of the treatment and services, medical curricula, shortage of professionals and allied staff, lack of funding and awareness, has left the patients with inadequate provisions of palliative care.

Both in Uganda and China, palliative care services have emerged recently in response to the needs of their population. Though the services are established recently, these countries are delivering palliative care services to their population utilising community-based approaches.

Palliative Care in India

The palliative care provisions in India are provided through both governmental and non-governmental efforts. Apart from public hospitals, there are private facilities provided by private hospitals and hospices which cater to the needs of critically ill patients in need of care. However, the number of such palliative care providers is extremely inadequate to serve the growing number of needy patients in a country like India.

Yet, the south Indian state of Kerala has developed a unique integrated palliative care service model - The Neighbourhood Network in Palliative Care (NNPC). The NNPC of Kerala is structured around the healthcare system of the state (Kumar, 2013). It aims to address the issues of the incurably ill, immobilised and dying individuals, regardless of their prognosis (Kumar, 2013). The NNPC is a community led initiative, developed in 2001, by four NGOs and eight palliative care centres, providing outpatient and home-based palliative care in Kerala (Kumar, 2013). The model is grounded on the concept of primary health care, elucidated by World Health Organisation (World Health Organisation, 1978). It operates by (a) mobilising the community and ownership by the local community members, (b) incorporating local self-government institutions and lastly, (c) integrating palliative care in the primary healthcare system. The NNPC emphasises on active participation of local people in addressing the social requirements of the patients and families. It up-skills the community volunteers to provide assistance, enable development of locally sustainable home care programs. The broad objective of the NNPC is to build a network of medical and care professionals to support palliative care

initiatives (Bollini, Venkateswarn, & Kumar, 2004; Paleri & Numpeli, 2005; Rajagopal & Kumar, 1999; Ajithakumari, Kumar, & Rajagopal, 1997). This model is cost-efficient and provides both coverage and quality, leading to a wider integration of the program into the mainstream health infrastructure (Kumar, 2013).

Besides NNPC, there are a few non-governmental organizations in the country, providing efficient palliative care service to the needy. Karunashraya is one such organization located in Bengaluru, Karnataka.

Karunashraya in Karnataka, established in 1994, is managed by Bangalore Hospice Trust of the Indian Cancer Society and Rotary Club of Bangalore. It aims to deliver pain relief and palliative care services to advanced stage cancer patients and their families. It is the first palliative care in India to provide free home-care for terminally ill cancer patients. This organisation provides free inpatient facilities and home care by teams of multi-disciplinary nurses, physiotherapists, health assistants and social workers. Need based medical care, food, medicines and counselling are given free of cost by the professionals through the inpatient facilities. Through home care facility, the multi-disciplinary team provides physical and psychological support including dressing of wounds, relief from pain and other symptoms, counselling services and bereavement support to the patients and their relatives. Bangalore Hospice Trust also runs a nursing aid training program, where women are given a six-month training course on patient care. Bangalore Hospice Trust, in collaboration with Indian Cancer Society and Rotary International Bangalore Indiranagar, serves more than a thousand patients per month.

India has both Government-led as well as non-governmental models of palliative care. The former, as exemplified by NNPC model, incorporates local self-government institutions, and NGOs. The non-governmental philanthropic initiatives in the country primarily focus on cost-effective palliative care, and capacity building through small scale training programmes and advocacy. Government-led models have a wider reach among the people, which can be seen by the fact that this model is successfully running in all the fourteen districts of Kerala. Whereas, the reach of the non-governmental model is comparatively less as is evidenced by the fact that Karunashraya is operational in only one city in the

state of Karnataka.

DISCUSSION

Palliative care aims at enhancing the quality of life of patients and their family members, with life-limiting conditions such as cancer, HIV/AIDS, neurodegenerative disorders and chronic respiratory diseases. Various countries have developed varied approaches, according to their population, health and policy infrastructure, for providing palliative care among their citizens. In addition, it is pertinent to note that a country's health care delivery system influences and plays an important role in deliverance of care provisions. Various countries have different systems; for instance, United Kingdom follows the system of socialised medicine (Cockerham 2017). Socialised medicine indicates a system of healthcare where the health care is delivered as a "state-supported consumer service" (Cockerham 2017). In this system, the government directly regulates the financing and organisation of health services, including the ownership of the facilities and the remittance of the providers. This mode of system, thereby, allows equal access of health care facilities including palliative care provisions to citizens (Cockerham 2017). This system also allows some facilities of private care for those patients who are capable of affording or bearing the expenses. In China, a system of socialist medicine operated in which healthcare is a "state-provided public service" (Cockerham 2017). This mode is quite similar to the system of socialised medicine; the only difference between the two is that the system of socialist medicine bans private care. Although, politically, People's Republic of China adheres to socialist ideology, but its shift from socialism to a market driven economy has immensely affected the health care delivery system of the country; as a result, the socialist system of health care, where the state controlled, organised and financed free health care services, is now replaced by private enterprises or/and, financed by the patients, employers and health insurance companies (Cockerham 2017). There are other forms of health care delivery system too. In the United States, a "fee- for- service" model operates, in which services and facilities have to be purchased from health practitioners, agencies and institutions. In a free market system like the United States, national health insurance plays a crucial

role in accessing health care facilities, especially by the poor (Cockerham 2017). Based on these and similar other delivery systems, countries have introduced varied approaches to deliver palliative care. Population-based models, community-based programmes and care pathways are often utilised by countries, mostly developed ones such as Australia, USA, and UK and a few developing countries such as China, and Uganda while delivering palliative care services.

CONCLUSION

Keeping these models in mind, one can introduce and integrate palliative care with respect to their health care delivery system. The advantage of this concept and the provision comes from its uniqueness, as it can be delivered effectively and accessibly in a community from both resource-rich and resource-poor countries through primary health care teams, especially by family doctors and community nurses and volunteers in collaboration with palliative care specialists. Irrespective of the health care system, primary care is evident in both developed and developing countries and incorporating palliative care in primary care will help in identifying and addressing people with any and all forms of life-threatening illness at any point in the illness trajectory by assessing their current and future needs with systematic planning and interventions. The provisions could be improved and integrated through various collaborations.

Notes

1. Fraternity groups are a group of individuals sharing the same profession, interests or beliefs.
2. Respite care refers to a short-term care that is provided for very old or very sick people so that the person who usually cares for them can have a break.
3. GP Macmillan Facilitators are practicing general practitioners who devote one or two sessions per week towards enhancing palliative and cancer care delivery in the community.

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