

Public Health and Palliative Care in 2015



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KEYWORDS

- Public health • Palliative care • Cost-effectiveness • End-of-life
- Quality adjusted life year

KEY POINTS

- Palliative care is a public health concern, because the problems faced by patients and their families represent a substantial burden of illness and cost to society, which is likely to increase markedly in the future as the world's population continues to age.
- There is evidence to support palliative care services, but not yet enough information on the cost-effectiveness of many specific palliative care treatments/interventions.
- The lack of economic evaluations deprives decision makers of information required to best meet the needs of patients with progressive disease and at the end of life.
- It would be useful to empirically assess the appropriateness of generic measures of health-related quality of life (such as the EQ-5D) and the quality-adjusted life year framework in palliative care.

WHY IS PALLIATIVE CARE A MAJOR PUBLIC HEALTH CHALLENGE?

Palliative Care: Traditional Roots

The World Health Organization (WHO) defines 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.”^{1,2}

The principles that underpin palliative care are based on the integration of symptom control, psychosocial care, and disease management, and so require true interdisciplinary collaboration. The goals of palliative care include improving patient and family quality of life,^{3,4} satisfaction, and patients' perceptions of purpose and meaning of life.⁵ Additionally, there is evidence to suggest that palliative care reduces emergency department attendances and hospital admissions toward the end of life and so provides benefits to the health care system and wider society.^{6–8}

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Palliative care was initially developed in the British hospice movement in the 1960s. Guided by the pioneering work of Cicely Saunders, the concept evolved to include multidimensional needs of patients with a comprehensive approach practiced by a multidisciplinary team focusing initially, on end-of-life cancer patients attended to in hospices.

An early reference to palliative care being identified as a public health topic was published by Eric Wilkes⁹ in the 1980s, following the recognition that most deaths were related to chronic conditions other than cancer, and that these occurred in hospitals and at home without any palliative care specialist intervention. On the basis of this reality, he proposed developing palliative care in all settings.

Global Health Policy

At the 67th World Health Assembly (May 23, 2014), the WHO passed the first ever resolution on palliative care recommending national health systems to provide palliative care in conjunction with potentially curative treatment, and not just as an optional extra.⁶ The resolution also urges member states to develop and implement policies that support the integration of cost-effective and equitable palliative care services in the continuum of care, across all levels.¹

Earlier resolutions regarding palliative care mainly focused on cancer patients and the end of life.¹⁰ However, the WHO mandate on palliative care has evolved and currently extends to include patients with chronic noncancer conditions, in the early phase of their disease, as highlighted in the first ever palliative care resolution. It is evident that this evolution of the WHO mandate reflects the evolution of the concept of palliative care as a whole, which consists of

- Extending care beyond cancer and into more general chronic conditions
- Promoting early palliative interventions in the clinical evolution of the disease
- Applying palliative care measures in all settings of the health care system
- Identifying complexity versus prognosis as criteria for specialist interventions

In other words, the focus of palliative care has shifted from the concept of terminal illness to advanced chronic illness with a limited prognosis, and from a specialty (oncology) approach, to a national health care system approach.^{10,11}

Aging Population and Shift in Causes of Morbidity and Mortality

According to the United Nations (UN), the life expectancy of the world's population has increased from 48 years from 1950 to 1955 to 68 years from 2005 to 2010.¹² This increase in life expectancy has been attributed to a decrease in mortality rates and a decline in fertility.¹² All regions of the world have experienced an increase in life expectancy, and this is predicted to increase in the future.^{4,13,14} Currently, the pattern varies, with higher numbers of people dying in late old age in developed countries compared with lower and middle income countries. For example, Evans and colleagues¹⁵ found that centenarian (a person aged 100 years or over) deaths increased by 56% between 2001 and 2010 in England.

The exact number of centenarians living worldwide is uncertain but is thought to be around 317,000 and is projected to rise to about 18 million by the end of this century.¹⁵ In 2011, it was estimated that the 22% of the world's population was aged 60 years or older, and this proportion is expected to reach 32% in 2050 and 33% in 2100.¹² The number of persons aged 80 or over (oldest-old) is projected to increase almost eightfold in 2050.^{4,12}

Over the last 6 decades, there has also been a shift in causes of morbidity and mortality. This shift can be attributed to 2 concepts of population transition: the

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