



Policy

Brief

Integrating Palliative Care
into the Health System
in Lebanon

K2P Policy Briefs bring together global research evidence, local evidence and context-specific knowledge to inform deliberations about health policies and programmes. It is prepared by synthesising and contextualizing the best available evidence about the problem and viable solutions through the involvement of content experts, policymakers and stakeholders.



Policy Brief

+ Included



Description of a health system problem



Viable options for addressing this problem



Strategies for implementing these options

× Not Included



Does not make recommendations



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K2P Policy Brief

Integrating Palliative Care into the Health System in Lebanon



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Key Messages

Key Messages

The problem

The high burden of non-communicable diseases (NCDs) and the rapidly aging population in Lebanon makes palliative care (PC) an essential component of health services needed to relieve the suffering of patients. According to a report published in 2017, an estimated number of 15,000 patients need PC services each year. This number is expected to increase due to a number of factors such as the aging population and the rise in NCDs. Yet, current health system arrangements do not ensure adequate access to PC services.

Elements of a comprehensive approach

Element 1› Integrate palliative care services within health care facilities

- Integrating PC in hospitals and primary healthcare centers improves patient outcomes, reduces healthcare costs, and enhances quality of life.
- Advance care planning is an essential component of PC. Evidence shows that advance care planning is associated with fewer hospital admissions, improved patient and family satisfaction, and reduced healthcare costs.
- An essential package for PC can be provided at all levels of care from hospital to home to primary care centers. The essential package includes essential medicines, equipment, and human resources necessary for the provision of effective and essential PC and pain relief services. Evidence shows that the essential package can strengthen health systems and save enormous costs incurred by patients and their families.

Element 2› Provide palliative care at patients' residence

- Home care is a viable option in Lebanon where family ties are strong and play an important role in patient's healthcare decisions.
- Home-based PC is associated with improved patient outcomes, better symptom management, and healthcare savings.
- Evidence shows that home is the preferred place of care for patients and family caregivers.

Element 3> Strengthen education and training in palliative care among health professionals

-> Multifaceted educative interventions about PC such as group discussions, case management, role-play, didactic courses, tutorial educational sessions, and interdisciplinary team meetings can improve primary care physicians' knowledge about PC.
-> Integrating PC sessions at the undergraduate level provides students with knowledge, skills, and competencies for the provision of PC and improves their ability to deal with patients suffering from advanced diseases
-> Classroom-based and training courses about end-of-life care and PC for health and social staff improve skills and readiness for providing PC.

Element 4> Improve public awareness about palliative care

-> Improving public awareness about PC and its benefits can enhance access to PC, increase referrals to PC, and can help in identifying gaps in services provided.
-> Social network interventions can promote health behavior change of consumers and can be used as a tool by organizations and policy makers to influence health behavior changes.
-> Increasing knowledge and promoting awareness about PC can empower communities to participate in decision-making related to PC

Implementation considerations

To enhance integration of PC services into the health system in Lebanon and improve access to PC, a variety of implementation considerations need to be kept in mind at the level of patients, professionals, organizations, and systems.

الرسائل الأساسية

تعريف المشكلة

إن العبء الثقيل للأمراض غير المعدية وإزدياد فئة كبار السنّ في لبنان يجعل من الرعاية التلطيفية عنصراً أساسياً في الخدمات الصحية اللازمة لتخفيف معاناة المرضى. بالإستناد إلى تقرير نُشرَ في عام 2017، حوالى 15000 مريض بحاجة إلى خدمات الرعاية التلطيفية سنوياً ومن المُتوقَّع ارتفاع هذا الرقم لأسباب عديدة مرتبطة بشيخوخة السكان وارتفاع نسبة الإصابة بالامراض غير المعدية. على الرغم من ذلك، فإن الترتيبات الحالية للقطاع الصحي لا تسمح بالوصول إلى خدمات الرعاية التلطيفية بشكل كافٍ.

ما الذي نعرفه حول العناصر الأربعة التي يتم اعتمادها في

المقاربات لمعالجة هذه المشكلة؟

العنصر الأول > دمج خدمات الرعاية التلطيفية ضمن مرافق الرعاية الصحية

← دمج الرعاية التلطيفية في المستشفيات ومراكز الرعاية الصحية الأولية يحسّن النتائج الصحية للمرضى/ مخرجات الرعاية الصحية ويقلل من تكاليف الرعاية الصحية ويحسن نوعية الحياة.

← التخطيط للرعاية المتقدمة هو عنصر أساسي للرعاية التلطيفية. حيث تشير الأدلة إلى أن التخطيط للرعاية المتقدمة مرتبط بانخفاض حالات الدخول إلى المستشفيات، تحسين رضا المرضى وعائلاتهم، و تقليص تكاليف الرعاية الصحية.

← يمكن توفير حزمة أساسية للرعاية التلطيفية على جميع مستويات الرعاية من المستشفى إلى المنزل إلى مراكز الرعاية الأولية. تتضمن الحزمة، الأدوية الأساسية والمعدات والموارد البشرية اللازمة لتوفير خدمات فعّالة وضرورية للرعاية التلطيفية ولخدمات تخفيف الآلام. وتشير الأدلة إلى أن الحزمة الأساسية يمكن أن تعزز الأنظمة الصحية وتوفر التكاليف الهائلة التي يتكبدها المرضى وعائلاتهم.

العنصر الثاني > توفير الرعاية التلطيفية في مكان إقامة المرضى

← الرعاية المنزلية هي خيار قابل للتطبيق في لبنان حيث الروابط العائلية قوية وتلعب دوراً هاماً في قرارات الرعاية الصحية للمريض.

← ترتبط الرعاية التلطيفية المنزلية بتحسين النتائج الصحية للمرضى/ مخرجات الرعاية الصحية ، وإدارة أفضل لأعراض المرض وتوفير تكاليف الرعاية الصحية.

← تُظهر الأدلة أن المنزل هو مكان الرعاية المفضّل للمرضى وأسرهم.

العنصر الثالث > تعزيز التعليم والتدريب حول الرعاية التلطيفية بين المتخصصين في الرعاية الصحية.

← التدخلات التثقيفية المتعددة الأوجه حول الرعاية التلطيفية مثل المناقشات الجماعية وإدارة الحالات والدورات التعليمية والدروس التثقيفية التعليمية واجتماعات الفرق متعددة التخصصات، تحسّن المعرفة حول الرعاية التلطيفية للأطباء في مجال الرعاية الصحية الأولية.

← دمج الرعاية التلطيفية في الدراسة الجامعية تؤمن للطلاب المعرفة والمهارات والكفاءات اللازمة في مجال الرعاية التلطيفية، وتحسّن كيفية تعاملهم مع المرضى الذين يعانون من الأمراض المتقدمة.

← الدورات التعليمية القائمة في الصفوف والدورات التدريبية حول خدمات الرعاية في مرحلة نهاية الحياة والرعاية التلطيفية، تحسّن مهارات العاملين في القطاع الصحي والإجتماعي وقدرتهم على تقديم خدمات الرعاية التلطيفية.

العنصر الرابع > تحسين الوعي العام حول الرعاية التلطيفية

← تحسين الوعي العام حول الرعاية التلطيفية وفوائدها يستطيع أن يعزز الوصول إلى خدمات الرعاية التلطيفية، وزيادة الإحالات إليها، ويمكن أن يساعد في تحديد الفجوات في الخدمات المقدمة.

← يمكن لوسائل الشبكات الإجتماعية أن تكون فعّالة في تحفيز المستعملين لتغيير سلوكهم العام ومن ضمنه السلوك الصحي، كما تتيح المجال للمؤسسات وصانعي السياسات لإستعمال هذه الشبكات للتأثير على السلوك الصحي.

← زيادة المعرفة ونشر الوعي حول الرعاية التلطيفية يمكّننا المجتمعات من المشاركة بعملية صناعة القرارات المتعلقة بالرعاية التلطيفية.

ما هي العوامل التي يجب أخذها بعين الاعتبار عند التطبيق العملي؟

هناك عدة عوامل يجب أخذها بعين الاعتبار على مستوى المرضى ومتخصّصي الرعاية الصحية والمؤسسات والأنظمة، وذلك لتعزيز دمج خدمات الرعاية التلطيفية في القطاع الصحي في لبنان وتحسين الوصول إلى خدمات الرعاية التلطيفية.

Policy Brief

K2P Policy Brief

The Problem

The high burden of non-communicable diseases (NCDs) and the rapidly aging population in Lebanon makes palliative care (PC) an essential component of health services needed to relieve the suffering of patients. According to a report published in 2017, an estimated number of 15,000 patients need PC services each year. This number is expected to increase due to a number of factors such as the aging population and the rise in NCDs. Yet, current health system arrangements do not ensure adequate access to PC services.

Size of the Problem

Worldwide, it is estimated that 40 million people need PC each year, yet only 14% receive the services they need (World Health Organization, 2018a). Countries in the Eastern Mediterranean region suffer from deficiencies in the field of PC which are not fully integrated into their health systems (Zeinah, Al-Kindi, & Hassan, 2013). Only an estimated 5% of adults living in the Eastern Mediterranean region receive PC services (Worldwide Hospice Palliative Care Alliance, 2014). Common barriers to the development and integration of PC include the absence of national health policies and systems that include PC, poor or absent training on PC for health professionals, and inadequate access to opioid drugs (World Health Organization, 2018a).

In Lebanon, the demand for PC is expected to increase with the aging population and the high burden of NCDs. In 2015, Lebanon had the highest percentage of people aged 65 years and older (7.3%) in the Arab region and this number is projected to reach 12% by the year 2030 (Mehio, Rizk, & Kronfol, 2015). NCDs account for 85% of total deaths, with four types of NCDs accounting for the largest proportions of deaths: cardiovascular disease (47%), cancers (22%), chronic respiratory diseases (4%) and diabetes (4%) (World Health Organization, 2014). In addition, children are also less likely to receive PC in Lebanon (Osman et al., 2017). Despite these observations, few patients who need PC receive the care they need (M Daher, Estephan, Abu-Saad, & Naja, 2008) and most PC services are provided in large cities (Michel Daher et al., 2013).

Despite progress toward developing PC services in the past decade in Lebanon, substantial challenges remain. PC services are still not financially covered by public and most private insurance parties. Only two medical schools have integrated PC in their curricula, whereas PC residency and fellowship programs are still lacking. PC consult services are now available in

several hospitals in Lebanon; however, specialized PC services remain limited. In addition, Lebanon does not have a national PC law or a stand-alone national plan to support PC development and integration (Osman et al., 2017).

Underlying Factors

The following section focuses on the underlying factors at the governance, financial and delivery arrangement levels of the health system that may have contributed to the problem.

At the **governance level**, significant efforts have been ongoing to enhance PC in Lebanon since 1995, yet there remain many barriers impeding the development of PC. Law 240 which regulates PC under the code of medical ethics mentions that patients' will should be respected, yet still allows physicians to conceal terminal illness and serious diagnosis from patients (Rida & Zeineldine, 2013). Furthermore, advance directives do not exist and even though patients can legally assign a health proxy, most of them are not aware that they have this option. Therefore, families can choose to ignore the patient's wishes and make decisions without consulting with the patient. In addition, some essential opioids for pain management are still not available in the market (Osman et al., 2017).

At the **financing level**, public and most private insurance parties do not cover PC services. This limits access to PC services and discourages health professionals from pursuing PC as a profession. As such, healthcare providers interested in providing PC in Lebanon are mainly family physicians, geriatricians, oncologists or pain specialists and only devote part of their time to providing PC (Osman, 2015).

Furthermore, patients who need PC services are forced to pay out of pocket or resort to the only two non-governmental organizations (NGOs)- Balsam and SANAD- that provide PC services free of charge. However, these NGOs have limited human and financial resources and cannot meet the needs of all patients who need PC.

At the **delivery level**, lack of knowledge and skills in PC among healthcare providers is a major barrier facing the health system in Lebanon (M. Silbermann et al., 2012; Zeinah et al., 2013). Although several medical schools are integrating PC courses or lectures into their undergraduate and graduate medical education curricula, there are no formal fellowships or residency training programs for physicians in PC (Osman et al., 2017).

In addition, lack of awareness and wrong perceptions about PC among the public is another cited barrier. In Lebanon, PC is considered a luxury rather than a need and there are many misconceptions about PC among patients and their families (Osman et al., 2017). PC is associated with death, terminal illnesses, and is viewed as a last resort when all other treatments fail (Michel Daher et al., 2013). Patients and their families opt for treatments that

prolong life, even if that means suffering from severe physical and psychological pain (Mouhaweij, Maalouf-Haddad, & Tohmé, 2017).

Elements of a comprehensive approach to address the problem

The following four elements form part of a comprehensive approach tackling the issue of inadequate access to PC services, and therefore can be adopted independently or could complement one another.

Element 1

Integrate palliative care services within health care facilities

At the hospital level

World Health Organization (WHO) strongly calls for the integration of PC in hospitals especially those involved in treating cancer and chronic diseases. Hospital-based PC can improve patient outcomes and symptom control, facilitate the discussion of patient's goals of care, reduce length of stay, and enhance the transition of care to the community. Hospital-based PC can be integrated in different ways: as an outpatient PC clinic; a PC consultation service for hospital inpatients; a PC day-care service; an inpatient PC unit; and PC outreach service (World Health Organization, 2016).

Compelling evidence demonstrates the effectiveness and cost-effectiveness of hospital-based PC. Three systematic reviews found that PC services are associated with decreased length of stay (Martins, Oliveria, & Cataneo, 2017; I. J. Higginson & Evans, 2010; Kyeremanteng et al., 2016). In addition, two systematic reviews reported the cost-effectiveness of hospital-based PC (Kyeremanteng, Gagnon, Thavorn, Heyland, & D'Egidio, 2016; May, Normand, & Morrison, 2014; Siouta et al., 2016). One systematic review found that inpatient PC consultation teams save hospital costs in the range of 9% to 25% (May et al., 2014). Another systematic review found that PC consultations reduced ICU costs from USD \$7,533 to USD \$6,406 and hospital direct variable costs from USD \$9,518 to USD \$8,971 (Kyeremanteng et al., 2016).

At the primary health care level

In 2014, the World Health Assembly resolution WHA67.19- called WHO and the Member States to enhance access to PC, specifically through the provision of PC in primary health care (World Health Organization, 2018a).

Evidence shows that the integration of PC in primary health care leads to reduced healthcare costs and improved health outcomes and quality of life (Sion L Kim & Derjung M Tarn, 2016; Meiklejohn et al., 2016; Totten et al., 2016). One systematic review found that patients who received PC by primary care providers were more likely to be discharged or die outside of the

hospital. PC provided at the primary care level can help strengthen patient's autonomy by involving them in the treatment process and decision-making (S. L. Kim & D. M. Tarn, 2016). Another systematic review found that home-based primary care reduces hospitalizations and length of stay, improves patient and caregiver satisfaction, and enhances quality of life (Totten et al., 2016). Moreover, one systematic review found that general practitioners, family physicians, and primary care physicians provide great support for care coordination and management, symptom and pain relief, health promotion, PC, and continuing healthcare provision (Meiklejohn et al., 2016).

Integrate advance care planning into practice

Advance care planning is defined as “ a process of discussion about goals of care and means of setting on record preferences for care of patients who may lose capacity or communicating ability in the future”(Seymour, Almack, & Kennedy, 2010). Advance care planning enables patients and their families to choose their treatment plan according to their wishes (Brinkman-Stoppelenburg, Rietjens, & van der Heide, 2014).

The effectiveness of advance care planning has been portrayed in various studies. Four systematic reviews found that advance care planning reduce hospital admissions (Brinkman-Stoppelenburg et al., 2014; Khandelwal et al., 2015; Martin, Hayes, Gregorevic, & Lim, 2016; Robinson et al., 2012). A systematic review found that advance care planning decreases life-sustaining treatment, increases the use of PC, and prevents hospitalization (Brinkman-Stoppelenburg et al., 2014). Reported benefits of advance care planning include improved patient-provider communication, increased patient satisfaction (Lotz, Jox, Borasio, & Fuhrer, 2013; Martin et al., 2016), and higher incidence of patients dying in their preferred place of death (Martin et al., 2016).

