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Integrating palliative care in public health: The Colombian experience following an International Pain Policy Fellowship

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Abstract

Access to palliative care is insufficient in many countries around the world. In an effort to improve access to palliative care services and treatments, a public health approach as suggested by the World Health Organization was implemented in Colombia to improve opioid availability, increase awareness and competences about palliative care for healthcare workers, and to include palliative care as a component of care in legislation. As a result, opioid availability has improved, a mandatory palliative care course for medical undergraduate students has been implemented and a palliative care law is being discussed in the Senate. This article describes the strategy, main achievements and suggestions for implementing similar initiatives in developing countries.

Keywords

Access, developing countries, education, legislation, palliative care, opioid availability

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Introduction

Palliative care relieves suffering and improves quality of life of patients and families of malignant and nonmalignant illness.¹⁻⁵ However, access to palliative care is limited in many countries for the population in need.⁶⁻⁹ The World Health Organization (WHO) developed a Public Health Model to integrate palliative care into society. This model includes adequate drug availability, appropriate policies, education of health workers and the public, and implementation of services.¹⁰ The public health model has been implemented successfully in several countries, including Romania, India and Hungary,¹¹⁻¹³ and in an effort to improve access to palliative care services and treatments, the WHO public health model was implemented to improve opioid availability, increase awareness and competences about palliative care for healthcare workers, and to include palliative care as a component of care in the Colombian legislation. This article describes the strategy, main achievements and suggestions for implementing similar initiatives in developing countries.

In regard to the different components of the WHO model, there are several challenges faced by those in need of palliative care services.

Policy

Palliative care in Colombia is not recognized yet as a component of health and thus it is not included in public health insurance programs, and although a palliative care law has been drafted and presented in the senate, it has not been approved by the government.

Drug availability

Opioids are available in a few hospitals and some retail pharmacies in major urban centers (with populations of more than 1 million). However, there are problems in several of the states (departamentos) throughout the country which have not adopted the necessary steps to ensure availability and accessibility of the appropriate medications.

Education

There are several palliative care postgraduate programs, but only one undergraduate teaching program in the medical school at Universidad de la Sabana in Bogotá.

Provision of services

While there are a few palliative care services in major hospitals in some large urban centers, provision of services is delivered mostly through private insurance or private consultations paid out-of-pocket by the patient.

Method of work

Interventions to improve opioid availability

The Pain and Policy Studies Group (PPSG) at the University of Wisconsin, a WHO Collaborating Center for Policy and Communications in Cancer Care, has supported different initiatives to improve opioid availability in countries around the world.^{14,15} These initiatives include collaboration between government entities, non-governmental organizations (NGOs), stakeholders and health professionals to diagnose the problems and barriers in the availability and access to opioids, as well as identify solutions and put them in practice with the purpose of improving access to pain treatment.^{12,16} The International Pain and Policy Fellowship (IPPF) Program was developed by the PPSG and funded by the Open Society Institute to improve opioid availability in low- and middle-income countries. The lead author (ML) was awarded an IPPF in 2006 and a mentor (LDL) was assigned to work with her.

According to data from the International Narcotics Control Board (INCB), Colombia reported a consumption of 1.6613 mg/capita in 2007, which is significantly lower than the global average of 5.9823 mg/capita.¹⁷ The Fellow and her mentor used the WHO Guidelines¹⁸ to develop an Action Plan. Three interventions were proposed as part of the Action Plan: An opioid workshop for the national and regional competent authorities; the design and implementation of educational courses and supporting interventions to include palliative care in legislation.

In November 2007, the opioid availability workshop was held in Bogota which included the following participants:

- Pain and palliative care specialists from different regions of the country;
- The National Competent Authorities (NCAs);
- The Regional Competent Authorities (RCAs) of the 32 states;
- Representatives of the Ministry of Health;
- Representatives of multilateral and international organizations (WHO, Pan American Health Organization, International Association for Hospice and Palliative Care (IAHPC), and the PPSG;
- Representatives of national NGOs: Colombian Palliative Care Association and the Colombian Chapter of the International Association for the Study of Pain;
- Representative of the French Health Products Safety Agency – Narcotics and the Psychotropics
- Department;
- Representatives of academic institutions (Universidad de La Sabana).

