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Review

(Dis)organization of Palliative Care as a Potential Quality-of-Life Issue in the Senior Population – Croatian Experiences

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ABSTRACT

This paper analyses the current situation in the Croatian health-care system, with special emphasis on the (dis)organization of palliative care within the public health, more precisely gerontology context. Namely, population world-wide is getting older, that is both a statistical and an everyday-medical fact. Today we consider citizens after the age of 65 as the elderly, with a tendency to move the age-limit to 75 years. Croatia on the matter swiftly follows global trends, while literature points to the fact that an increase in the elderly population dictates the need for an organized system of palliative care and hospice building. Although we cannot ignore the fact that children can become palliative care patients, we can conclude that these are predominantly elderly patients. In fact, approximately half of patients – users of palliative care – have some type of oncological diagnosis; a significant number of patients suffer from dementia, stroke, or heart failure. As for the Primorsko-goranska county and the City of Rijeka, they show similar trend, as can be illustrated with data from the 2011 census, when the share of citizens over 65 years in the population of the Primorsko-goranska county reached 18.91%, and in the population of the City of Rijeka 19.74%. Thus, one of the main quality-of-life issues in the Croatian senior population is the (dis)function of the palliative medicine/care system. Practice, namely, shows that there has still been no implementation. In particular, palliative medicine is not yet recognized as a speciality or sub-speciality, standards and norms for this activity are not set, palliative care is still not included in the system of obligatory health insurance, and as far as the national strategy of health policy for the area of palliative care, Croatian Government at its meeting held on 27^{h} December 2013 finally adopted the »Strategic Plan for Palliative Care of the Republic of Croatia for the period from 2014 to 2016«. Exactly because we are a decade behind European standards (Recommendation Rec (2003) 24 of the Committee of Ministers to member states on the organization of palliative care), it is more than legitimate to place this subject at the centre of the current Croatian gerontology interest.

Key words: *Croatia, gerontology, palliative medicine/care*

Introduction

Our society is faced with one of the biggest challenges in the public health sector in its history – the increase of the older population on a local and on a global level! Today we consider citizens after the age of 65 as the elderly, with a tendency to move the age-limit to 75 years[1,2]. This prolonged life-expectancy results in the prolonged duration of chronic diseases, connected with many physical, psychological, social, but also economical and ethical issues in the terminal phase of an illness[3].

According to the recent demographic data about the ageing index in the Primorsko-goranska county and the City of Rijeka[4], which are shown in the Table 1 and Figure 1, a growing emphasis should be made on the health-care interest in the linkage of the population's increased age with the mortality, morbidity and the structure of the health-care usage[3]. This is why the concept of ageing becomes the focus of public-health interest also on a local level, as shown through the recent symposia »IInd meeting

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TABLE 1
POPULATION IN THE PRIMORSKO-GORANSKA COUNTY AND THE CITY OF RIJEKA ACCORDING TO THE 2011 CENSUS

Population in the 2011	N	0–19	20–64	65>
P-G county	296195	50759	189432	56004
City of Rijeka	128624	20733	82503	25388

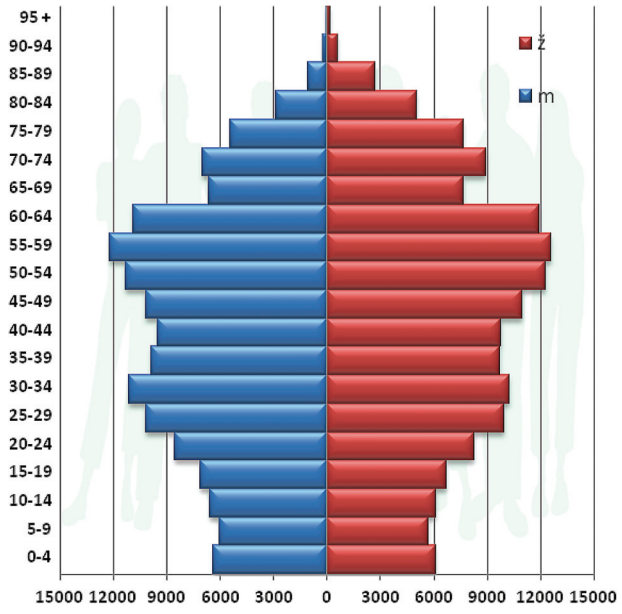

Fig. 1. Age pyramid of the Primorsko-goranska county in the 2011.

of Experts for the Quality of Life Problems in the Senior Population« and »Health for All?! Healthy Ageing!« recently held in Rijeka and Opatija[5,6].