Essential package for palliative care

According to WHO, essential health packages use cost-effective interventions that can reduce poverty, enhance health equity, and improve service delivery (World Health Organization, 2008). In fact, several countries have implemented comprehensive benefits packages as part of Universal Health Coverage (UHC) and showed favorable healthcare outcomes and reduction in healthcare costs. One review report assessing Thailand's Universal Coverage Scheme (UCS) that includes a comprehensive benefits package showed a significant reduction in healthcare costs incurred by the poor and out of pocket expenditures (Evans et al., 2012). Similarly, the national health insurance program in Mexico which provides a package of comprehensive health services reduced the prevalence of catastrophic health expenditures, especially for the poor (F. M. Knaul et al., 2012). In

addition, one primary study from Ghana mentioned that the benefits package improved access and provision of healthcare services (Odeyemi & Nixon, 2013).

In Lebanon, the Ministry of Public Health (MOPH) received 150 million dollars from the World Bank and Islamic Development Bank for “Supporting the steadfastness of Health sector in Lebanon” project in 2017. These funds will be used to support the health system in Lebanon through funding a larger package that aims at providing vital health services to the poorest families (MOPH, 2017). The MOPH can consider developing a tailored essential package for PC to enhance accessibility to PC services and reduce healthcare costs.

Element 2

Provide palliative care at patients’ residence

Home care is a viable option in Lebanon where family ties are strong and play an important role in patient’s healthcare decisions (Michel Daher, 2011).

Home-based PC services have numerous benefits, some of which include respecting patient’s wishes, saving costs, and improving patient outcomes (Ventura, Burney, Brooker, Fletcher, & Ricciardelli, 2014). Four studies found that home-based PC increases the chance of dying at home (Gomes, Calanzani, Curiale, McCrone, & Higginson, 2013; Jordhøy et al., 2000; Pham & Krahn, 2014; Shepperd, Wee, & Straus, 2011) and reduces symptom burden (Gomes et al., 2013). Two systematic reviews found that home is the preferred place of care for patients and their family caregivers (Gomes et al., 2013; Murray, Fiset, Young, & Kryworuchko, 2009; Woodman, Baillie, & Sivell, 2016). In addition, one primary study concluded that PC at home was associated with better satisfaction among patients’ caregivers (Singer, Bachner, Shvartzman, & Carmel, 2005). One study found that in-home PC improves patient satisfaction, reduces hospital admissions and costs, and increases the likelihood of dying at home (Brumley et al., 2007). In addition, two studies showed that PC at home is cost-effective (McCaffrey et al., 2013; Pham & Krahn, 2014).

Element 3

Strengthen education and training in palliative care among health professionals

This element addresses education and training of health professionals that can be achieved through various tools. One systematic review concluded that including PC at the undergraduate level provides students with knowledge, skills, and competencies about PC and improves their behaviors towards patients suffering from advanced diseases (Centeno & Rodriguez-Nunez, 2015). A systematic review found that classroom-based and

training courses about end-of-life care and PC for healthcare and social care staff is beneficial for improving skills and readiness for providing PC (Pulsford, Jackson, O'Brien, Yates, & Duxbury, 2013). In addition, one systematic review suggested that using multifaceted educative interventions about PC such as group discussions, case management, role-play, didactic courses, tutorial educational sessions, and interdisciplinary team meetings can improve primary care physicians' knowledge (Alvarez & Agra, 2006).

Element 4

Improve public awareness about palliative care

Improving public awareness about the concept of PC and its benefits can enhance referrals to PC services and can help in identifying gaps in services provided.

One citizen brief about improving access to PC in Ontario mentioned that social media campaigns about PC can be used as a tool to improve public awareness about PC (Gauvin, Abelson, & Lavis, 2013). Four systematic reviews found that social network interventions can promote health behavior change (Cugelman, Thelwall, & Dawes, 2011; Laranjo et al., 2014; Maher et al., 2014; Stead, Gordon, Angus, & McDermott, 2007). One systematic review mentioned that social marketing campaigns can be effective in changing behaviors of consumers and patients and can be used as a tool by professionals, organizations, and policymakers and can influence public policy changes (Stead et al., 2007). One primary study found that improving awareness among the public is needed to increase knowledge and access to PC services and empower communities to participate in decision-making related to PC (McIlpatrick et al., 2013). One Lancet report mentioned that the strong collaboration between PC providers, advocacy groups, and international societies has been proven to be effective in changing national policies about PC (Felicia Marie Knaul et al., 2017).

Implementation considerations

Barriers to implementation can be overcome at the patient, professional, organizational and system levels.

-➤ Raising awareness about PC and pain management through public awareness campaigns, media outlets, and educational leaflets
-➤ Training caregivers to assist in caring for the patients at home
-➤ Providing professional training and education in PC for health professionals through national and regional training courses, didactic courses, and continuing medical education.
-➤ Designating specific institutions as training centers for PC

-> Enhancing partnership between NGOs, charitable religious associations, and hospitals can help standardize PC training and increase capacity of health professionals involved in PC
-> Setting standards and guidelines related to PC in hospitals
-> Training of community volunteers to increase their capacity to support patients receiving PC
-> Initiating sensitive discussions of end-of-life issues and developing clear referral pathways
-> Adjustment of the article 44 of the Lebanese code of medical ethics mandating physicians to disclose dangerous diagnosis results to patients
-> Reviewing and modifying national legislation related to advance directives and the availability and affordability of opioids
-> Conducting high-quality research such as systematic reviews and intervention studies about PC

موجز للسياسات الصحية العامة

تعريف المشكلة

إن العبء الثقيل للأمراض غير المعدية وإزدياد فئة كبار السن في لبنان يجعل من الرعاية التلطيفية عنصراً أساسياً في الخدمات الصحية اللازمة لتخفيف معاناة المرضى. بالإستناد إلى تقرير نُشر في عام 2017، حوالى 15000 مريض بحاجة إلى خدمات الرعاية التلطيفية سنوياً ومن المُتَوَقَّع ارتفاع هذا الرقم لأسباب عديدة مرتبطة بشيخوخة السكان و ارتفاع نسبة الإصابة بالامراض غير المعدية. على الرغم من ذلك، فإن الترتيبات الحالية للقطاع الصحي لا تسمح الوصول إلى خدمات الرعاية التلطيفية بشكل كافٍ.

حجم المشكلة

تشير التقديرات إلى أن 40 مليون شخص يحتاج إلى الرعاية التلطيفية كل عام في جميع أنحاء العالم ، ولكن 14% فقط يحصلون على الخدمات التي يحتاجونها (World Health Organization, 2018a) تعاني بلدان منطقة الشرق المتوسط من قصور في مجال الرعاية التلطيفية حيث لا يتم دمج خدمات الرعاية التلطيفية بشكل كامل في أنظمة الرعاية الصحية الخاصة بها (Zeinah et al., 2013). وتشير التقديرات إلى أن 5% فقط من كبار الذين يعيشون في منطقة الشرق المتوسط يحصلون على خدمات الرعاية التلطيفية (Worldwide Hospice Palliative Care Alliance, 2014). إن العوائق الشائعة أمام تطوير ودمج الرعاية التلطيفية تشمل غياب السياسات والنظم الصحية الوطنية المرتبطة الرعاية التلطيفية، ضعف أو غياب التدريب حول الرعاية التلطيفية للعاملين الصحيين وعدم الوصول الكافي إلى العقاقير الأفيونية (World Health Organization, 2018a).

من المتوقع أن يرتفع الطلب في لبنان على خدمات الرعاية التلطيفية بسبب زيادة فئة كبار السن وارتفاع عبء الأمراض غير المعدية. وقد سجل لبنان في العام 2015، اعلى نسبة للأشخاص الذين تبلغ اعمارهم 65 سنة وأكثر (7.3%) فى المنطقة العربية، ومن المتوقع ان يصل هذا الرقم إلى 12% بحلول عام 2030 (Mehio et al., 2015). بالإضافة إلى ذلك، فإن الأمراض غير المعدية تشكل 85% من مجمل الوفيات في لبنان، في حين أن أربعة أنواع من هذه الأمراض مسؤولة عن أعلى نسب الوفيات: أمراض القلب والشرايين (47%)، السرطانات (22%)، أمراض التنفس المزمنة (4%) والسكري (4%) (World Health Organization, 2014). كما يقل احتمال حصول الأطفال على هذه الخدمات في لبنان (Osman et al., 2017) ومع

ذلك، فإن العديد من المرضى الذين يحتاجون الى خدمات الرعاية التلطيفية لا يتلقونها، و تبقى معظم خدمات الرعاية التلطيفية متركزة في المدن الكبرى (Daher et al., 2013).

على الرغم من التقدم الذي شهده قطاع خدمات الرعاية التلطيفية في لبنان خلال العقد الماضي، لا تزال هناك تحديات كبيرة. حيث لا تزال خدمات الرعاية التلطيفية غير مغطاة مالياً من قبل أطراف التأمين العامة ومعظم شركات التأمين الخاصة. كما أدرجت الرعاية التلطيفية في المناهج الدراسية في اثنين من كليات الطب فقط في لبنان، في حين لا يزال هناك نقص في برامج التخصص في الرعاية التلطيفية. على الرغم من أن خدمات الإستشارة الخاصة بالرعاية التلطيفية متوفرة في عدة مستشفيات في لبنان؛ تظل خدمات الرعاية التلطيفية المتخصصة محدودة. بالإضافة إلى ذلك فإن لبنان يفتقر لقانون يُعنى بالرعاية التلطيفية وإلى خطة محلية قائمة بحد ذاتها بشأن تنمية الرعاية التلطيفية ودمجها (Osman et al., 2017).

العوامل المسببة

يركز القسم التالي على العوامل التي تساهم في زيادة حجم المشكلة، وتختلف هذه العوامل في طبيعتها ومستوياتها عبر القطاع الصحي، سواء على مستوى الحوكمة أو على مستوى تكلفة الخدمات والترتيبات المتعلقة بتقديمها التي قد تساهم في المشكلة.

على مستوى الحوكمة، تم بذل جهود كبيرة لتطوير الرعاية التلطيفية في لبنان منذ 1995، ومع ذلك لا تزال هناك العديد من الحواجز التي تعيق تطور خدمات الرعاية التلطيفية. فيذكر القانون رقم 240 الذي ينظم الرعاية التلطيفية بموجب مدونة أخلاقيات الطب "أن ارادة المريض يجب أن تُحترم"، ولكن من ناحية أخرى يسمح هذا القانون للأطباء بإخفاء مرض العضال والتشخيص الخطير عن المريض (Rida & Zeineldine, 2013). وعلى الرغم من أن المرضى يمكنهم تعيين وكيل صحي بشكل قانوني، فإن معظمهم لا يدركون أن لديهم هذا الخيار. لذلك، يمكن للعائلات اختيار تجاهل رغبات المريض واتخاذ القرارات دون استشارته. بالإضافة إلى ذلك، بعض الأدوية الأفيونية اللازمة لتخفيف الألم غير متوفرة في الاسواق اللبنانية (Osman et al., 2017).

على المستوى المالي/المادي، لا تغطي شركات التأمين العامة ومعظم شركات التأمين الخاصة خدمات الرعاية التلطيفية ما يحد من الوصول الى خدمات الرعاية التلطيفية ويُثني بعض المتخصصين في مجال الصحة عن متابعة الرعاية التلطيفية كمهنة. على هذا النحو، فإن مقدمي الرعاية الصحية المهتمين بتوفير

الرعاية التلطيفية في لبنان هم بمعظمهم أطباء العائلة وأطباء الشيخوخة وأطباء أورام أو متخصصين في معالجة الألم ولا يكرسون سوى جزء من وقتهم لتقديم الرعاية التلطيفية (Osman et al., 2017)

ويضطر المرضى الذين يحتاجون إلى هذه الخدمات إلى الدفع من أموالهم الشخصية (*out-of-pocket*) أو اللجوء إلى المنظمات غير الحكوميتين (بلسم وسند) اللتان توفران خدمات الرعاية التلطيفية مجاناً. ومع ذلك، فإن هذه المنظمات غير الحكومية لديها موارد بشرية ومالية محدودة ولا يمكنها تلبية الاحتياجات المرتبطة بالرعاية التلطيفية لجميع المرضى.

على مستوى تقديم الخدمات، يعتبر نقص المعرفة والمهارات في الرعاية التلطيفية بين مقدمي الرعاية الصحية عائقاً رئيسياً يواجه قطاع الرعاية الصحية في لبنان (M. Silberman et al., 2012; Zeinah et al., 2013). وعلى الرغم من أن العديد من كليات الطب تقوم بدمج محاضرات حول الرعاية التلطيفية في مناهج التعليم الطبي الجامعي والدراسات العليا، إلا أنه لا توجد برامج الزمالة أو الإقامة للأطباء المتخصصين في الرعاية التلطيفية (Osman et al., 2017).

بالإضافة إلى ذلك، فإن غياب الوعي وشيوع المفاهيم الخاطئة حول الرعاية التلطيفية بين الناس هو عائق آخر. في لبنان، تُعتبر الرعاية التلطيفية ترفاً وليس حاجة، وهناك العديد من المفاهيم الخاطئة حولها بين المرضى وأفراد العائلة (Osman et al., 2017). لا تزال الرعاية التلطيفية مرتبطة بالوفاة وأمراض العضال، وينظر إليها على أنها الملاذ الأخير عندما تفشل جميع العلاجات الأخرى (Daher et al., 2013). ويختار المرضى وعائلاتهم العلاجات التي تطيل العمر، حتى لو كان ذلك يعني المعاناة من الألم البدني والنفسي الشديد (Mouhawej et al., 2017).

العناصر المطلوبة لمعالجة المشكلة بشكل شامل

تشكّل العناصر الأربعة التالية بمجموعها مقاربة متكاملة لمعالجة مسألة الوصول غير الكافي إلى خدمات الرعاية التلطيفية ويمكن اعتماد أيّة منها بصورة مستقلة أو اعتمادها جميعاً لتكمّل بعضها بعضاً.

العنصر الأول < دمج الخدمات التلطيفية داخل مرافق الرعاية الصحية

على مستوى المستشفى

تدعو منظمة الصحة العالمية بشدة إلى دمج الرعاية التلطيفية في المستشفيات، خصوصاً تلك المعنية بعلاج السرطان والأمراض المزمنة. يمكن للرعاية التلطيفية القائمة في المستشفى تحسين النتائج الصحية للمرضى/ مخرجات الرعاية

الصحية والتحكم في عوارض المرض، وتسهيل مناقشة أهداف رعاية المريض، وخفض مدة الإقامة في المستشفى، وتعزيز انتقال الرعاية من المستشفى إلى المجتمع. يمكن دمج الرعاية التلطيفية في المستشفى بطرق مختلفة: كعيادة للرعاية التلطيفية الخارجية؛ أو كخدمة استشارة للرعاية التلطيفية للمرضى في المستشفى؛ أو كخدمة يومية للرعاية التلطيفية؛ أو كوحدة خاصة للرعاية التلطيفية للمرضى في المستشفيات؛ أو كخدمات متنقلة للرعاية التلطيفية (*World Health Organization, 2016*).

تثبت أدلة دامغة فعالية الرعاية التلطيفية في المستشفيات على صعيد المرضى ومن ناحية توفير الكلفة. حيث أظهرت ثلاثة دراسات منهجية أن الرعاية التلطيفية مرتبطة بانخفاض مدة الإقامة في المستشفى (*Martins et al., 2017*). أظهرت *J. Higginson & Evans, 2010; Kyeremanteng et al., 2016* دراستان منهجيتان فعالية الرعاية التلطيفية في تخفيض التكاليف في المستشفيات (*Kyeremanteng et al., 2016; May et al., 2014; Siouta et al., 2016*). وجدت دراسة منهجية واحدة أن فرق الإستشارات في الرعاية التلطيفية داخل المستشفى توفر تكاليف المستشفى من حوالي 9% إلى 25% (*May et al., 2014*). ووجدت دراسة منهجية أخرى أن استشارات الرعاية التلطيفية خفضت التكاليف المتعلقة بوحدة العناية المركزة من 7,533 دولاراً أمريكياً إلى 6,406 دولاراً أمريكياً والتكاليف المباشرة المتغيرة للمستشفى من 9,518 دولاراً أمريكياً إلى 8,971 دولاراً أمريكياً (*Kyeremanteng et al., 2016*).