The objectives of the workshop were to:

- (1) Identify main barriers and possible solutions in the six geographic regions in Colombia;
- (2) Inform regulators about the challenges that physicians identify in the prescription process;
- (3) Inform physicians about the limitations that the regional competent authorities (regulators) face.¹⁹

During the workshop, several presentations were made and the participants were divided into groups representing major regions of the country. During these group discussions, the participants were able to identify barriers to adequate opioid availability in their regions and propose solutions to overcome those barriers.

Intervention to improve education

The development of skills and competences required for the evaluation and treatment of pain and other symptoms²⁰ is critical to ensure quality of care. A survey was conducted by the Universidad de la Sabana with Colombian undergraduate medical students in their final year to identify their perception of knowledge in pain and palliative care. The 32 schools that comprise the National Association of Schools of Medicine were invited to participate in the survey. Results were collected during a period of 6 months.

Intervention to improve policy

Thanks to a contact through the IAHPC, the University of La Sabana, the National Cancer Institute, the National Association of Palliative Care and the Colombian International Association for the Study of Pain were invited to advise two senators who were working on the development of a palliative care law.²¹ The draft was reviewed, and recommendations for changes were made and suggested. Several meetings with the senators took place and the health law was presented to the lower house for approval.

Results

Interventions to improve opioid availability

As a result of the recommendations of the Workshop, the NCA issued a letter requesting the RCAs to establish agreements to guarantee availability and accessibility of controlled medications in the different regions.²² A letter was also sent by the NCA to the Health Maintenance Organizations (HMOs) underscoring the importance of an adequate supply of control medications to meet prescription demand.²³ This led to a new Regulation with revised procurement agreements between state hospitals, pharmacies at the HMOs and the RCAs. Previously, there were only six states which guaranteed permanent access to opioids. The new regulation mandates all 32 states to have at least one place where opioids are guaranteed to be in stock.

An important indicator of progress is the increase in number of units sold reported by the NCA. For morphine, the increase from 2006 to 2009 was 42%. For hydromorphone, the increase for the same period was 195%. After a 3-year process, the inclusion of three new formulations of opioids (morphine injectable 3%; hydromorphone tablets 5 mg; methadone tablets 10 mg) in the List of Essential Medicines in Colombia are now the subject of debate at the Regulatory Commission of Health.

Interventions to improve education

Of the 32 medical schools invited to the survey, 11 responded (34%). Survey responses indicated that 67% of the students felt that they did not receive enough symptom management education, 53% had no knowledge or did not use the WHO analgesic ladder, and 73% and 68% identified addiction and respiratory depression as barriers to prescribing opioids.²⁴

In accordance with the action plan for Colombia, the Pain and Palliative Care Group at the Universidad de la Sabana has been working to improve education in this field, specifically about symptom mechanisms, evaluation and treatment. A mandatory course in palliative care for undergraduate students of the school of medicine at the Universidad de la Sabana was implemented. In this course, students have the opportunity to increase knowledge and skills, develop appropriate opioid prescription habits, change attitudes and behaviors, and incorporate the core competences of palliative care. The purpose of the course is to offer tools related to symptom management, good prescription habits, communication and resolution of ethical dilemmas related to palliative care to all of the future doctors so that they can provide appropriate care to patients in need.²⁵ Other educational strategies that have been implemented are an online course in palliative care and continuing education for primary care health workers.

The Fellow has also shared the success of this teaching experience with the Ministry of Education and the Colombian Association of Medical Schools. A continuing challenge that we have encountered is expanding the implementation of mandatory undergraduate palliative care courses beyond the Universidad de La Sabana, to other medical and health professional schools in our country.

As a result of the implementation of the educational courses mentioned above, at the time of the preparation of this paper, 227 undergraduate medical students had taken the Pain and Palliative Care course at the Universidad de la Sabana and 324 interns had taken the Good Prescription Practices with students from several medical schools in Bogota, and this model has been presented to the National Association of Medical Schools.

Interventions to improve policy

Following the workshop discussions, recommendations were drafted to deliver to the Ministry of Health by the national competent authority. Some of the recommendations were as follows: (1) Modify a national policy (Resolution 1478)²⁶ to guarantee availability of opioid analgesics 24 hours a day/ 7 days a week in the capital cities of the 10 main states (Departamentos).

(2) Involve and engage the health maintenance organizations in order to inform them of the results of the workshop so that they can incorporate strategies in their quality improvement process to improve opioid accessibility.

