The public health approach to palliative care: sharing practice on a global level

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Palliative care has grown tremendously as a specialty since its inception in the late 1960s in London, UK. The concepts of holistic assessment of the dying patient and their family, the importance of good pain relief and the support of the bereaved have been firmly incorporated into the philosophy and practice of hospices worldwide. However, in resource-poor countries, geography, poverty and the lack of infrastructure and education mean that care of those with life-limiting diseases remains lamentably poor. Institutions, often hundreds of kilometers away from a patient’s family, are not able to provide comprehensive care for those with long-term and chronic diseases. Care must be made available on the patient’s doorstep and appropriate to their needs. Professionals are unable to meet the myriad of social, psychological and spiritual needs that patients and their families present. For this, the patient’s local community is best placed to understand the nature of the problems and to help find solutions.

The public health approach to palliative care attempts to provide solutions to these problems [1]. It emphasizes the role of the local community in supporting the dying person and their family, and recognizes the social nature of a long-term or life-threatening disease. The WHO has long advocated a participatory notion and positive definition of health, illustrated by the Alma Ata Declaration [2] and the Ottawa Charter [3], and has advocated a public health approach to palliative care since the early 1980s [4]. Initially focusing on cancer pain, the WHO advocated this approach, as it was seen as the only way to reach the maximum number of people suffering globally. The approach emphasized the importance of the three components of education, policy and drug availability, and has been successful in improving access to palliative care services and opioid analgesics worldwide. In the UK, the End of Life Care Strategy recognized that in order to improve care at the end of life and to allow people to die in the place they wish, attitudes and behaviors towards death and dying needed to be changed [5]. This led to a series of initiatives such as ‘Dying Matters’, which involve the community in planning their own end-of-life care [6].

**Conference proceedings**

Speakers represented a range of countries from the UK, Ireland, Canada and Australia, to India, Pakistan and Bangladesh. Mohammad Shahidullah (Pro-Vice Chancellor of Bangabandhu Sheikh Mujib Medical University [BSMMU], Dhaka, Bangladesh) and Farzana Khan (Medical Officer, Centre for Palliative Care, BSMMU) opened the scientific program with descriptions of the current palliative care
provision in Dhaka, and a review of the demographics and needs of the patients that had attended over the past 3 years. Suresh Kumar and Anil Paleri from the Institute of Palliative Medicine, Kerala, India, presented their innovative model of community-based palliative care in the South Indian state of Kerala. The ‘Neighbourhood Network in Palliative Care’ is a community-led initiative providing home-based palliative and supportive care to patients. The service is funded by donations from the local community, and a network of trained volunteers provide comprehensive care, working closely with the medical professionals. The model was recently afforded the status of a ‘WHO Collaborating Centre in Community Participation in Palliative and Long Term Care’ in 2010 [102].

Two innovative solutions to the problems that geographical distance can present to management and follow-up of patients with life-threatening diseases were presented by delegates. Cherian Koshy from the Regional Cancer Centre, Trivandum, Kerala, has used telemedicine to allow outpatient clinics to be conducted in rural Kerala from the nodal center in the capital city, allowing close follow-up of new analgesics, side effects and deterioration. Rumala Dowla, from the Bangladesh Palliative and Supportive Care Foundation, described a new project in northern Bangladesh in which mobile phones are used to track symptom burden. Patients complete Likert-scale symptom scales using the phones and the results are then reviewed centrally. Changes in the scores alert the healthcare team to assess the patient further.

Heather Richardson, Clinical Director of St Joseph’s Hospice, London, UK, gave the keynote address on the second day, presenting solutions to the problems of access, equity and community engagement, as experienced in the different urban setting of East London. An Australian perspective was provided by Deborah O’Connor from La Trobe University, Melbourne, Australia. She showed how health promotion has been incorporated into the fabric of palliative care practice and has been endorsed by policy from the government. Jim Rhatighan from the Milford Care Centre in Limerick, Ireland, presented his organization’s attempts to initiate a health-promoting palliative care approach on a local and national strategic level. A short DVD that had been created to allow the concepts of community engagement in end-of-life care to be understood on a wider, more profound level as ideas of loss and legacy was presented in the context of a community supporting someone facing a life-limiting illness.

In an interesting project looking at how caring for someone can actually increase social networks and social capital, Kerrie Noonan (University of Western Sydney, Australia) presented a project from Australia that used photovoice, a method of participatory photography and digital story telling that allows marginalized and disadvantaged communities to tell their stories [103]. This was used to illustrate how a Community Mentoring Program for carers helped develop social capital.

Impact of the conference
The conference drew tremendous media and popular attention. The issue of promoting palliative care provision was felt to be of such immediate and pressing importance that the conference was inaugurated by the President of Bangladesh, The Honorable Md. Zillur Rahman. He described how delivering palliative care services to the doorsteps of those in need was ‘the best example of humanity’. He asked for services to be coordinated such that home care and inpatient services ran seamlessly. He also requested the Ministry of Health and Welfare to set up palliative care departments in all government hospitals.

The success of the conference was due in part to the support from the medical university in Dhaka, the BSMMU, who have been firm supporters of the palliative care service since it started in 2007. The service started as a small unit with two beds in a makeshift building with no running water or electricity. The dedicated team worked steadily to gain recognition for the role of palliative care over the past 4 years, and the service has now been given a new 15-bed inpatient unit by the university, which opened in March 2011. This recognition of the importance of palliative care by the university has been central to the development of services and the conference reflected this support. All sessions were chaired by an international delegate and a professor from the university, from specialties not traditionally allied with palliative care, such as neuroscience and gynecology. This meant the conference served a major educational function among the wider university faculty.

Next conference
The next conference will be held at the Milford Care Centre, Limerick, Ireland, in 2013. For further details, please contact pubhealthpallicare@gmail.com.

Financial & competing interests disclosure
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6 Sallnow, Khan & Uddin

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