على مستوى الرعاية الصحية الأولية

في عام 2014 صدر عن جمعية الصحة العالمية قرار رقم *WHA67-19* يدعو منظمة الصحة العالمية والدول الأعضاء إلى تعزيز الوصول إلى الرعاية التلطيفية مع التركيز على دمج الرعاية التلطيفية ضمن الرعاية الصحية الأولية. يضمن دمج الرعاية التلطيفية في الرعاية الصحية الأولية وفي المجتمع الوصول إلى خدمات الرعاية التلطيفية المستدامة (*World Health Organization, 2018a*). تظهر الأدلة أن دمج الرعاية التلطيفية في الرعاية الصحية الأولية يؤدي إلى خفض تكاليف الرعاية الصحية وتحسين النتائج الصحية /مخرجات الرعاية الصحية ونوعية الحياة (*Sion L Kim & Derjung M Tarn, 2016; Meiklejohn et al., 2016*). وجدت دراسة منهجية أن المرضى الذين تلقوا الرعاية التلطيفية من قبل عاملين متخصصين في الرعاية الأولية، كانوا قابليين للخروج من المستشفى و الموت خارجها. وبالتالي، يمكن أن تساعد الرعاية الأولية في تعزيز استقلالية المرضى بإشراكهم في عملية المعالجة واتخاذ القرار (*S. L. Kim & D. M.*

(Tarn, 2016) ووجدت دراسة منهجية أخرى أن الرعاية الأولية في المنزل تقلل من مدة الإقامة في المستشفى ، وتحسن من رضا المريض ومقدّم الرعاية وتحسّن من نوعية الحياة (Totten et al., 2016). علاوة على ذلك، وجدت دراسة منهجية أن أطباء الصحة العامة، وأطباء العائلة، وأطباء الرعاية الأولية يقدمون دعماً كبيراً لتنسيق الرعاية، وإدارة عوارض المرض وتخفيف الألم، وتعزيز الصحة، والرعاية التلطيفية، وتوفير الرعاية الصحية المستمرة (Meiklejohn et al., 2016).

دمج خطة الرعاية المتقدمة في الممارسات الصحية

يُعرّف تخطيط الرعاية المتقدمة (Advance Care Planning) على أنه "عملية مناقشة أهداف الرعاية ووسائل تحديد أولويات رعاية المرضى الذين قد يفقدون القدرة على التواصل في المستقبل" (Seymour et al., 2010). ويسمح تخطيط الرعاية المسبق للمرضى وعائلاتهم باختيار خطة علاجهم وفقاً لرغباتهم (Brinkman-Stoppelenburg et al., 2014).

تمت مناقشة فعالية تخطيط الرعاية المتقدمة في دراسات مختلفة. وأظهرت أربع دراسات منهجية أن التخطيط للرعاية المتقدمة يقلل من الدخول إلى المستشفى (Brinkman-Stoppelenburg et al., 2014; Khandelwal et al., 2012; Robinson et al., 2016; Martin et al., 2015). ووجدت دراسة منهجية أن تخطيط الرعاية المتقدمة يقلل من استعمال العلاجات التي من شأنها أن تحافظ على الحياة ويزيد من استخدام الرعاية التلطيفية، ويحول دون الدخول إلى المستشفى (Brinkman-Stoppelenburg et al., 2014). تشمل فوائد تخطيط الرعاية المتقدمة تحسين التواصل بين المريض ومقدّم الخدمة الصحية وزيادة رضا المرضى (Lotz et al., 2016; Martin et al., 2013). وارتفاع حالات المرضى الذين يموتون في المكان الذي يتماشى مع رغباتهم (Martin et al., 2016).

الحزمة الأساسية للرعاية التلطيفية

وفقاً لمنظمة الصحة العالمية، تستخدم الحزم الصحية الأساسية تدخلات فعالة من حيث التكلفة التي يمكن أن تؤدي إلى الحد من الفقر وتعزيز العدالة الصحية وتحسين تقديم الخدمات (World Health Organization, 2008) في الواقع، قامت العديد من البلدان بتطبيق حزم مزايا شاملة كجزء من التغطية الصحية الشاملة وأظهرت نتائج من شأنها تحسين نتائج الرعاية الصحية وخفض تكاليفها. وأظهرت إحدى الدراسات التي تقيّم خطة التغطية الشاملة في تايلاند والتي تشمل حزمة مزايا صحية شاملة، انخفاضاً كبيراً في تكاليف الرعاية الصحية التي يتكبدها الفقراء ومدفوعات الأموال الخاصة (Out-of-pocket) (Evans et al., 2012) وبالمثل، أدى برنامج التأمين الصحي

الوطني في المكسيك، والذي يوفر مجموعة من الخدمات الصحية الشاملة، إلى الحد من النفقات الصحية الكارثية، وخاصة بالنسبة للفقراء (F.M.Knaul et al, 2012). بالإضافة إلى ذلك، ذكرت دراسة أولية من غانا أن حزمة المزايا الصحية قد ساهمت في تحسين الوصول إلى خدمات الرعاية الصحية (Odeyemi & Nixon, 2013).

في لبنان، تلقت وزارة الصحة العامة 150 مليون دولار من البنك الدولي والبنك الإسلامي للتنمية لدعم مشروع " دعم صمود قطاع الصحة في لبنان " في عام 2017. وستستخدم هذه الأموال لدعم قطاع الرعاية الصحية في لبنان من خلال تمويل حزمة أكبر والتي تهدف إلى توفير الخدمات الصحية الأساسية للأسر الأكثر فقراً (MOPH, 2017). يمكن أن تنظر وزارة الصحة العامة في تطوير حزمة أساسية للرعاية التلطيفية لضمان تعزيز الوصول إلى خدمات الرعاية التلطيفية وتقليل تكاليف الرعاية الصحية.

العنصر الثاني < توفير الرعاية التلطيفية في مكان إقامة المرضى

الرعاية المنزلية هي خيار قابل للتطبيق في لبنان حيث الروابط العائلية قوية وتلعب دوراً هاماً في قرارات الرعاية الصحية للمريض (Daher, 2011). تتمتع خدمات الرعاية التلطيفية القائمة في المنزل بالعديد من الفوائد، يشمل بعضها احترام رغبات المريض وتوفير التكاليف وتحسين النتائج الصحية / مخرجات الرعاية الصحية (Ventura et al, 2014). وجدت أربع دراسات أن الرعاية التلطيفية في المنزل تزيد احتمال الموت في المنزل (Jordoy et al, 2013; Gomes et al, 2014; Pham & Krahn, 2014; et al, 2000). وتقلل من عبء عوارض المرض. (Gomes et al, 2013) أظهرت دراستان منهجيتان أن المنزل هو المكان المفضل لرعاية المرضى ومقدمي الرعاية من الأسرة (Murray et al, 2009; Gomes et al, 2013). بالإضافة إلى ذلك، خلصت دراسة أولية إلى أن الرعاية التلطيفية في المنزل ارتبطت بزيادة الرضى عند مقدمي الرعاية للمرضى (Singer et al, 2005). وأظهرت دراسة أن الرعاية التلطيفية تقلل من الدخول إلى المستشفى وتكاليفها وتزيد من احتمالات الموت في المنزل (Brumley et al, 2017) بالإضافة إلى ذلك، أظهرت دراستان أن الرعاية التلطيفية في المنزل تشكل تدخلا فعالا من حيث التكاليف (McCaffrey et al., 2013; Pham & Krahn, 2014).

العنصر الثالث < تعزيز التعليم والتدريب حول الرعاية التلطيفية بين

المتخصصين في الرعاية الصحية

يتناول هذا العنصر تعليم وتدريب العاملين في الرعاية الصحية والذي يمكن تحقيقه من خلال أدوات مختلفة. فخلّصت إحدى الدراسات المنهجية إلى أن دمج الرعاية التلطيفية في المرحلة الجامعية يؤمن للطلاب المعرفة والمهارات والكفاءات اللازمة في مجال الرعاية التلطيفية، وتحسّن كيفية تعاملهم مع المرضى الذين يعانون من أمراض العضال (Centeno & Rodriguez-Nunez, 2015). وجدت دراسة منهجية أخرى أن الدورات الدراسية والتدريب في مجال رعاية مرحلة نهاية الحياة والرعاية التلطيفية لعاملِي الرعاية الصحية والاجتماعية، هي مفيدة لتحسين المهارات والإستعداد لتوفير الرعاية التلطيفية (Pulsford et al, 2013) بالإضافة إلى ذلك، أظهرت دراسة منهجية أن التدخلات التثقيفية المتعددة الأوجه حول الرعاية التلطيفية مثل المناقشات الجماعية وإدارة الحالات والدورات التعليمية والدروس التثقيفية التعليمية واجتماعات الفرق متعددة التخصصات، تحسّن المعرفة حول الرعاية التلطيفية للعاملين في مجال الرعاية الصحية الأولية (Alvarez & Agra, 2006).

العنصر الرابع > تحسين الوعي العام حول الرعاية التلطيفية

يمكن أن يؤدي تحسين الوعي العام حول مفهوم الرعاية التلطيفية وفوائدها إلى تعزيز الإحالات إلى خدمات الرعاية التلطيفية ويمكن أن يساعد في تحديد الفجوات في الخدمات المقدمة. أظهر ملّخص سياسات موجّه للمواطنين حول تحسين الوصول إلى الرعاية التلطيفية في أونتاريو، أنه يمكن استخدام حملات وسائل التواصل الإجتماعي حول الرعاية التلطيفية كأداة لتحسين الوعي العام حول الرعاية التلطيفية (Gauvin et al, 2013) أظهرت أربع دراسات منهجية أن وسائل الشبكات الاجتماعية قد تعزز تغيير السلوك الصحي (Cugelman et al, 2011; Laranjo et al, 2014; Maher et al, 2007) وذكر دراسة أخرى ان حملات التسويق الإجتماعي يمكن ان تكون فعالة في تغيير سلوكيات المستهلكين والمرضى/والمنظمات وصانعي السياسات و التأثير على تغييرات السياسات العامة (Stead et al, 2007). وأظهرت دراسة أولية أن هناك حاجة لتحسين الوعي بين الناس لزيادة المعرفة والوصول إلى خدمات الرعاية التلطيفية وتمكين المجتمعات المشاركة في صنع القرار المتعلق بالرعاية التلطيفية (McLiftrick et al, 2013). ذكرت إحدى تقارير "Lancet" أن التعاون القوي بين مقدمي الرعاية التلطيفية وجماعات المناصرة والمجتمعات الدولية قد أثبت فعاليته في تغيير السياسات الوطنية المتعلقة بالرعاية التلطيفية (Felicia Marie Knaul et al, 2017).

ما هي العوامل التي يجب أخذها بعين الاعتبار عند التطبيق العملي؟

نشير في ما يلي إلى أبرز الإعتبارات المطلوبة على مستوى المرضى، ومتخصّصي الرعاية الصحية، والمؤسسات، والأنظمة:

- ← تحسين الوعي حول الرعاية التلطيفية وإدارة معالجة الألم من خلال حملات التوعية العامة ووسائل الإعلام والنشرات التعليمية
- ← تدريب مقدمي الرعاية للمساعدة في رعاية المرضى في المنزل
- ← تأمين التدريب المهني والتعليم حول الرعاية التلطيفية لمتخصّصي الرعاية الصحية من خلال دورات تدريبية محلية وإقليمية، ودورات توجيهية والتعليم الطبي المستمر.
- ← تحديد مؤسسات معيّنة كمراكز تدريب للرعاية التلطيفية
- ← تعزيز الشراكة بين المنظمات غير الحكومية والجمعيات الدينية الخيرية والمستشفيات مما يساعد في توحيد التدريب على الرعاية التلطيفية وزيادة قدرة المتخصّصين في الرعاية الصحية على تقديم الرعاية التلطيفية.
- ← تحديد المعايير والتوجيهات المرتبطة بالرعاية التلطيفية داخل المستشفيات
- ← تدريب المتطوعين من المجتمع لزيادة قدراتهم على دعم المرضى الذين يتلقون الرعاية التلطيفية.
- ← بدء مناقشات دقيقة وحساسة حول قضايا مرحلة نهاية الحياة وتطوير مسارات الإحالة الصحية الواضحة
- ← تعديل المادة 44 من القانون اللبناني لمدونة أخلاقيات الطب لحث الأطباء على اخبار المرضى عن الأمراض المستعصية والتشخيص الخطير لهم
- ← مراجعة التشريعات الوطنية المتعلقة بالتوجيهات المتقدمة وبتوافر العقاقير الأفيونية والقدرة على تحمل تكاليفها
- ← إجراء أبحاث عالية الجودة مثل الدراسات المنهجية والدراسات التدخلية حول الرعاية التلطيفية

Content

K2P Policy Brief- Full report

The Problem

The high burden of NCDs and the rapidly aging population makes PC an essential component of health services needed to relieve the suffering of patients. Access to PC is a basic health and human right and a core component of UHC. It is associated with many benefits including improved quality of life, increased patient satisfaction, and decreased hospitalization. According to a report published in 2017, an estimated number of 15,000 patients need PC services each year. This number is expected to increase due to a number of factors such as the aging population and the rise in NCDs. Yet, current health system arrangements do not ensure adequate access to PC services.

Palliative Care (PC) is defined 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 (World Health Organization, 2018c)

Size of the Problem

Worldwide, it is estimated that 40 million people need PC each year, yet only 14% receive the services they need. Common barriers to the development and integration of PC include the absence of national health policies and systems that include PC, poor or absent training on PC for health professionals, and inadequate access to opioid drugs (World Health Organization, 2018a). A study conducted to map the levels of PC development in 234 countries in 2011 found that PC services were well-integrated in only 20 countries (8.5%), while 42% had no PC services at all and a further 32% had only isolated PC services (T. Lynch, S. Connor, & D. Clark, 2013).

Background to Policy Brief

A K2P Policy Brief brings together global research evidence, local evidence and context-specific knowledge to inform deliberations about health policies and programs. It is prepared by synthesizing and contextualizing the best available evidence about the problem and viable solutions and options through the involvement of content experts, policymakers and stakeholders.

The preparation of the Policy Brief involved the following steps:

- 1) *Selecting a priority topic according to K2P criteria*
- 2) *Selecting a working team who deliberates to develop an outline for the policy brief and oversee the litmus testing phase.*
- 3) *Developing and refining the outline, particularly the framing of the problem and the viable elements*
- 4) *Litmus testing by conducting one to one interviews with up to 15 selected policymakers and stakeholders to frame the problem and make sure all aspects are addressed.*
- 5) *Identifying, appraising and synthesizing relevant research evidence about the problem, elements, and implementation considerations*
- 6) *Drafting the brief in such a way as to present concisely and in accessible language the global and local research evidence.*
- 7) *Undergoing merit review*
- 8) *Finalizing the Policy Brief based on the input of merit reviewers, translating into Arabic, validating translation, and disseminating through policy dialogues and other mechanisms.*

Countries in the Eastern Mediterranean region suffer from deficiencies in the field of PC where PC services are not fully integrated into their health systems. When PC services are available, they are delivered by NGOs, charities, and hospital units (Zeinah et al., 2013). Only an estimated 5% of the adults living in the Eastern Mediterranean region receive PC services (Worldwide Hospice Palliative Care Alliance, 2014). According to an NCDs country capacity survey conducted by WHO in 2015, only Saudi Arabia and Syria reported that at least 50% of patient with NCDs had access to primary care-based PC services within the public health system. In addition, home-based PC was available to cover at least 50% of the population in only Saudi Arabia, Syria, and Qatar. However, PC services are likely to be lower in Syria due to the current conflict (Fadhil, Lyons, & Payne, 2017)

In Lebanon, the demand for PC service is expected to rise with the aging population and the high burden of NCDs. In 2015, Lebanon had the highest percentage of people aged 65 years and older (7.3%) in the Arab region and this number is projected to reach 12% by the year 2030 (Mehio et al., 2015). According to the National Pan Arab Project for Family Health (Papfam) Survey, 75% of people aged 65 years and older reported suffering from at least one co-morbidity, where the leading causes of morbidity were hypertension (36.7%), heart disease (23.1%), and diabetes (21.4%) (Mehio et al., 2015). In addition, NCDs account for 85% of total deaths, with four types of NCDs accounting for the largest proportions of deaths: cardiovascular disease (47%), cancers (22%), chronic respiratory diseases (4%) and diabetes (4%) (World Health Organization, 2014). Moreover, children are less likely to receive PC (Osman et al., 2017). A survey conducted among Lebanese nurses and physicians found that 98% of pediatric nurses and 100 % of physicians reported the need for developing pediatric PC (H. H. Abu-Saad & Dimassi, 2007). Furthermore, a study assessing the quality of pediatric PC for children with cancer in Lebanon found that management of distressing symptoms such as fatigue and difficulty sleeping was inadequate and focused mainly on treating symptoms such as pain and nausea (H. H. Abu-Saad, Sagherian, Tamim, Naifeh, & Abboud, 2013). Despite the latter, few patients who need PC receive the care they need. Furthermore, most PC services are provided in large cities and many patients can't afford PC services (Michel Daher et al., 2013).