(3) Include in the Mandatory Health Plan all essential analgesics in the WHO Model List of Essential Medicines.

(4) Require Regional Hospitals to provide opioid medication for outpatients.¹⁹

As an outcome from the contact of the IAHP, the law that was introduced in the Health Care Commission on May 2009 was approved in a second debate in December of 2009.²⁷ It is currently scheduled for discussion by the full Senate. This is a comprehensive project that includes the importance of adequate opioid availability, adequate quality of care for patients and their families, development and implementation of service delivery and education of health workers and caregivers, among other issues.

Discussion

Implementation of the comprehensive WHO public health strategy requires a broad focus on multiple factors to overcome specific challenges.

Opioid availability

Some of the challenges and barriers to opioid availability and accessibility are related to bureaucracy, lack of reimbursement of palliative care in insurance plans and focus on the prevention and treatment of infectious diseases as compared with non-communicable diseases (such as cancer), as has been demonstrated in Eastern Europe countries.^{28,29} Additional contributing factors include a general lack of knowledge by the national and regional competent authorities about the important role of opioid analgesics in pain treatment and palliative care, the benefits that guaranteed access to opioid analgesics would have to public health and poor communications between regulators and physicians. Finally, the absence of a reliable monitoring system at the final stage of the opioid distribution chain, which could document the safe medical use of opioids to both regulators and physicians, may also contribute to continued reluctance to improve opioid availability.

Education

Introducing palliative care in the undergraduate curriculum is critically important but difficult to achieve due to competing subjects and colleagues who want to protect their share of time within the curriculum. Most of the courses in undergraduate medical schools are focused on trauma and infectious diseases, even as the WHO is reminding governments that every year cancer and cardiovascular diseases kill more people than AIDS, malaria and tuberculosis combined, a trend that is expected to increase over the coming decades.

Policy

Efforts to eliminate barriers in laws and regulations and to improve policy to ensure access to palliative care is a long process. It requires advocating with regulators and policy makers so that when laws and policies are drafted, all of the appropriate components are included. There are many challenges faced by the approval of a new law in Colombia and this requires continued political support, commitment and persistence. Changes in policies and adoption of new legislation will take longer than changes in other areas, but are necessary to provide the framework needed to ensure availability and accessibility of services. Local data about cost-effectiveness of palliative care would be of extreme importance to support changes in legislation.

The Fellowships help to improve some of the process described here, including the senators commitment in the law project and the interest of academic institutions on palliative care. It is important to note that the results are preliminary, and more results will be seen in the future.

There was no implementation of services because that was out of the scope of the Fellowship, and requires more complex and profound changes to the Colombian health system.

The WHO public health approach give guidance for implementing palliative care in developing countries that face similar barriers to those described in this paper.

Conclusion

The improvements in palliative care provision in Colombia, including issues related to increased access to opioid analgesics, improved education in palliative care, and the adoption of regulations and norms to ensure these changes, have been crucial in the development of palliative care in the country. The WHO Public Health strategy served as a trigger for many of the improvements described in this paper.

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Competing interests

The authors have no competing interests to declare.

