**International Strategies Evidence Session Briefing**

**Overview:**

The oral evidence session focused on international perspectives on palliative care, highlighting the experiences, challenges, and recommendations from experts in Portugal, Catalonia (Spain), the Netherlands, the USA, and Canada.

**Dr Isabel Neto (Portugal)**

Palliative care legislation exists in Portugal, however practical application is limited due to a shortage of resources, including hospital support teams:

* 1. Right to have access to palliative care
  2. Access to good global care, including palliative sedation

Critical issues facing palliative care services in Portugal:

* Lack of political investment
* Inadequate paediatric care coverage
* Insufficient public awareness of legal rights.

Key Statistics:

* Approximately 125,000 patients and families in Portugal need palliative care annually, but over 70% do not have access.
* Paediatric palliative care coverage is minimal, leaving most regions underserved.

Recommendations:

1. Elevate palliative care as a high political priority.
2. Create a palliative care specialty with defined career paths.
3. Mandatory palliative care training for medical residents in key specialties.

**Prof Xavier Gomez-Batiste (Catalonia, Spain)**

Le Kesha Programme:

1. Universal coverage
2. Essential needs of patients are covered, including spiritual care and care of the family

WHO Project in Catalonia- three phases:

1. Developed palliative care services, mostly devoted to cancer and terminal patients. Then, shifting towards non-cancer and community patients.
   1. 86% of patients with palliative care needs are living in the community or nursing homes
   2. 80% have no cancer but other conditions
2. Developed the chronic programme and generalist palliative care, and compassionate communities
   1. Department of Health developments:
      1. To implement palliative care
      2. Generalist palliative care in the community
      3. Develop community case managers as nurses who were on charge to identify and look after these patients
3. Created the agency for integrated care
   1. More than 50% of patients have been identified in the community, with 70% being non-cancer patients
   2. Patients are identified 18 months before they die
   3. Many are pleased with the results of this policy due to the early and timely identification in the community

Recommendations:

1. Ensure vulnerable populations have community-based palliative care.
2. Integrate palliative care pathways across all territories.
3. Promote compassionate community initiatives.

**Prof. Jeroen Hasselaar (Netherlands)**

Strong role of GPs as gatekeepers in palliative care, with a focus on community and home-based care.

One success factor for palliative care in the Netherlands is that it is well endorsed at both the political and royal level.

The national research and development programme started with an injection of 50 million euros, which also runs the settlement of palliative care clinical and research education programmes. A key success factor from this is the unity between national and regional players.

It is stated in the Ministry of Health coalition agreement that there needs to be more attention for palliative care education and integration.

Key Statistics:

* Peak mortality expected around 2050, increasing palliative care demands.
* All Dutch hospitals have palliative care inpatient teams.
* Over 50% of patients identified as needing palliative care are non-cancer cases.

Recommendations:

1. Reduce fragmentation across palliative care services.
2. Strengthen integration with regular healthcare systems.
3. Enhance training for professionals and support for informal care.

**Prof. Eduardo Bruera (USA)**

Advocates for administrative autonomy for palliative care units within healthcare institutions.

Highlights the importance of patient-centered outcomes and virtual care accessibility.

Key Statistics:

* 85% of hospices in the USA are for-profit organizations.
* For-profit hospices have seen a 600% increase in billing over a decade.
* Virtual palliative care shows outcomes comparable to in-person care.

Recommendations:

1. Establish independent palliative care departments.
2. Implement universal patient assessments focused on suffering.
3. Promote virtual palliative care services to bridge access gaps.

**Laurel Gillespie (Canada)**

National palliative care framework exists, but implementation is inconsistent due to lack of federal investment.

There are significant concerns over disparities in access, particularly in rural, Indigenous, and vulnerable populations.

Canada doesn’t have the ability to measure the quality of palliative care across the country because there are no standardised measures ;the provinces are allowed to come up with these measures themselves.

Key Statistics:

* Less than 50% of Canadians have access to palliative care.
* There is a goal set that there should be seven hospice beds per 100,000 people; this goal is unmet in many regions.
* One in four Canadians are informal caregivers, which is expected to rise to one in two by 2030.

Recommendations:

1. Recognize palliative care as a fundamental human right.
2. Ensure sustainable federal funding with measurable outcomes.
3. Improve training and education across healthcare professions.

**Cross-Cutting Issues across the International Strategies**

1. **Legislative Gaps**

Legal rights to palliative care often lack enforcement mechanisms.

1. **Resource Shortages**

Universal issue of insufficient trained professionals and funding.

1. **Public and Professional Literacy:**

Need for increased awareness and education about palliative care.

1. **Integration Challenges**

Difficulty in embedding palliative care within broader healthcare systems.

1. **Equity Concerns:**

Disparities in access, particularly for vulnerable and underserved populations.

**Key Strategies:**

1. Political commitment
2. Systemic integration
3. Robust training
4. Community engagement to improve access and quality of palliative care globally