Despite progress towards developing PC services in Lebanon, substantial challenges remain. PC services are still not financially covered by public and most private insurance parties. Only two medical schools have integrated PC in their curricula, and PC residency and fellowship programs are still lacking. PC consult services are available in several hospitals in Lebanon; however, specialist PC services remain limited. In addition, Lebanon does not have a national PC law to support PC development and integration (Osman et al., 2017). Moreover, poor coordination of care, problems with drug availability

and accessibility, lack of resources, poor public awareness, and inappropriate attitudes among health professional are also challenges hampering the development of PC in Lebanon (Zeinah et al., 2013).

Underlying Factors

The following section focuses on the underlying factors at the governance, financial and delivery arrangement levels of the health system that may have contributed to the problem.

Governance

The development of PC is difficult without policies and laws that support its provision. Based on data from Atlas for PC in the Eastern Mediterranean Region, Tunisia is the only country with a national PC plan; while Jordan, Lebanon, Morocco, and Qatar have developed and published national documents for the provision of PC services. Iran, Lebanon, and Oman are the only countries that reported that a law for PC is under development (Osman et al., 2017).

In Lebanon, significant efforts have been ongoing to develop PC since 1995. These include, introduction of PC during a National Cancer Control workshop, conduction of the first Palliative Care and ethics symposium, initiation of the Lebanese Pain and Palliative Care Initiative within the Lebanese Cancer Society, introduction of PC as a patient right in the first article of the law 574, amendment of Narcotic law, introduction of PC as a patient right, establishment of the National Committee for Pain Relief and Palliative Care, introduction of new narcotics in the market, launching a national strategy to raise awareness about PC, and recognition of palliative medicine as a medical specialty (figure 1).

Advancement of Palliative Care in Lebanon

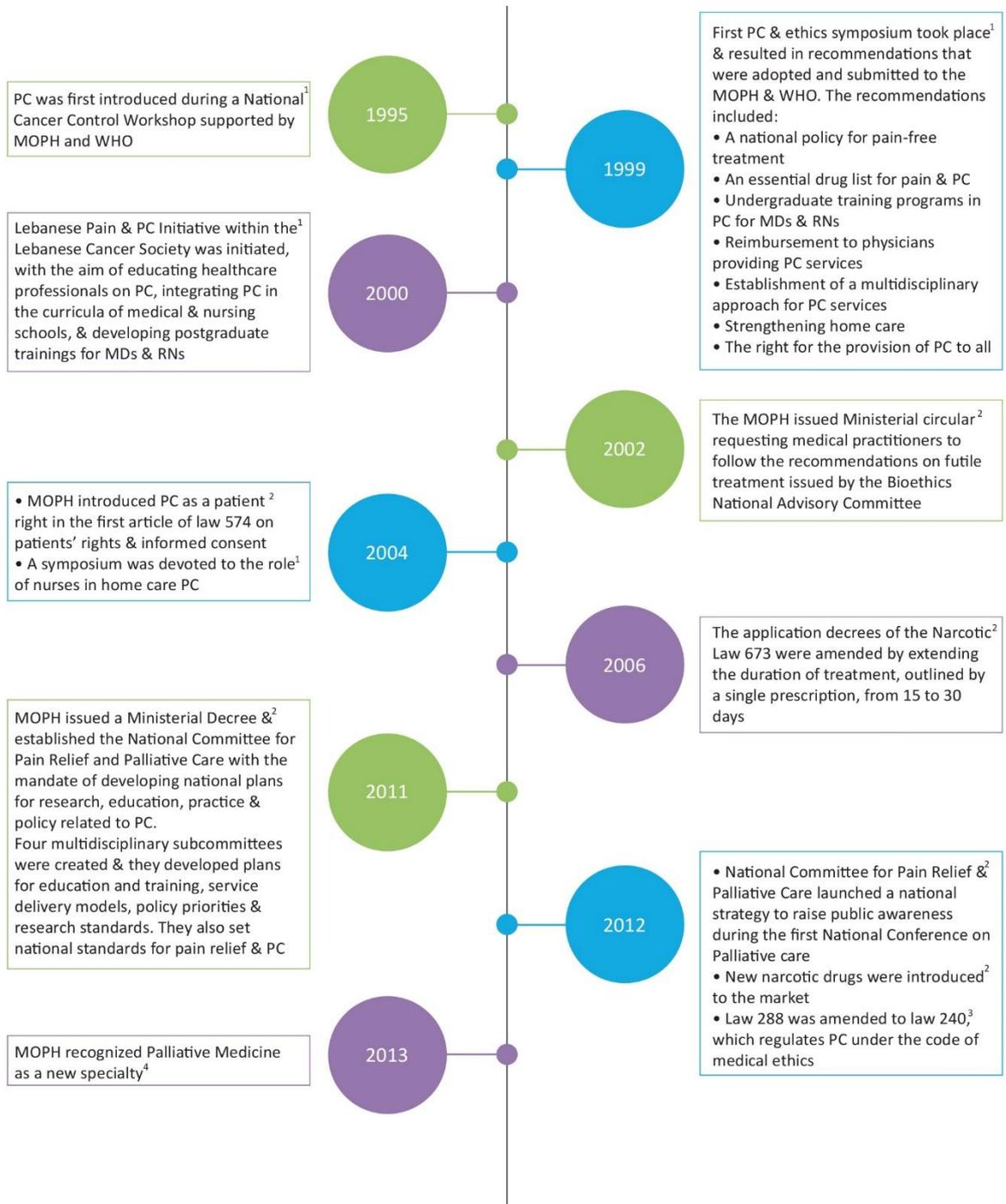


Figure 1. Advancement of Palliative Care in Lebanon

(1) M. Silbermann et al., 2012; (2) Ammar & Hamra, 2013; (3) Rida & Zeineldine, 2013; (4) Osman, 2015

*MD: Medical Doctor; RN: Registered Nurse

In October 2012, law 288 was amended to law 240, which regulates PC under the code of medical ethics. According to article 27 of law 240, the will of the patient should always be respected. Article 27 also states that the role of the physician is to reduce physical and mental pain and provide comfort to patients suffering from terminal illnesses. This decision should be made in coordination between the patient or surrogate, the treating physician, and the head of the department. However, the code of medical ethics is not clear about the role of the surrogate in decision-making or how the “will” of the patient can be determined or expressed, whether it should be written, oral, or documented in the patient's medical records. In addition, article 44 of law 240 allows the physician to conceal terminal illness and serious diagnosis results from the patient, which deprives the patient from the right to choose the treatment plan he wants and from seeking PC. Article 44 contradicts with the principle of human dignity and patient autonomy and requires adjustment to respect patients choice (Rida & Zeineldine, 2013). Furthermore, advance directives do not exist and even though patients can legally assign a health proxy, most of them are not aware that they have this option. Therefore, families can choose to ignore the patient’s wishes and make decisions without consulting with the patient (Osman et al., 2017).

Several regulatory changes have been made to reduce the barriers to access pain medication. These include laws allowing physicians to prescribe higher doses for longer periods and simplifying the process of having prescriptions filled for patients and families, which have reduced the bureaucratic hurdles of obtaining opioids. Importantly, opioid analgesics are no longer restricted to patients with a documented diagnosis of cancer, thus allowing patients suffering from other diseases to be treated (Osman, 2015). However, there are still many barriers to opioid prescription and access. Oncologists, pain specialists, and PC providers are the only healthcare providers able to prescribe opioid analgesics to patients (Osman, 2015), which restricts physicians of other specialties to prescribe opioids to a wide range of patients. In addition, medications such as hydrocodone and immediate-release morphine which are essential for adequate pain management but are still not available in the market, whereas methadone is still not accessible for pain management (Osman et al., 2017).

Financing

Financial coverage for PC services is one of the most significant barriers to access. It is estimated that the healthcare costs associated with the provision of palliative and social care services toward end of life range from 10% of all healthcare costs in the Netherlands (Polder, Barendregt, & van Oers, 2006), 25% of Medicare Hospice spending in the United States (Riley & Lubitz,

2010) and 29% of English National Health Service hospital spending (Barnato, 2007). Adequate medical treatment for life-threatening illnesses may only be available to those able to pay.

In Lebanon, the main barrier to access PC services is the lack of financial coverage. A national PC program has been proposed to the MOPH to provide financial coverage to PC services in hospitals and homes but is not implemented yet (Osman et al., 2017). To this date, public and most private insurance parties do not cover PC services. This limits access to PC services and also discourages health professionals from pursuing PC as a profession. Therefore, healthcare providers interested in providing PC in Lebanon are mainly family physicians, geriatricians, oncologists or pain specialists and only devote part of their time to providing PC (Osman, 2015).

Patients who need PC services are forced to pay out of pocket or resort to the only two NGOs-Balsam and SANAD- that provide PC services free of charge. However, these NGOs have limited human and financial resources and cannot meet the needs of all people who need PC. According to Balsam's annual report in 2016, the NGO provided care to 215 patients, a 35% increase from 2015. Due to this increase and limited resources, Balsam was unable to accommodate all requests and had to prioritize new patients based on need and urgency. A total of 30% of referred patients had to wait more than 6 days before being enrolled in the PC program. Twenty nine patients living outside Greater Beirut Area received PC through the distance support program (Balsam, 2016). In 2017, out of the 194 patients admitted to Balsam, 147 patients received regular support, nine patients were assessed but did not need PC, and 38 patients living outside Greater Beirut Area received distance PC support. Forty percent of patients discharged from hospitals received home care in less than 2 days (Balsam, 2017). Moreover, SANAD provided care for 183 patients in 2017 compared to 85 patients in 2016. In 2017, more than half of the patients who received PC were 65 years and older and more than 90% of the referred patients suffered from cancer. In Beirut, 55% of patients were referred to SANAD by their primary physicians, while this proportion was 67% in Beqaa. The average length of stay with SANAD was 34 days in Beirut and 23 days in Beqaa. In addition, 74% of patients in Beirut and 47% of patients in Beqaa died at home (SANAD, 2017). Despite concerted efforts of these NGOs to provide PC, a large proportion of patients who need PC services cannot access PC due to the lack of financial coverage of PC services.

Delivery

Worldwide, the majority of health professionals have limited knowledge about PC (Worldwide Hospice Palliative Care Alliance, 2014). Lack

of trained health professionals in PC is a major barrier to daily practice (Gibbins, McCoubrie, & Forbes, 2011; Prem et al., 2012) and to improving access to PC (World Health Organization, 2018a). Countries in the Eastern Mediterranean region suffer from similar challenges hampering the development of PC. For example, education of health professionals in PC is limited to a fellowship program and short courses in Iran. In Oman, PC is not integrated into the curricula of medical or nursing schools, whereas in Egypt the PC diploma in the Alexandria University is strictly provided to oncologists (Osman et al., 2017).

Similarly, lack of knowledge and skills in PC among healthcare providers is a major barrier facing the health system in Lebanon (Michel Daher et al., 2002; M. Silberman et al., 2012; Zeinah et al., 2013). A survey assessing Knowledge, Practice, and Attitudes of nurses and physicians on PC in Lebanon found that only 14.8% of nurses and 11.6% of physicians with medical specialties reported receiving continuing education in PC. Only 8.3% of oncology physicians compared to around 25% of physicians in other specialties reported that they inform the patients suffering from a terminal illness about their diagnosis. 24.4% of oncology nurses reported that PC is a practice that destroys hope and leads to despair and depression indicating a lack of awareness on the importance of PC and the need to improve PC education. Continuing education in PC, better knowledge and attitudes in PC, and being exposed to terminally ill patients were positively associated with improved PC practices among health professionals. The study concluded the need to improve PC education and training of health professionals in Lebanon through integrating PC in all nursing and medical school curricula and continuing medical education (Abu-Saad Huijjer, Dimassi, & Abboud, 2009). According to Doumit (2015), PC education is integrated in some undergraduate nursing curricula and provided by some university hospitals through continuing medical education; however, PC education can be more structured. Although several medical schools are integrating PC lectures into their undergraduate and graduate medical education curricula, there are no formal fellowships or residency training programs for physicians in PC (Osman et al., 2017).

In addition, lack of awareness and wrong perceptions about PC among the public is another cited barrier. Evidence shows that lack of awareness about PC leads to inequitable access to services and negatively impacts the quality of care (McIlpatrick et al., 2013). In Lebanon, PC is considered a luxury rather than a need and there are many misconceptions about PC among patients and their families (Osman et al., 2017). PC is associated with death, terminal illnesses, and is viewed as a last resort when all other treatments fail (Michel Daher et al., 2013). Patients and their families

opt for treatments that prolong life, even if that means suffering from physical and psychological pain (Mouhaweij et al., 2017). According to a study conducted in 2015 among university students in Lebanon, 65% of students believe that death is still a taboo in our society and that patients cannot choose their place of death. Overall, 65% of students wished better management of end-of-life care which can be achieved through the establishment of PC units (40%), home-based PC (34%), and the development of pain management in hospitals (34%). 50% of students stated that efforts should be made to ensure financial coverage for patients who need PC, 43% stated that a policy should be implemented to develop PC units, and 27% stated that health professionals need to receive training to care for terminally ill patients (Tohme, Younes, & Mouhaweij, 2018).

Elements of a policy approach to address the problem

The following four elements form part of a comprehensive approach tackling the issue of inadequate access to PC services, and therefore can be adopted independently or could complement one another.

Element 1 ▶ Integrate palliative care services within healthcare facilities

Element 2 ▶ Provide palliative care at patients' residence

Element 3 ▶ Strengthen education and training in palliative care among health professionals

Element 4 ▶ Improve public awareness about palliative care

Elements

Policy Elements and Implementation Considerations

Element 1

Integrate palliative care services within healthcare facilities

At the hospital level

WHO strongly calls for the integration of PC in hospitals especially those involved in treating cancer and chronic diseases. Hospital-based PC can improve patient outcomes and symptom control, facilitate the discussion of patient's goals of care, reduce length of stay, and enhance transition of care to the community. In addition, hospital-based PC can help health professionals working in other fields to engage and learn about PC. Hospital-based PC can be integrated in different ways: as an outpatient PC clinic; a PC consultation service for hospital inpatients; a PC day-care service; an inpatient PC unit; and PC outreach service (World Health Organization, 2016).

Compelling evidence demonstrates the effectiveness and cost-effectiveness of hospital-based PC. Three systematic reviews found that PC services are associated with decreased length of stay (Martins et al., 2017; I. J. Higginson & Evans, 2010; Kyeremanteng et al., 2016). Similarly, one comprehensive literature review assessing the cost-effectiveness of PC interventions reported that patients who received PC had fewer acute care admissions and significantly shorter length of stay (S. Smith, Brick, O'Hara, & Normand, 2014).

In addition, two systematic reviews showed that specialist PC services improved symptom control (Higginson & Evans, 2010; Mitchell, Morris, Bennett, Sajid, & Dale, 2017), patient satisfaction (Higginson & Evans, 2010; Mitchell et al., 2017) and quality of life of patients and their families (Mitchell et al., 2017). Similarly, three primary studies found that PC can improve the quality of care (Bakitas et al., 2009; Casarett et al., 2008; Temel et al., 2010), improve family perceptions of care (Casarett et al., 2008), decrease depression, and extend survival among patients (Bakitas et al., 2009; Temel et al., 2010).

Two systematic reviews reported the cost-effectiveness of hospital-based PC (Kyeremanteng et al., 2016; May et al., 2014; Siouta et al., 2016). One systematic review found that inpatient PC consultation teams save hospital costs in the range of 9% to 25% (May et al., 2014). Another systematic

S U M M A R Y

Element 1

Integrate palliative care services within healthcare facilities

Element 2

Provide palliative care at patients' residence

Element 3

Strengthen education and training in palliative care among health professionals

Element 4

Improve public awareness about palliative care

review found that PC consultations reduced ICU costs from USD \$7,533 to USD \$6,406 and hospital direct variable costs from USD \$9,518 to USD \$8,971 (Kyeremanteng et al., 2016). In addition, one primary study found that patients who received PC incurred fewer hospital costs and spent less time in ICUs (R Sean Morrison et al., 2011).