References

1. World Health Organization. WHO Definition of Palliative Care. Available from <http://www.who.int/cancer/palliative/definition/en/>. Accessed 12 January 2010.
2. Gilbert CR and Smith CM. Advance lung disease quality of life and role of palliative care. *Mt Sinai J Med* 2009; 76:63–67.
3. Morrison LJ and Morrison RE. Palliative Care and Pain Management. *Med Clin North Am* 2006; 90: 983–1004.
4. Leleszi JP and Lewandowski GJ. Pain management in end of life care. *J Am Osteopath Assoc* 2005; 105:S6–S11.
5. Holley JL. Palliative care in end-stage renal disease: illness trajectories, communication and hospice use. *Adv Chronic Kidney Dis* 2007; 14: 402–408.
6. Wright M, Wood J, Lynch T and Clark D. Mapping levels of palliative care development: a global view. *J Pain Symptom Manage* 2008; 35: 469–485.
7. Walshe C, Todd C, Caress A and Crew-Graham C. Patterns of access to community palliative care services: a literature. *J Pain Symptom Manage* 2009; 37: 884–912.
8. Goldsmith B, Dietrich J, Du Q and Morrison RS. Variability in access to hospital palliative care in the United States. *J Palliat Med* 2008; 11: 1094–1102.
9. Beccaro M, Constantini M and Merlo DF ISDOC Study Group. Inequity in the provision of and access to palliative care for cancer patients. Results from the Italian survey of the dying of cancer (ISDOC). *BMC Public Health* 2007; 7: 66.
10. Stjernswärd J, Foley K and Ferris F. The public health strategy for palliative Care. *J Pain Symptom Manage* 2007; 33: 486–493.
11. Mosoiu D, Mungiu O, Gigore B and Landon A. Romania: changing the regulatory environment. *J Pain Symptom Manage* 2007; 33: 610–614.
12. Rajagopal M and Joranson D. India: opioid availability: an update. *J Pain Symptom Manage* 2007; 33: 615–622.
13. Muszbek K. Enhancing Hungarian palliative care delivery. *J Pain Symptom Manage* 2007; 33: 605–609.
14. Ryan K. The Pain & Policy Studies Group International Program. *J Pain Palliat Care Pharmacother* 2007; 21:35–37.
15. Joranson D and Ryan K. Ensuring opioid availability: methods and resources. *J Pain Symptom Manage* 2007; 33: 527–532.
16. Mosoiu D, Ryan K, Joranson D and Garthwaite J. Reforming drug control policy for palliative care in Romania. *Lancet* 2006; 367: 2110–2117.
17. Pain & Policy Studies Group. Colombia Opioid Consumption trends. Available from <http://www.painpolicy.wisc.edu/internat/AMRO/Colombia/index.htm>. Accessed 21 January 2010.
18. Pain & Policy Studies Group. Achieving balance in national opioids control policy. Available from <http://www.painpolicy.wisc.edu/publicat/00whoabi/00whoabi.htm>. Accessed 21 January 2010.
19. Leon MX, De Lima L, Florez S, Torres M, Daza M, Mendoza L, et al. Improving availability of and access to opioids in Colombia: description and preliminary results of an action plan for the country. *J Pain Symptom Manage* 2009; 38: 758–766.
20. Weissman D and Blust L. Education in palliative care. *Clin Geriatr Med* 2005; 21: 165–175.
21. Senate of the Republic of Colombia. Bill project N_ 15, 2008 Available from: http://servoaspr.imprenta.gov.co:7778/gacetap/gaceta.mostrar_texto?p_tipo%05&p_numero%15&p_consec%19057. Accessed on 5 January 2009.
22. Colombian Ministry of Health. National Competent Authority. Letter 0002, February 2008. Available from <http://www.fne.gov.co/Index.aspx?Id%12900>. Accessed 19 January 2010.
23. Colombian Ministry of Health. National Competent Authority. Letter 011, April 2008. Available from <http://www.fne.gov.co/Index.aspx?Id%12900>. Accessed 18 January 2010.
24. Leon MX, Corredor M, Rios F, Sanabria A, Montenegro M, Gonima E, et al. Que perciben los estudiantes de Medicina sobre sus conocimientos en dolor? Análisis de la situación en Colombia. *Med Pal* 2007; 14: 33–39.
25. Leon MX, Florez S, Torres M, Trujillo C and Castilla M. Educación en cuidado paliativo para pregrado en medicina: resultados de una encuesta acerca de la percepción de los conocimientos adquiridos. *Med Pal* 2009; 16:28–33.
26. Colombian Ministry of Health. 001478 of 2006. Available from: <http://www.fne.gov.co/userResources/Uploads/EditorUsers/administrador/Res%201478.pdf>. Accessed 17 January 2010.
27. Senate of the Republic of Colombia. Bill project N_ 15, 2008 Available from: http://servoaspr.imprenta.gov.co:7778/gacetap/gaceta.mostrar_texto?p_tipo%05&p_numero%15&p_consec%19057. Accessed 5 January 2010.
28. Cherry N, Baselga J, de Conno F and Radbruch L. Formulary availability and regulatory barriers to accessibility of opioids for cancer in Europe: a report from the ESMO/EAPC Opioid Policy Initiative. *Ann Oncol* 2010;213: 615–626.
29. Lynch T, Clark D, Centeno C, Rocafort J, Flores L, Greenword A, et al. Barriers to the development of palliative care in the countries of Central and Eastern Europe and the Commonwealth of Independent States. *J Pain Symptom Manage* 2009; 37: 305–315.