At the primary health care level

In 2014, the World Health Assembly resolution WHA67.19- called WHO and the Member States to enhance access to PC, specifically through the provision of PC in primary health care (World Health Organization, 2018a).

Evidence shows that the integration of PC in primary healthcare leads to reduced healthcare costs and improved health outcomes and quality of life. (Sion L Kim & Derjung M Tarn, 2016; Meiklejohn et al., 2016; Totten et al., 2016). One systematic review that examined the relationship between primary care involvement in end-of-life (EOL) care and health and utilization outcomes found that patients who received PC by primary care providers were more likely to be discharged or die outside of the hospital. Thus, primary care can help strengthen patient's autonomy by involving them in the treatment process and decision-making (S. L. Kim & D. M. Tarn, 2016). Another systematic review found that home-based primary care reduces hospitalizations and length of stay, improves patient and caregiver satisfaction, and enhances quality of life (Totten et al., 2016). Moreover, one systematic review found that general practitioners, family physicians, and primary care physicians provide great support for care coordination and management, symptom and pain relief, health promotion, PC, and continuing healthcare provision (Meiklejohn et al., 2016).

In addition, a review concluded that the integration of PC in primary care can promote quality of life, support patients and caregivers, and provide patient-centered care (Gorman, 2016). One primary study found that primary care visits among Medicare beneficiaries at end of life were associated with less hospitalization, lower costs, and reduced hospital deaths (Kronman, Ash, Freund, Hanchate, & Emanuel, 2008). Similarly, one primary study found that patients suffering from life-limiting illnesses who received care in primary care setting have less utilization of emergency departments and some reported improvements in symptom assessment (Owens et al., 2012). In addition, one primary study mentioned that PC services delivered through primary health care increased access to these services among children with chronic diseases and enhanced PC knowledge among primary care providers (Lieberman, Song, Radbill, Pham, & Derrington, 2016).

Integrate advance care planning into practice

Advance care planning is defined as “ a process of discussion about goals of care and means of setting on record preferences for care of patients who may lose capacity or communicating ability in the future”(Seymour et al., 2010). Advance care planning enables patients and their families to choose their treatment plan according to their wishes (Brinkman-Stoppelenburg et al., 2014).

The effectiveness of advance care planning has been portrayed in various studies. Four systematic reviews found that advance care planning reduce hospital admissions (Brinkman-Stoppelenburg et al., 2014; Khandelwal et al., 2015; Martin et al., 2016; Robinson et al., 2012). A systematic review found that advance care planning decreases life-sustaining treatment, increases the use of PC, and prevents hospitalization (Brinkman-Stoppelenburg et al., 2014). Reported benefits of advance care planning include improved patient-provider communication, increased patient satisfaction (Lotz et al., 2013; Martin et al., 2016), and higher incidence of patients dying in their preferred place of death (Martin et al., 2016). One randomized clinical trial (RCT) concluded that advance care planning improves end-of-life care, reduces anxiety and depression, and enhances patient and family satisfaction (Detering, Hancock, Reade, & Silvester, 2010).

Furthermore, two systematic reviews found that advance care planning is associated with healthcare savings (Dixon, Matosevic, & Knapp, 2015; Klingler, in der Schmitt, & Marckmann, 2016). In fact, one systematic review found that advance care planning can save costs ranging from \$1,041 to \$64,830 per patient (Klingler et al., 2016).

Essential package for palliative care

UHC is defined as "ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation, and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship” (World Health Organization, 2018b). All people should have access to basic PC services irrespective of their ability to pay, disease type, or age. The WHO states that countries need to establish financial and social protection systems for the poor to ensure that they have adequate access to PC (World Health Organization, 2018a).

Although PC is a core component of UHC and a human right, poor people around the world do not receive PC and pain relief. Poor access to PC and pain relief causes profound social and health inequities. The Lancet Commission on Global Access to PC and Pain relief of PC providers developed a low-cost essential package that any resource-strained health system can make

universally accessible. The essential package can be provided at all levels of care from hospital to home to primary care centers. The package includes essential medicines, equipment, and human resources necessary for the provision of effective and essential PC and pain relief services (Felicia Marie Knaul et al., 2017). According to Felicia Marie Knaul et al. (2017), the essential package for PC can strengthen health systems and save enormous healthcare costs incurred by patients and their families.

According to WHO, essential health packages use cost-effective interventions that can lead to poverty reduction, enhance health equity, and improve service delivery (World Health Organization, 2008). In fact, several countries have implemented comprehensive benefits packages as part of UHC and showed favorable healthcare outcomes and reduction in healthcare costs. One review report assessing Thailand's Universal Coverage Scheme (UCS) that includes a comprehensive benefits package showed a significant reduction in healthcare costs incurred by the poor and out of pocket expenditures (Evans et al., 2012). Similarly, the national health insurance program in Mexico which provides a package of comprehensive health services reduced the prevalence of catastrophic health expenditures, especially for the poor (F. M. Knaul et al., 2012). In addition, one primary study from Ghana mentioned that the benefits package improved access and provision of healthcare services (Odeyemi & Nixon, 2013). A primary study assessing the use of an essential health package in Malawi found an improved provision of healthcare services and increased outpatient attendance, particularly for lower income groups (Bowie & Mwase, 2011). One report mentioned that benefits packages included in the general health insurance scheme in Turkey provided insurance coverage for the poorest population, improved maternal and child health service, and helped reduce the maternal mortality ratio, under five, infant, and neonatal mortality ratios (Atun et al., 2013).

In Lebanon, the MOPH received 150 million dollars from the World Bank and Islamic Development Bank for "Supporting the steadfastness of Health sector in Lebanon" project in 2017. These funds will be used to support the health care system in Lebanon through funding a larger package that aims at providing vital health services to the poorest families (MOPH, 2017). The MOPH can consider developing a tailored essential package for PC to enhance accessibility to PC services and reduce healthcare costs. However, implementation barriers for this option exist and include inadequate funding, shortage of trained and available health professionals (Opon, 2016; Ssenkooba, 2004), shortages of essential drugs (Felicia Marie Knaul et al., 2017; Mueller, Lungu, Acharya, & Palmer, 2011), poor health infrastructure (Opon, 2016), cultural and religious barriers, and political instability (Frost, Wilkinson, Boyle, Patel, & Sullivan, 2016).

Table 1 **Key findings from systematic reviews and single studies**

Category of finding	Element 1
Benefits	<p>At the hospital level</p> <p>2 systematic reviews found that PC services improve satisfaction and symptom control (Higginson & Evans, 2010; Mitchell et al., 2017).</p> <p>3 systematic reviews found that PC services are associated with decreased length of stay (Aslakson, Curtis, & Nelson, 2014; Higginson & Evans, 2010; Kyeremanteng et al., 2016).</p> <p>1 primary study found that patients receiving PC incurred fewer hospital costs and spent less time in ICUs compared to patients receiving usual hospital care (R Sean Morrison et al., 2011).</p> <p>1 primary study found that PC consultation services can improve the quality of care and early PC consultations are associated with improved family perceptions of care (Casarett et al., 2008).</p> <p>1 primary study found that PC patients had less acute care admissions and shorter length of stay (S. Smith et al., 2014).</p> <p>3 primary studies found that PC can improve the quality of care (Bakitas et al., 2009 ; Casarett et al., 2008; Temel et al., 2010), improve family perceptions of care (Casarett et al., 2008), decrease depression, and extend survival among patients (Bakitas et al., 2009; Temel et al., 2010).</p> <p>At the primary health care level</p> <p>1 systematic review found that patients who received care from primary care providers were more likely to be discharged or die outside of the hospital (S. L. Kim & D. M. Tarn, 2016).</p> <p>1 systematic review found that home-based primary care reduces hospitalizations and length of stay and hospitals, improves patient and caregiver satisfaction, and enhances quality of life (Totten et al., 2016).</p> <p>1 systematic review found that general practitioners, family physicians, and primary care physicians provide great support for care coordination, screening, diagnosis and management of physical and psychological effects of cancer and its treatment, symptom and pain relief, health promotion, PC and continuing general health care provision (Meiklejohn et al., 2016).</p>

Category of finding	Element 1
	<p>1 review about elements of effective PC models concluded that specialist PC should be integrated in primary and community care (Lockett et al., 2014).</p> <p>1 primary study found that patients and their caregivers believe that primary care staff play an important role in their continuity of care and providing patient-centered information (Kendall et al., 2006).</p> <p>1 review concluded that the integration of PC in primary care can promote quality of life, support patient, and caregivers, and provide patient-centered care (Gorman, 2016).</p> <p>1 primary study found that patients with a life-limiting illness who received care in primary care setting have less utilization of emergency departments and some reported improvements in symptom assessment (Owens et al., 2012).</p> <p>1 pilot study found that PC services delivered through primary health care increases access to these services among children with chronic diseases and enhance PC knowledge among primary care providers (Lieberman et al., 2016)</p>
	<p>Integrate advance care planning into practice</p> <p>4 systematic reviews found that advance care planning reduce hospital admissions (Brinkman-Stoppelenburg et al., 2014; Khandelwal et al., 2015; Martin, Hayes, Gregorevic, & Lim, 2016; Robinson et al., 2012).</p> <p>1 systematic review found that pediatric advance care planning, when implemented properly, can improve positive emotions and communication between the patient and healthcare providers (Lotz, Jox, Borasio, & Fuhrer, 2013).</p> <p>1 systematic review found that advance care planning is associated with high incidence of dying in the preferred place of death for patients and increased patients' satisfaction with medical treatments (Martin et al., 2016).</p> <p>1 RCT concluded that advance care planning improves end-of-life care, reduces anxiety and depression, and enhances patient and family satisfaction (Detering, Hancock, Reade, & Silvester, 2010).</p>
	<p>Essential package</p> <p>1 review assessing Thailand's Universal Coverage Scheme (UCS) that includes a comprehensive benefits package showed a dramatic reduction in healthcare costs incurred by the poor and out of pocket expenditures (Evans et al., 2012).</p>

Category of finding	Element 1
	<p>1 Lancet report showed that the national health insurance program in Mexico which provides a package of comprehensive health services reduced the prevalence of catastrophic health expenditures, especially for the poor (F. M. Knaul et al., 2012)</p> <p>1 report mentioned that benefits packages included in the general health Insurance scheme in Turkey provided insurance coverage for the poorest population, improved maternal and child health services, and helped reduce different mortality ratios (Atun et al., 2013)</p> <p>1 primary study mentioned that Ghana’s benefits package improved access and provision of healthcare services (Odeyemi & Nixon, 2013)</p>
Potential harms	<p>At the primary health care level</p> <p>1 primary study conducted in primary care in England found that health professionals experience stress when placing patients with non-malignant diseases on a PC register (Dalkin, Lhussier, Philipson, Jones, & Cunningham, 2016).</p> <p>Essential package for palliative care</p> <p>1 case study in South Africa found that benefits packages applied in private sector schemes created inequities by excluding patients with underlying diseases from the packages (Taylor, Ostermann, Van Houtven, Tulsy, & Steinhauser, 2007)</p>
Cost and/ or cost effectiveness in relation to the status quo	<p>At the hospital level</p> <p>2 primary studies found that costs were significantly lower in PC patients compared to control groups (Lewin et al., 2005; R Sean Morrison et al., 2011; T. J. Smith et al., 2003).</p> <p>1 RCT showed that the total health costs for patients receiving PC services were lower by \$6,766 per patient compared to patients receiving the usual hospital care. This was largely attributed to less hospital readmission costs for patients receiving PC services (Gade et al., 2008).</p> <p>1 primary study found that patients receiving PC incurred \$6,900 fewer hospital costs compared to patients' receiving regular care. The costs were reduced by \$4098 for patients discharged alive and \$7,563 for patients who died in the hospital (R Sean Morrison et al., 2011)</p> <p>1 primary study found that the overall cost savings from PC of \$3,426 per patient for those dying in the hospital. However, it</p>

Category of finding	Element 1
	<p>found no significant cost savings for patients discharged alive (McCarthy, Robinson, Huq, Philastre, & Fine, 2015)</p> <p>1 primary study found that PC patients discharged alive had net savings of \$1,696 in direct costs per admission and \$279 per day, and those who died in the hospital had adjusted net savings of \$4,908 in direct costs per admission and \$374 per day (R. S. Morrison et al., 2008)</p> <p>At the primary health care level</p> <p>1 primary study found that primary care visits among Medicare beneficiaries at end of life were associated with less hospitalization, lower costs, and less in-hospital death (Kronman et al., 2008)</p> <p>Advance care planning</p> <p>2 systematic reviews found that advance care planning is associated with healthcare savings (Dixon et al., 2015; Klingler et al., 2016). According to Klingler et al. (2016) found that advance care planning saves costs ranging from USD 1,041 to USD 64,827 per patient.</p> <p>Essential package for palliative care</p> <p>1 primary study conducted in Malawi found that 33 of the 55 essential health package interventions were cost-effective (Bowie & Mwase, 2011)</p> <p>A Lancet commission report projected the cost savings of introducing the essential package in 2015 in Mexico and found that cost savings would have been \$66–92 million. It also found that access to best international prices for medications would reduce overall costs of the essential package for low-income countries by about 25% (Felicia Marie Knaul et al., 2017)</p>
<p>Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the approach element were pursued)</p>	<p>At the hospital level</p> <p>1 RCT found no significant differences in survival and hospital utilization between PC group and control group (Gade et al., 2008)</p> <p>1 RCT found that PC consultations had limited effect on symptom intensity scores and resource utilization (Bakitas et al., 2009)</p> <p>1 primary study found that PC consultations do not improve all health outcomes (Casarett et al., 2008).</p>

Category of finding	Element 1
	Essential package for palliative care
	1 case study found that that the minimum healthcare package in Uganda was ineffective and inefficient (Ssenkooba, 2004)

Element 2

Provide palliative care at patients' residence

Most patients suffering from terminal illnesses who require PC prefer to receive care at home while being surrounded by family members. The Middle Eastern culture supports the establishment of home-based PC services due to the strong family and social bonds (Fadhil et al., 2017). Home care is a viable option in the Lebanon where family ties are strong and play an important role in patient's healthcare decisions (Michel Daher, 2011).

Home-based PC services have numerous benefits, some of which include respecting patient's wishes, saving costs, and improving patient outcomes (Ventura et al., 2014). One systematic review, one RCT, one primary study, and one meta-analysis found that home-based PC increases the chance of dying at home (Gomes et al., 2013; Jordhøy et al., 2000; Pham & Krahn, 2014; Shepperd et al., 2011) and reduces symptom burden (Gomes et al., 2013). Two systematic reviews found that home is the preferred place of care for patients and their family caregivers (Murray et al., 2009; Woodman et al., 2016). In addition, one primary study concluded that PC at home was associated with better satisfaction among patients' caregivers (Singer et al., 2005). One RCT found that in-home PC improves patient satisfaction, reduces hospital admissions and costs, and increases the likelihood of dying at home (Brumley et al., 2007). One primary study found that patients receiving home-based PC services had statistically significantly less symptom severity, lower depression, and better physical health and quality of life than those receiving inpatient care. Patients also reported more control on their diseases, treatment and care received, and over the course of the disease (Peters & Sellick, 2006).

In addition, one literature review and one primary study showed that PC at home is cost-effective (McCaffrey et al., 2013; Pham & Krahn, 2014). According to Pham and Krahn (2014), in-home PC saved 4,400\$ per patient in Ontario and if these services are expanded to the rest of the population in need of PC services, it is estimated that healthcare cost savings can reach up to 190 million \$.

Table 2 **Key findings** from systematic reviews and single studies

Category of finding	Element 2
Benefits	1 systematic review, 1 RCT, 1 primary study, and 1 meta-analysis found that home-based PC increases the chance of

Category of finding	Element 2
	<p>dying at home (Gomes et al., 2013; Jordhøy et al., 2000; Pham & Krahn, 2014; Shepperd et al., 2011) and reduces symptom burden (Gomes et al., 2013)</p> <p>2 systematic reviews found that home is the preferred place of care for patients and their family caregivers (Murray et al., 2009; Woodman et al., 2016).</p> <p>1 RCT found that in-home PC improves patient satisfaction, reduces hospital admissions and costs increases the likelihood of dying at home (Brumley et al., 2007).</p> <p>1 primary study concluded that PC at home was associated with better satisfaction among patients' caregivers (Singer et al., 2005).</p> <p>1 primary study found that PC at home reduces length of stay at the hospital and allows patients to spend more time at home (Costantini et al., 2003)</p> <p>1 primary study found that families of patients receiving PC at home reported higher satisfaction with care and less unmet needs compared to those receiving PC in other settings (Teno et al., 2004).</p>
Potential harms	<p>1 systematic review identified several unmet needs such as communication, loss of autonomy, and emotional needs among patients receiving home-based PC (Ventura et al., 2014).</p>
Cost and/ or cost effectiveness in relation to the status quo	<p>1 literature review conducted in Ontario found that in-home PC increased the chance of dying at home, increased the number of days at home, and reduced costs by 4400\$ per patient. It also mentioned that expanding in-home PC to patients not receiving such services can improve quality of life, reduce the use of resources, and save more than 190 million \$ (Pham & Krahn, 2014).</p>
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the approach element were pursued)	<p>1 systematic review and meta-analysis found insufficient evidence that community specialist PC services providing home nursing have increased the rate of home deaths (Lockett et al., 2013).</p> <p>1 RCT found that PC at home has no effect on caregiver bereavement outcome (Grande, Farquhar, Barclay, & Todd, 2004)</p>

Element 3

Strengthen education and training in palliative care among health professionals

All health professionals should receive basic training on PC and continuing medical education. The WHO calls countries to strengthen training of health professionals and include PC in curricula of health professionals (World Health Organization, 2018a).

One systematic review found that there is a dire need to improve education and knowledge about PC among healthcare providers. This can be achieved through tailored educational programs for health professionals, integrated PC services in all clinical practices, clear referral guidelines, and timely referral, and proper marketing of PC services (Ahmed et al., 2004). One systematic review concluded that including PC at the undergraduate level provides students with knowledge, skills, and competencies about PC and improves their behaviors towards patients suffering from advanced diseases (Centeno & Rodriguez-Nunez, 2015). A systematic review found evidence that multi-faceted interventions, reminders, and educational outreach are effective in improving the performance of health professionals (Grimshaw et al., 2004). Another systematic review found that classroom-based and training courses about end-of-life care and PC for healthcare and social care staff is beneficial for improving skills and readiness for providing PC (Pulsford et al., 2013). In addition, one systematic review suggested that using multifaceted educative interventions about PC such as group discussions, case management, role-play, didactic courses, tutorial educational sessions, and interdisciplinary team meetings, can improve primary care physicians' knowledge (Alvarez & Agra, 2006). Another systematic review found that workshops with simulated patients or role-plays improved communication skills whereas multi-faceted interventions improved health professionals' knowledge (Shaw et al., 2010)

Lastly, one systematic review and meta-analysis mentioned that there is insufficient evidence that educational interventions to train health professionals in end-of-life communication affect patient outcomes (Chung, Oczkowski, Hanvey, Mbuagbaw, & You, 2016).

Table 3 **Key findings** from systematic reviews and primary studies

Category of finding	Element 3
Benefits	1 systematic review concluded that including PC at the undergraduate level provides students with knowledge, skills, and competencies about PC and improves their behaviors towards patients suffering from advanced diseases (Centeno & Rodriguez-Nunez, 2015)

Category of finding	Element 3
	<p>1 systematic review concluded that PC education is effective in improving nurses' attitudes towards death and the care of dying patients and their families (Bassah, Seymour, & Cox, 2014).</p> <p>1 systematic review found that classroom-based and training courses about PC for health and social care staff are beneficial for improving skills and readiness for providing PC (Pulsford et al., 2013).</p> <p>1 systematic review suggested that using multifaceted educative interventions about PC such as group discussions, case management, role-play, didactic courses, tutorial educational sessions, and interdisciplinary team meetings, can improve primary care physicians' knowledge (Alvarez & Agra, 2006)</p> <p>A systematic review found evidence that multi-faceted interventions, reminders, and educational outreach are effective in improving the performance of health professionals (Grimshaw et al., 2004)</p>
Potential harms	1 primary study found little impact of a curriculum designed to teach palliative care on critical care medicine fellows' knowledge, and some attitudes were worse after the clinical rotation (DeVita, Arnold, & Barnard, 2003).
Cost and/ or cost effectiveness in relation to the status quo	None found
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the approach element were pursued)	<p>1 systematic review and meta-analysis found insufficient evidence that educational interventions affect patient-level outcomes (Chung, Oczkowski, Harvey, Mbuagbaw, & You, 2016)</p> <p>1 report showed that classroom interventions had no significant effect on residents' attitudes towards knowledge the end-of-life care (Fischer & Arnold, 2007)</p>

Element 4

Improve public awareness about palliative care

Improving public awareness about the concept of PC and its benefits can enhance referrals to PC services and can help in identifying gaps in services provided. A recent Lancet Commission report on PC and pain relief

stressed on the need of national and local governments to improve healthcare education and build public awareness about PC through collaboration between NGOs and international and civil society organizations. Several small but high-quality PC initiatives have been implemented in many countries and have proven to be effective in changing national policies about PC (Felicia Marie Knaul et al., 2017).

One citizen brief about improving access to PC in Ontario mentioned that social media campaigns about PC can be used as a tool to improve public awareness about PC (Gauvin et al., 2013). Four systematic reviews found that social network interventions can promote health behavior change (Cugelman et al., 2011; Laranjo et al., 2014; Maher et al., 2014; Stead et al., 2007). Stead et al. (2007) mentioned that social marketing campaigns can be effective in changing behaviors of consumers, patients, professionals, organizations, and policymakers and can influence public policy changes. One primary study found that improving awareness among the public is needed to increase knowledge and access to PC services and empower communities to participate in decision making related to PC (McIlfatrick et al., 2013).

Public awareness campaigns about PC, advance care planning, and end-of-life should use clear terminologies, piloted material, and different mass media outlets (Seymour, 2018). One systematic review concluded that the use of social media provides support for patients and can improve patient care (Patel, Chang, Greysen, & Chopra, 2015). In addition, one primary study found that providing PC information through small media and lectures improved the perception of PC among the public and caregivers of patients (Akiyama et al., 2016). One primary study showed that the implementation of an art project helped normalize death among school students (Lindqvist & Tishelman, 2015). An evaluation of a one-week social marketing campaign on PC in Ireland showed that 42% of people in the Republic of Ireland were aware of the campaign and reported an improved understanding of PC (Ronan Cavanagh, 2015).

Table 4 **Key findings** from systematic reviews and single studies

Category of finding	Element 4
Benefits	<p>4 systematic reviews found that social network interventions can promote health behavior change (Cugelman et al., 2011; Laranjo et al., 2014; Maher et al., 2014; Stead et al., 2007)</p> <p>1 systematic review concluded that community-based interventions that encourage discussions about preferences of the end of life care are effective when people are actively engaged in the interventions (Abba, Byrne, Horton, & Lloyd-Williams, 2013)</p>

Category of finding	Element 4
	<p>1 systematic review concluded that the use of social media provides support for patients and can improve patient care (Patel et al., 2015).</p> <p>1 citizen brief on improving access to PC in Ontario mentioned that social media campaigns about PC can be used as a tool to improve public awareness about PC (Gauvin et al., 2013).</p> <p>1 primary study found that an educational intervention study for the public was effective in changing perceptions about home care, life-prolonging treatment, and end-of-life care (Miyashita, Sato, Morita, & Suzuki, 2008)</p> <p>1 primary study found that providing PC information through small media and lectures has positive effects on the perception of PC among the public and caregivers of the patients (Akiyama et al., 2016).</p> <p>1 primary study showed that the implementation of an art project helped normalize death among school students (Lindqvist & Tishelman, 2015).</p> <p>1 primary study found that improving awareness among the public is needed to increase knowledge and access about PC services and empower communities to participate in decision making related to PC (McIlpatrick et al., 2013).</p> <p>An evaluation of a one-week social marketing campaign on PC in Ireland showed that 46 % of people in the Republic of Ireland were aware of the campaign and reported an improved understanding of PC (Ronan Cavanagh, 2015).</p>
Potential harms	None found
Cost and/ or cost effectiveness in relation to the status quo	<p>1 meta-analysis found that online interventions can reach a large population at lower cost (Cugelman et al., 2011).</p> <p>1 systematic review found that social networking presents a low-cost opportunity to virally spread health information (Laranjo et al., 2014)</p>
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the approach element were pursued)	1 primary study conducted in Japan found that a population-based educational intervention was unsuccessful in changing public's perception on PC in the long-term (Sato, Miyashita, Morita, & Suzuki, 2009)

Implementation considerations and counterstrategies

Barriers to implementation of the four elements are at the patient, professional, organizational and system levels. Counterstrategies to overcome these barriers are suggested and are retrieved from evidence.

Level	Barriers	Element(s)	Counterstrategies
Patient	Fear of losing a loved one can force people to continue curative treatments even when they are not working (Tedder, Elliott, & Lewis, 2017).	1, 2	Information can be made available through government or community portals to raise awareness about the benefits of PC (Fadhil et al., 2017)
	Patient's families do not tell the patients about their terminal illness (M. Silbermann et al., 2012)	1, 2	Healthcare providers can engage in early and open discussions about different treatment plans with their patients (Thomas Lynch, Stephen Connor, & David Clark, 2013)
	Misconceptions and poor awareness about PC among patients and families and the difficulty to discuss end-of-life care (Osman, 2015; M Silbermann et al., 2012; Tedder et al., 2017)	1, 2	Involve and train caregivers to assist in caring for the patient at home (Osman, 2015)
	Cultural taboos, religious beliefs, and perceptions of death among patients and their families complicate end-of-life care management (M. Silbermann et al., 2012)	1, 2	Develop an advocacy strategy to increase public awareness about pain management and PC (H. Abu-Saad & Daher, 2005) Educate the public about PC and its benefits through public awareness campaigns, media outlets, and educational leaflets (Michel Daher et al., 2013).
	Lack of knowledge about advance care planning among patients and difficulties to discuss death are barriers to implementing advance care planning (Seymour et al., 2010)	1, 2	Healthcare provider organizations can embed patient preferences in their clinical governance procedures (Lund, Richardson, & May, 2015) Educate the public about PC and its benefits through public awareness campaigns, media outlets, and educational

Level	Barriers	Element(s)	Counterstrategies
			leaflets (Michel Daher et al., 2013).
Professional	Poor training in pain management and PC during health professional education (Osman, 2015; M. Silbermann et al., 2012)	3	Professional training and education in PC for health professionals can be accredited and certified (Fadhil et al., 2017; M. Silbermann et al., 2012). This can be achieved through national and regional training courses, didactic courses (M. Silbermann et al., 2012) and continuing medical education for health professionals (M. Daher, 2013)
	Poor prognostic skills among physicians, reluctance to communicate information with the patient and their family (Dalgaard, Bergenholtz, Nielsen, & Timm, 2014; Osman, 2015) and misconceptions about PC (Dalgaard, Bergenholtz, Nielsen, & Timm, 2014), and focus on curative treatment among physicians (Visser, Deliens, & Houttekier, 2014).	3	Introduce a primary PC curriculum and primary care residency programs to ensure that all primary care physicians can provide a basic level of PC to the community (Osman et al., 2013)
	Poor preparedness to manage terminal diseases and difficulty to find continuing education classes. In fact, many schools do not integrate end-of-life care into their standard curriculum (Lynch et al., 2010).	3	Designate specific institutions as training centers for PC (e.g. King Hussein Cancer Centre in Amman or King Faisal Cancer Centre in Riyadh) (Michel Daher, 2013). The partnership between NGOs, charitable religious associations, and private and government hospitals can help provide standardized training and increase capacity of health professionals involved in PC (Fadhil et al., 2017)
	Poor awareness among health professionals about PC and its benefits (Fadhil et al., 2017).	3	Incorporate PC in curriculums and integrate more clinical rotations about PC (Tedder et al., 2017)

Level	Barriers	Element(s)	Counterstrategies
	Poor education about PC referral procedures (Freeman et al., 2013) and about advance care planning (De Vleminck et al., 2013)	3	Access to electronic libraries can help professionals keep up-to-date with PC (Rosenberg & Canning, 2004)
	Shortages of PC providers (Campbell et al., 2009; Freeman, Heckman, Naus, & Marston, 2013; Fadhil et al., 2017)	3	<p>Training of community volunteers to increase capacity in the provision of support for patients receiving PC (Fadhil et al., 2017)</p> <p>Involve and train caregivers to assist in caring for the patient at home (Osman, 2015)</p> <p>Train healthcare providers who treat chronically ill patients on PC (Michel Daher, 2013).</p>
	<p>Late consultation of the PC team and late referral of patients (Mouhawej et al., 2017)</p> <p>The reluctance of professionals to tell the patients about their diagnosis due to cultural barriers (Mouhawej et al., 2017)</p>	3	<p>Increase collaboration between health professionals and clear role definition for health professionals in PC (Oishi & Murtagh, 2014)</p> <p>Initiate sensitive discussions about end of life issues and developing clear referral pathways (Selman et al., 2007)</p>
Organizational	Lack of collaboration between primary and secondary care is a barrier for the implementation of advance care planning (Boyd et al., 2010)	1	Consultation between general practitioners, healthcare professional, and hospital policy to support advance care planning (De Vleminck et al., 2013)
	The Lebanese code of medical ethics does not require physicians to inform patients of their terminal diagnosis (Rida & Zeineldine, 2013)	1, 2	<p>The Lebanese code of medical ethics can legalize written documents for patients where their wishes and treatments plans are documented (Rida & Zeineldine, 2013)</p> <p>Adjustment of the article 44 of the Lebanese code of medical ethics mandating physicians to disclose dangerous diagnosis results to patients (Rida & Zeineldine, 2013)</p>

Level	Barriers	Element(s)	Counterstrategies
			Initiate sensitive discussions about end of life issues (Selman et al., 2007)
	Limited evidence about PC and its benefits in Lebanon (Mouhaweij et al., 2017)	1, 2	Conduct high-quality research such as systematic reviews and intervention studies about PC (Abu-Saad Huijjer H., 2013)
System	Lack of reimbursement of PC by private and public insurance parties.	1, 2	Sensitize policymakers and decision makers through advocacy to promote investment and secure the resources required for PC development (Cleary, 2016).
	The scarcity of national plans and policies and poor funding for PC (Fadhil et al., 2017; M. Silbermann et al., 2012)	1, 2	Develop national PC plans in line with the local context and health-care needs (Fadhil et al., 2017). A national strategy for the development of PC is being developed by the National Committee for Pain Relief and PC (Osman, 2015).
	The absence of a legal process to document patients' choices in a legally binding manner (Osman, 2015).	1, 2	Policymakers can develop a law that would allow advance directives to be used (Osman, 2015).
	Inadequate availability and access to opioids due to restrictive laws and policies, insufficient knowledge regarding the use of controlled medicines, and inappropriate attitudes towards controlled medicines (World Health Organization, 2016)	1, 2	Review and modify national legislation related to the availability and affordability of opioids for pain management (Fadhil et al., 2017). The MOPH can adopt the WHO essential drug list for PC (H. Abu-Saad & Daher, 2005).
	Prescription of opioid analgesics is restricted to oncologists and pain specialists which limits access to care (Osman, 2015).	1, 2	WHO has designated six PC collaborating centers that support the development of PC programs around the world and can help Lebanon in integrating PC in the health system (Osman, 2015).

A subcommittee of the National Committee for Pain Relief and PC is reviewing best approaches to improve access to opioids (Osman, 2015).

Next Steps

Next Steps

The aim of this policy brief is to foster dialogue informed by the best available evidence. The intention is not to advocate specific policy options/elements or close off discussion. Further actions will flow from the deliberations that the policy brief is intended to inform. These may include:

- Deliberation amongst policymakers and stakeholders regarding the policy elements described in this policy brief.
- Refining elements, for example by incorporating, removing or modifying some components

References

References

- Abba, K., Byrne, P., Horton, S., & Lloyd-Williams, M. (2013).** Interventions to encourage discussion of end-of-life preferences between members of the general population and the people closest to them - a systematic literature review. *BMC Palliat Care*, 12(1), 40. doi:10.1186/1472-684x-12-40
- Abu-Saad, H., & Daher, M. (2005).** The View from Lebanon. Palliative care is fairly a new development in Lebanon. *European Journal of palliative care*, 12, 257-260.
- Abu-Saad, H. H., & Dimassi, H. (2007).** Palliative care in Lebanon: knowledge, attitudes and practices of physicians and nurses. *Le Journal medical libanais. The Lebanese medical journal*, 55(3), 121-128.
- Abu-Saad, H. H., Sagherian, K., Tamim, H., Naifeh, M. K., & Abboud, M. (2013).** Quality of palliative care in children with cancer in Lebanon. *Le Journal medical libanais. The Lebanese medical journal*, 61(4), 228-236.
- Abu-Saad Huijjer, H., Dimassi, H., & Abboud, S. (2009).** Perspectives on palliative care in Lebanon: knowledge, attitudes, and practices of medical and nursing specialties. *Palliat Support Care*, 7(3), 339-347. doi:10.1017/S1478951509990277
- Abu-Saad Huijjer H., D. M. E., Ghush H., Karam G.E., Zeineddine S., (2013).** Palliative care research in Lebanon. *Lebanese Medical Journal*, 61(4), 204-209.
- Ahmed, N., Bestall, J. C., Ahmedzai, S. H., Payne, S. A., Clark, D., & Noble, B. (2004).** Systematic review of the problems and issues of accessing specialist palliative care by patients, carers and health and social care professionals. *Palliat Med*, 18(6), 525-542.
- Akiyama, M., Hirai, K., Takebayashi, T., Morita, T., Miyashita, M., Takeuchi, A., . . . Eguchi, K. (2016).** The effects of community-wide dissemination of information on perceptions of palliative care, knowledge about opioids, and sense of security among cancer patients, their families, and the general public. *Support Care Cancer*, 24(1), 347-356. doi:10.1007/s00520-015-2788-4
- Alvarez, M. P., & Agra, Y. (2006).** Systematic review of educational interventions in palliative care for primary care physicians. *Palliat Med*, 20(7), 673-683.

- Aslakson, R. A., Curtis, J. R., & Nelson, J. E. (2014).** The changing role of palliative care in the ICU. *Critical Care Medicine*, 42(11), 2418-2428. doi:<https://dx.doi.org/10.1097/CCM.0000000000000573>
- Atun, R., Aydın, S., Chakraborty, S., Sümer, S., Aran, M., Gürol, I., . . . Ayar, B. (2013).** Universal health coverage in Turkey: enhancement of equity. *The Lancet*, 382(9886), 65-99.
- Bakitas, M., Lyons, K. D., Hegel, M. T., Balan, S., Brokaw, F. C., Seville, J., . . . Byock, I. R. (2009).** Effects of a palliative care intervention on clinical outcomes in patients with advanced cancer: the Project ENABLE II randomized controlled trial. *Jama*, 302(7), 741-749.
- Balsam. (2016).** *The Lebanese Center for Palliative Care-Balsam*. Retrieved from <http://balsam-lb.org/wp-content/uploads/2018/01/Balsam-Annual-Report-Final-2016-.pdf>
- Balsam. (2017).** The Lebanese Center Center for Palliative Care-Annual Report 2017. doi:<http://balsam-lb.org/wp-content/uploads/2018/04/Balsam-Annual-report-2017.pdf>
- Barnato, A. E. (2007).** End-of-life spending: can we rationalise costs? *Critical Quarterly*, 49(3), 84-92.
- Bassah, N., Seymour, J., & Cox, K. (2014).** A modified systematic review of research evidence about education for pre-registration nurses in palliative care. *BMC Palliative Care*, 13, 56. doi:<https://dx.doi.org/10.1186/1472-684X-13-56>
- Bowie, C., & Mwase, T. (2011).** Assessing the use of an essential health package in a sector wide approach in Malawi. *Health Research Policy and Systems*, 9, 4-4. doi:10.1186/1478-4505-9-4
- Boyd, K., Mason, B., Kendall, M., Barclay, S., Chinn, D., Thomas, K., . . . Murray, S. A. (2010).** Advance care planning for cancer patients in primary care: a feasibility study. *Br J Gen Pract*, 60(581), e449-e458.
- Brinkman-Stoppelenburg, A., Rietjens, J. A., & van der Heide, A. (2014).** The effects of advance care planning on end-of-life care: a systematic review. *Palliative Medicine*, 28(8), 1000-1025. doi:<https://dx.doi.org/10.1177/0269216314526272>
- Brumley, R., Enguidanos, S., Jamison, P., Seitz, R., Morgenstern, N., Saito, S., . . . Gonzalez, J. (2007).** Increased satisfaction with care and lower costs: results of a randomized trial of in-home palliative care. *Journal of the American Geriatrics Society*, 55(7), 993-1000.
- Casarett, D., Pickard, A., Bailey, F. A., Ritchie, C., Furman, C., Rosenfeld, K., . . . Shea, J. A. (2008).** Do palliative consultations improve patient outcomes? *Journal of the American Geriatrics Society*, 56(4), 593-599.
- Centeno, C., & Rodriguez-Nunez, A. (2015).** The contribution of undergraduate palliative care education: does it influence the clinical patient's care?

Current Opinion in Supportive & Palliative Care, 9(4), 375-391.

doi:<https://dx.doi.org/10.1097/SPC.0000000000000169>

- Chung, H.-O., Oczkowski, S. J. W., Hanvey, L., Mbuagbaw, L., & You, J. J. (2016).** Educational interventions to train healthcare professionals in end-of-life communication: a systematic review and meta-analysis. *BMC Medical Education*, 16(1), 131. doi:10.1186/s12909-016-0653-x
- Cleary, A. S. (2016).** Integrating palliative care into primary care for patients with chronic, life-limiting conditions. *Nurse Practitioner*, 41(3), 42-48; quiz 49.
doi:<https://dx.doi.org/10.1097/01.NPR.0000480588.01667.58>
- Costantini, M., Higginson, I. J., Boni, L., Orengo, M. A., Garrone, E., Henriquet, F., & Bruzzi, P. (2003).** Effect of a palliative home care team on hospital admissions among patients with advanced cancer. *Palliat Med*, 17(4), 315-321.
- Cugelman, B., Thelwall, M., & Dawes, P. (2011).** Online Interventions for Social Marketing Health Behavior Change Campaigns: A Meta-Analysis of Psychological Architectures and Adherence Factors. *Journal of Medical Internet Research*, 13(1), e17. doi:10.2196/jmir.1367
- Daher, M. (2011).** Opioids for cancer pain in the Middle Eastern countries: a physician point of view. *Journal of pediatric hematology/oncology*, 33, S23-S28.
- Daher, M. (2013).** Palliative Care in Arab Countries: Challenges and Achievements. *ACCESS Health Journal*(2), 1-189.
doi:<https://www.accesscommunity.org/sites/default/files/documents/access-6thhealthjournalproceedings3.pdf>
- Daher, M. (2013).** Palliative Medicine. A New Specialty in Lebanon. *Human & Health*.
- Daher, M., Doumit, M., Hajjar, R., Hamra, R., Houry, M. N., & Tohmé, A. (2013).** Integrating palliative care into health education in Lebanon. *Lebanese Medical Journal*, 103(888), 1-8.
- Daher, M., Estephan, E., Abu-Saad, H. H., & Naja, Z. (2008).** Implementation of palliative care in Lebanon: past, present, and future. *Le Journal medical libanais. The Lebanese medical journal*, 56(2), 70-76.
- Daher, M., Tabari, H., Stjernswärd, J., Ammar, W., Nabhan, T. A., Khalil, M. B., . . . Stephan, E. (2002).** Lebanon: Pain relief and palliative care. *Journal of pain and symptom management*, 24(2), 200-204.
- Dalkin, S. M., Lhussier, M., Philipson, P., Jones, D., & Cunningham, W. (2016).** Reducing inequalities in care for patients with non-malignant diseases: Insights from a realist evaluation of an integrated palliative care pathway. *Palliative Medicine*, 30(7), 690-697.
doi:<https://dx.doi.org/10.1177/0269216315626352>

- De Vleminck, A., Houttekier, D., Pardon, K., Deschepper, R., Van Audenhove, C., Vander Stichele, R., & Deliens, L. (2013).** Barriers and facilitators for general practitioners to engage in advance care planning: a systematic review. *Scandinavian Journal of Primary Health Care*, 31(4), 215-226. doi:https://dx.doi.org/10.3109/02813432.2013.854590
- Detering, K. M., Hancock, A. D., Reade, M. C., & Silvester, W. (2010).** The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. *Bmj*, 340, c1345.
- DeVita, M. A., Arnold, R. M., & Barnard, D. (2003).** Teaching palliative care to critical care medicine trainees. *Critical care medicine*, 31(4), 1257-1262.
- Dixon, J., Matosevic, T., & Knapp, M. (2015).** The economic evidence for advance care planning: Systematic review of evidence. *Palliative Medicine*, 29(10), 869-884. doi:https://dx.doi.org/10.1177/0269216315586659
- Doumit, M. (2015).** Lebanese nurses outlooks on palliative care in Lebanon.
- Evans, T. G., Chowdhury, A., Evans, D., Fidler, A., Lindelow, M., Mills, A., . . . Team, T. R. (2012).** Thailand's universal coverage scheme: achievements and challenges: an independent assessment of the first 10 years (2001–2010). *Health Insurance System Research Office: Nonthaburi*.
- Fadhil, I., Lyons, G., & Payne, S. (2017).** Barriers to, and opportunities for, palliative care development in the Eastern Mediterranean Region. *The Lancet Oncology*, 18(3), e176-e184.
- Fischer, G. S., & Arnold, R. M. (2007).** Feasibility of a brief workshop on palliative care communication skills for medical interns. *Journal of palliative medicine*, 10(1), 19-23.
- Frost, A., Wilkinson, M., Boyle, P., Patel, P., & Sullivan, R. (2016).** An assessment of the barriers to accessing the Basic Package of Health Services (BPHS) in Afghanistan: was the BPHS a success? *Globalization and health*, 12(1), 71.
- Gade, G., Venohr, I., Conner, D., McGrady, K., Beane, J., Richardson, R. H., . . . Penna, R. D. (2008).** Impact of an inpatient palliative care team: a randomized controlled trial. *Journal of palliative medicine*, 11(2), 180-190.
- Gauvin, F.-P., Abelson, J., & Lavis, J. N. (2013).** Citizen brief: Improving access to palliative care in Ontario.
- Gibbins, J., McCoubrie, R., & Forbes, K. (2011).** Why are newly qualified doctors unprepared to care for patients at the end of life? *Medical Education*, 45(4), 389-399. doi:doi:10.1111/j.1365-2923.2010.03873.x

- Gomes, B., Calanzani, N., Curiale, V., McCrone, P., & Higginson, I. J. (2013).** Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers. *Cochrane Database Syst Rev*(6), CD007760. doi:10.1002/14651858.CD007760.pub2
- Gorman, R. D. (2016).** Integrating Palliative Care into Primary Care. *Nurs Clin North Am*, 51(3), 367-379. doi:10.1016/j.cnur.2016.05.002
- Grimshaw, J., Thomas, R., MacLennan, G., Fraser, C., Ramsay, C., Vale, L., . . . Shirran, L. (2004).** Effectiveness and efficiency of guideline dissemination and implementation strategies.
- Higginson, I. J., & Evans, C. J. (2010).** What is the evidence that palliative care teams improve outcomes for cancer patients and their families? *Cancer Journal*, 16(5), 423-435
doi:https://dx.doi.org/10.1097/PPO.0b013e3181f684e5
- Jordhøy, M. S., Fayers, P., Saltnes, T., Ahlner-Elmqvist, M., Jannert, M., & Kaasa, S. (2000).** A palliative-care intervention and death at home: a cluster randomised trial. *The Lancet*, 356(9233), 888-893.
- Kendall, M., Boyd, K., Campbell, C., Cormie, P., Fife, S., Thomas, K., . . . Murray, S. A. (2006).** How do people with cancer wish to be cared for in primary care? Serial discussion groups of patients and carers. *Family Practice*, 23(6), 644-650. doi:10.1093/fampra/cml035
- Khandelwal, N., Kross, E. K., Engelberg, R. A., Coe, N. B., Long, A. C., & Curtis, J. R. (2015).** Estimating the effect of palliative care interventions and advance care planning on ICU utilization: a systematic review. *Critical Care Medicine*, 43(5), 1102-1111.
doi:https://dx.doi.org/10.1097/CCM.0000000000000852
- Kim, S. L., & Tarn, D. M. (2016).** Effect of Primary Care Involvement on End-of-Life Care Outcomes: A Systematic Review. *Journal of the American Geriatrics Society*, 64(10), 1968-1974.
doi:https://dx.doi.org/10.1111/jgs.14315
- Kim, S. L., & Tarn, D. M. (2016).** Effect of Primary Care Involvement on End-of-Life Care Outcomes: A Systematic Review. *Journal of the American Geriatrics Society*, 64(10), 1968-1974.
- Klingler, C., in der Schmitt, J., & Marckmann, G. (2016).** Does facilitated Advance Care Planning reduce the costs of care near the end of life? Systematic review and ethical considerations. *Palliative Medicine*, 30(5), 423-433. doi:https://dx.doi.org/10.1177/0269216315601346
- Knaul, F. M., Farmer, P. E., Krakauer, E. L., De Lima, L., Bhadelia, A., Kwete, X. J., . . . Alleyne, G. A. (2017).** Alleviating the access abyss in palliative care and pain relief—an imperative of universal health coverage: the Lancet Commission report. *The Lancet*.
- Knaul, F. M., Gonzalez-Pier, E., Gomez-Dantes, O., Garcia-Junco, D., Arreola-Ornelas, H., Barraza-Llorens, M., . . . Frenk, J. (2012).** The quest for

- universal health coverage: achieving social protection for all in Mexico. *Lancet*, 380(9849), 1259-1279. doi:10.1016/s0140-6736(12)61068-x
- Kronman, A. C., Ash, A. S., Freund, K. M., Hanchate, A., & Emanuel, E. J. (2008).** Can primary care visits reduce hospital utilization among Medicare beneficiaries at the end of life? *Journal of General Internal Medicine*, 23(9), 1330-1335. doi:https://dx.doi.org/10.1007/s11606-008-0638-5
- Kyeremanteng, K., Gagnon, L.-P., Thavorn, K., Heyland, D., & D'Egidio, G. (2016).** The impact of palliative care consultation in the ICU on length of stay: a systematic review and cost evaluation. *Journal of intensive care medicine*, 0885066616664329.
- Laranjo, L., Arguel, A., Neves, A. L., Gallagher, A. M., Kaplan, R., Mortimer, N., . . . Lau, A. Y. (2014).** The influence of social networking sites on health behavior change: a systematic review and meta-analysis. *Journal of the American Medical Informatics Association*, 22(1), 243-256.
- Lewin, S. N., Buttin, B. M., Powell, M. A., Gibb, R. K., Rader, J. S., Mutch, D. G., & Herzog, T. J. (2005).** Resource utilization for ovarian cancer patients at the end of life: how much is too much? *Gynecologic oncology*, 99(2), 261-266.
- Liberman, D. B., Song, E., Radbill, L. M., Pham, P. K., & Derrington, S. F. (2016).** Early introduction of palliative care and advanced care planning for children with complex chronic medical conditions: a pilot study. *Child: Care, Health & Development*, 42(3), 439-449. doi:https://dx.doi.org/10.1111/cch.12332
- Lindqvist, O., & Tishelman, C. (2015).** Room for Death--International museum-visitors' preferences regarding the end of their life. *Soc Sci Med*, 139, 1-8. doi:10.1016/j.socscimed.2015.06.016
- Lotz, J. D., Jox, R. J., Borasio, G. D., & Fuhrer, M. (2013).** Pediatric advance care planning: a systematic review. *Pediatrics*, 131(3), e873-880. doi:https://dx.doi.org/10.1542/peds.2012-2394
- Luckett, T., Davidson, P. M., Lam, L., Phillips, J., Currow, D. C., & Agar, M. (2013).** Do community specialist palliative care services that provide home nursing increase rates of home death for people with life-limiting illnesses? A systematic review and meta-analysis of comparative studies. *Journal of Pain & Symptom Management*, 45(2), 279-297. doi:https://dx.doi.org/10.1016/j.jpainsymman.2012.02.017
- Luckett, T., Phillips, J., Agar, M., Virdun, C., Green, A., & Davidson, P. M. (2014).** Elements of effective palliative care models: a rapid review. *BMC Health Services Research*, 14, 136. doi:https://dx.doi.org/10.1186/1472-6963-14-136
- Lund, S., Richardson, A., & May, C. (2015).** Barriers to advance care planning at the end of life: an explanatory systematic review of implementation

- studies. *PLoS ONE [Electronic Resource]*, 10(2), e0116629.
doi:<https://dx.doi.org/10.1371/journal.pone.0116629>
- Lynch, T., Connor, S., & Clark, D. (2013).** Mapping levels of palliative care development: a global update. *Journal of Pain & Symptom Management*, 45(6), 1094-1106.
doi:10.1016/j.jpainsymman.2012.05.011
- Maher, C. A., Lewis, L. K., Ferrar, K., Marshall, S., De Bourdeaudhuij, I., & Vandelanotte, C. (2014).** Are Health Behavior Change Interventions That Use Online Social Networks Effective? A Systematic Review. *Journal of Medical Internet Research*, 16(2), e40.
doi:10.2196/jmir.2952
- Martin, R. S., Hayes, B., Gregorevic, K., & Lim, W. K. (2016).** The Effects of Advance Care Planning Interventions on Nursing Home Residents: A Systematic Review. *Journal of the American Medical Directors Association*, 17(4), 284-293.
doi:<https://dx.doi.org/10.1016/j.jamda.2015.12.017>
- May, P., Normand, C., & Morrison, R. S. (2014).** Economic impact of hospital inpatient palliative care consultation: review of current evidence and directions for future research. *Journal of Palliative Medicine*, 17(9), 1054-1063. doi:<https://dx.doi.org/10.1089/jpm.2013.0594>
- McCaffrey, N., Agar, M., Harlum, J., Karnon, J., Currow, D., & Eckermann, S. (2013).** Is home-based palliative care cost-effective? An economic evaluation of the Palliative Care Extended Packages at Home (PEACH) pilot. *BMJ supportive & palliative care*, 3(4), 431-435.
- McCarthy, I. M., Robinson, C., Huq, S., Philastre, M., & Fine, R. L. (2015).** Cost Savings from Palliative Care Teams and Guidance for a Financially Viable Palliative Care Program. *Health Services Research*, 50(1), 217-236. doi:10.1111/1475-6773.12203
- McIlfatrick, S., Hasson, F., McLaughlin, D., Johnston, G., Roulston, A., Rutherford, L., . . . Kernohan, W. G. (2013).** Public awareness and attitudes toward palliative care in Northern Ireland. *BMC palliative care*, 12(1), 34.
- Mehio, A. S., Rizk, A., & Kronfol, N. M. (2015).** Aging in Lebanon: perils and prospects. *Le Journal medical libanais. The Lebanese medical journal*, 63(1), 2-7.
- Meiklejohn, J. A., Mimery, A., Martin, J. H., Bailie, R., Garvey, G., Walpole, E. T., . . . Valery, P. C. (2016).** The role of the GP in follow-up cancer care: a systematic literature review. *Journal of Cancer Survivorship*, 10(6), 990-1011. doi:10.1007/s11764-016-0545-4
- Mitchell, S., Morris, A., Bennett, K., Sajid, L., & Dale, J. (2017).** Specialist paediatric palliative care services: what are the benefits? *Archives of*

Disease in Childhood, 102(10), 923-929.

doi:<https://dx.doi.org/10.1136/archdischild-2016-312026>

- Miyashita, M., Sato, K., Morita, T., & Suzuki, M. (2008).** Effect of a population-based educational intervention focusing on end-of-life home care, life-prolonging treatment and knowledge about palliative care. *Palliat Med*, 22(4), 376-382. doi:10.1177/0269216308090073
- MOPH. (2017).** A \$150 Million Package to Promote Health Care in Lebanon is Coming to Light.
- Morrison, R. S., Dietrich, J., Ladwig, S., Quill, T., Sacco, J., Tangeman, J., & Meier, D. E. (2011).** Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health affairs*, 30(3), 454-463.
- Morrison, R. S., Penrod, J. D., Cassel, J. B., Caust-Ellenbogen, M., Litke, A., Spragens, L., & Meier, D. E. (2008).** Cost savings associated with US hospital palliative care consultation programs. *Arch Intern Med*, 168(16), 1783-1790. doi:10.1001/archinte.168.16.1783
- Mouhaweij, M. C., Maalouf-Haddad, N., & Tohmé, A. (2017).** Cultural Challenges in Implementing Palliative Services in Lebanon. *Palliative Medicine and Hospice Care - Open Journal*, SE(1), S15-S18. doi:10.17140/pmhcoj-se-1-104
- Mueller, D. H., Lungu, D., Acharya, A., & Palmer, N. (2011).** Constraints to implementing the essential health package in Malawi. *PloS one*, 6(6), e20741.
- Murray, M. A., Fiset, V., Young, S., & Kryworuchko, J. (2009).** Where the dying live: a systematic review of determinants of place of end-of-life cancer care. *Oncology Nursing Forum*, 36(1), 69-77.
- Odeyemi, I. A. O., & Nixon, J. (2013).** Assessing equity in health care through the national health insurance schemes of Nigeria and Ghana: a review-based comparative analysis. *International Journal for Equity in Health*, 12, 9-9. doi:10.1186/1475-9276-12-9
- Oishi, A., & Murtagh, F. E. (2014).** The challenges of uncertainty and interprofessional collaboration in palliative care for non-cancer patients in the community: a systematic review of views from patients, carers and health-care professionals. *Palliative medicine*, 28(9), 1081-1098.
- Opon, S. O. (2016).** Provision of essential health package in public hospitals: a case of Homabay County hospitals, Kenya. *The Pan African Medical Journal*, 24, 8. doi:10.11604/pamj.2016.24.8.9280
- Osman, H. (2015).** Development of palliative care in Lebanon. Obstacles and opportunities. *Le Journal medical libanais. The Lebanese medical journal*, 63(1), 42-46.
- Osman, H., Abboud, M., El, L. Z., Ghusn, H., Hanna, J., & Kanazi, G. (2013).** Setting practice standards for palliative care in Lebanon--

recommendations of the Subcommittee on Practice--National Committee for Pain Control and Palliative Care. *Le Journal medical libanais. The Lebanese medical journal*, 61(4), 199-203.

Osman, H., Rihan, A., Garralda, E., Rhee, J. Y., Pons-Izquierdo, J. J., Lima, L., . . . Centeno-Cortes, C. (2017). Atlas of Palliative Care in the Eastern Mediterranean Region.

Owens, D., Eby, K., Burson, S., Green, M., McGoodwin, W., & Isaac, M. (2012). Primary palliative care clinic pilot project demonstrates benefits of a nurse practitioner-directed clinic providing primary and palliative care. *Journal of the American Academy of Nurse Practitioners*, 24(1), 52-58. doi:https://dx.doi.org/10.1111/j.1745-7599.2011.00664.x

Patel, R., Chang, T., Greysen, S. R., & Chopra, V. (2015). Social Media Use in Chronic Disease: A Systematic Review and Novel Taxonomy. *Am J Med*, 128(12), 1335-1350. doi:10.1016/j.amjmed.2015.06.015

Peters, L., & Sellick, K. (2006). Quality of life of cancer patients receiving inpatient and home-based palliative care. *Journal of advanced nursing*, 53(5), 524-533.

Pham, B., & Krahn, M. (2014). End-of-Life Care Interventions: An Economic Analysis. *Ontario Health Technology Assessment Series*, 14(18), 1-70.

Polder, J. J., Barendregt, J. J., & van Oers, H. (2006). Health care costs in the last year of life—the Dutch experience. *Social science & medicine*, 63(7), 1720-1731.

Prem, V., Karvannan, H., Kumar, S. P., Karthikbabu, S., Syed, N., Sisodia, V., & Jaykumar, S. (2012). Study of nurses' knowledge about palliative care: a quantitative cross-sectional survey. *Indian journal of palliative care*, 18(2), 122.

Pulsford, D., Jackson, G., O'Brien, T., Yates, S., & Duxbury, J. (2013). Classroom-based and distance learning education and training courses in end-of-life care for health and social care staff: a systematic review. *Palliative Medicine*, 27(3), 221-235.

Rida, M., & Zeineldine, S. (2013). Palliative care in Lebanon: the law and the patient. *Le Journal medical libanais. The Lebanese medical journal*, 61(4), 237-239.

Riley, G. F., & Lubitz, J. D. (2010). Long-term trends in medicare payments in the last year of life. *Health services research*, 45(2), 565-576.

Robinson, L., Dickinson, C., Rousseau, N., Beyer, F., Clark, A., Hughes, J., . . . Exley, C. (2012). A systematic review of the effectiveness of advance care planning interventions for people with cognitive impairment and dementia. *Age & Ageing*, 41(2), 263-269. doi:https://dx.doi.org/10.1093/ageing/afr148

Ronan Cavanagh. (2015). *Public Awareness Raising Palliative Care Week 2014, October 6-11*. Retrieved from

<http://www.thepalliativehub.com/sites/default/files/Public%20Awareness%20Impact%20Report%20Final%204.pdf>

- Rosenberg, J. P., & Canning, D. F. (2004).** Palliative care by nurses in rural and remote practice. *Australian Journal of Rural Health, 12*(4), 166-171.
- SANAD.(2017).** *SANAD ANNUAL REPORT 2017*. Retrieved from <http://www.sanadhospice.org/publications/SANAD%20-%20End%20of%20Year%20Report%202016.pdf>
- Sato, K., Miyashita, M., Morita, T., & Suzuki, M. (2009).** The long-term effect of a population-based educational intervention focusing on end-of-life home care, life-prolongation treatment, and knowledge about palliative care. *J Palliat Care, 25*(3), 206-212.
- Selman, L. E., Harding, R., Beynon, T., Hodson, F., Coady, E., Hazeldine, C., . . . Higginson, I. J. (2007).** Improving end of life care for chronic heart failure patients-" Let's hope it'll get better, when I know in my heart of hearts it won't". *Heart*.
- Seymour, J. (2018).** The Impact of Public Health Awareness Campaigns on the Awareness and Quality of Palliative Care. *Journal of palliative medicine, 21*(S1), S-30-S-36.
- Seymour, J., Almack, K., & Kennedy, S. (2010).** Implementing advance care planning: a qualitative study of community nurses' views and experiences. *BMC palliative care, 9*(1), 4.
- Shaw, E. A., Marshall, D., Howard, M., Taniguchi, A., Winemaker, S., & Burns, S. (2010).** A systematic review of postgraduate palliative care curricula. *Journal of Palliative Medicine, 13*(9), 1091-1108.
doi:<https://dx.doi.org/10.1089/jpm.2010.0034>
- Shepperd, S., Wee, B., & Straus, S. E. (2011).** Hospital at home: home-based end of life care. *The Cochrane database of systematic reviews*(7), CD009231.
- Silbermann, M., Arnaout, M., Daher, M., Nestoros, S., Pitsillides, B., Charalambous, H., . . . Khleif, A. (2012).** Palliative cancer care in Middle Eastern countries: accomplishments and challenges. *Annals of oncology, 23*(suppl_3), 15-28.
- Singer, Y., Bachner, Y. G., Shvartzman, P., & Carmel, S. (2005).** Home death--the caregivers' experiences. *J Pain Symptom Manage, 30*(1), 70-74.
doi:10.1016/j.jpainsymman.2005.01.016
- Siouta, N., Van Beek, K., van der Eerden, M. E., Preston, N., Hasselaar, J. G., Hughes, S., . . . Menten, J. (2016).** Integrated palliative care in Europe: a qualitative systematic literature review of empirically-tested models in cancer and chronic disease. *BMC Palliative Care, 15*, 56.
doi:<https://dx.doi.org/10.1186/s12904-016-0130-7>
- Smith, S., Brick, A., O'Hara, S., & Normand, C. (2014).** Evidence on the cost and cost-effectiveness of palliative care: a literature review. *Palliative*

Medicine, 28(2), 130-150.

doi:<https://dx.doi.org/10.1177/0269216313493466>

- Smith, T. J., Coyne, P., Cassel, B., Penberthy, L., Hopson, A., & Hager, M. A. (2003).** A high-volume specialist palliative care unit and team may reduce in-hospital end-of-life care costs. *Journal of palliative medicine*, 6(5), 699-705.
- Ssengooba, F. (2004).** Uganda's minimum health care package: rationing within the minimum?
- Stead, M., Gordon, R., Angus, K., & McDermott, L. (2007).** A systematic review of social marketing effectiveness. *Health education*, 107(2), 126-191.
- Taylor, D. H., Jr., Ostermann, J., Van Houtven, C. H., Tulskey, J. A., & Steinhauser, K. (2007).** What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program? *Soc Sci Med*, 65(7), 1466-1478.
doi:10.1016/j.socscimed.2007.05.028
- Tedder, T., Elliott, L., & Lewis, K. (2017).** Analysis of common barriers to rural patients utilizing hospice and palliative care services: An integrated literature review. *Journal of the American Association of Nurse Practitioners*, 29(6), 356-362. doi:<https://dx.doi.org/10.1002/2327-6924.12475>
- Temel, J. S., Greer, J. A., Muzikansky, A., Gallagher, E. R., Admane, S., Jackson, V. A., . . . Pirl, W. F. (2010).** Early palliative care for patients with metastatic non-small-cell lung cancer. *New England Journal of Medicine* 363(8), 733-742
- Teno, J. M., Clarridge, B. R., Casey, V., Welch, L. C., Wetle, T., Shield, R., & Mor, V. (2004).** Family perspectives on end-of-life care at the last place of care. *Jama*, 291(1), 88-93. doi:10.1001/jama.291.1.88
- Tohme, A., Younes, H., & Mouhaweij, M. C. (2018).** Regards sur les soins palliatifs et la fin de vie au Liban Résultats d'une enquête auprès d'étudiants universitaires. *Lebanese Medical Journal*, 1(66), 9.
doi:<http://www.lebanesemedicaljournal.org/lmj/2018/03/28/regards-sur-les-soins-palliatifs-et-la-fin-de-vie-au-liban-resultats-dune-enquete-aupres-detudiants-universitaires/>
- Totten, A. M., White-Chu, E. F., Wasson, N., Morgan, E., Kansagara, D., Davis-O'Reilly, C., & Goodlin, S. (2016).** Home-based primary care interventions.
- Ventura, A. D., Burney, S., Brooker, J., Fletcher, J., & Ricciardelli, L. (2014).** Home-based palliative care: a systematic literature review of the self-reported unmet needs of patients and carers. *Palliative Medicine*, 28(5), 391-402. doi:<https://dx.doi.org/10.1177/0269216313511141>

- Woodman, C., Baillie, J., & Sivell, S. (2016).** The preferences and perspectives of family caregivers towards place of care for their relatives at the end-of-life. A systematic review and thematic synthesis of the qualitative evidence. *BMJ supportive & palliative care*, 6(4), 418-429.
doi:<https://dx.doi.org/10.1136/bmjspcare-2014-000794>
- World Health Organization. (2008).** *Essential Health Packages: What are they for? What do they change.* Paper presented at the WHO Service Delivery Seminar Series :Draft Technical Brief
- World Health Organization. (2014).** *Noncommunicable Diseases (NCD) Country Profiles, 2014.* Retrieved from
- World Health Organization. (2016).** Planning and implementing palliative care services: a guide for programme managers.
- World Health Organization. (2018a).** Palliative Care. Retrieved from <http://www.who.int/mediacentre/factsheets/fs402/en/>
- World Health Organization. (2018b).** Universal health coverage.
- World Health Organization. (2018c).** WHO Definition of Palliative Care. Retrieved from <http://www.who.int/cancer/palliative/definition/en/>
- Worldwide Hospice Palliative Care Alliance. (2014).** Global atlas of palliative care at the end of life. *World Wide Palliative Care Alliance & World Health Organization.*
- Zeinah, G. F., Al-Kindi, S. G., & Hassan, A. A. (2013).** Middle East experience in palliative care. *Am J Hosp Palliat Care*, 30(1), 94-99.

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