The ageing process involves physiological, morphological and structural changes related to age. Ageing, as a physiological change in one's lifespan, often becomes accompanied by many pathological processes and multiple deficits of a disease, which can develop into a terminal one. Gerontology, as an integrative scientific discipline, has the task to prevent the occurrence of chronic degenerative diseases, disability and premature death, and to keep the elderly in the environment of their own homes as long as possible, satisfying both their physical, but also psychological and social needs. This should be achieved mostly through adequate preventive public-health measures, but relying on the entire health-care system[7,8]. Especially in the context of gerontology, this attempt to persist in the holistic approach to an elderly patient becomes quite an enterprise, taking into account that the trefoil of contemporary medicine – preventive, curative and palliative – is in the case of Croatian health-care system deficient[9].

Literature points out to a significant discrepancy between the particularities of the health-care needs of the elderly population and their satisfaction[10,11]. Satisfaction of these needs, taking into account present deficiency in the health-care system in Croatia, may represent a genuine health-care crisis, resulting in the low quality of health-care services available to patients in the terminal phase of their illness and their lives. This could be illustrated by the arrivals of terminally ill elderly patients in clinical hospital centres or in other curative systems on a daily basis[3]. After their release from the hospital, those patients are usually left to the care of their families, who provide well-intentioned but often inadequate medical assistance. This results in repeated calls to emergency services and an eventual return to the hospital care[12]. The problem lays in the fact that those patients do not belong in the curative setting! Their needs can successfully be met only in the palliative care setting!

Why Palliative Care Represents a New Gerontological Focus?

Palliative care, according to the World Health Organisation's (WHO) definition from 2002 is »an approach that improves the quality of life for patients and their families facing the problems 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«[13].

In 2003, the Committee of Ministers of the Council of Europe has issued a Recommendation to the member states on the organization of palliative care – REC (2003) 24[14].

The legal framework for organising palliative care in the Republic of Croatia was created in July 2003 when the new Health Care Law came into force. In this law, palliative care was listed as one of the health care measures (Article 8) and included in the primary level of health care (Article 25)[15]. Today, a decade after that law came into force, palliative medicine is not yet recognized as a speciality or sub-speciality, standards and norms for this activity are not set, palliative care is still not included in the system of obligatory health insurance[16], and as far as the national strategy of health policy for the area of palliative care, Croatian Government at its meeting held on 27th December 2013 finally adopted the »Strategic Plan for Palliative Care of the Republic of Croatia for the period 2014–2016« (Strategic Plan)[17]. In this context it is important to mention that in the Croatian Government' programme for a period of 2008–2011 (Chapter 17 – Health) stands a paragraph: »Palliative care and hospice facilities should be included in the health care system (national network with referral enter) – Deadline: December 2008«[18].

Exactly because we are a decade behind European standards **(**Rec (2003) 24), it is more than legitimate to place this subject at the centre of the current Croatian gerontology interest.

Namely, although we cannot ignore the fact that children can become palliative care patients, we can conclude that these are predominantly elderly patients. Approximately half of patients – users of palliative care – have

some type of oncological diagnosis, a significant number of patients suffers from dementia, stroke, or heart failure[9,13]. As for the citizens of the Primorsko-goranska county and the City of Rijeka[4], they present exactly those diagnosis as main causes of morbidity and mortality, as illustrated in the Tables 2, and 3, and in the Figure 2.

In this context, the »Pallium study« needs to be especially emphasized, as an argument *in favorem* of gerontological focus on issues of palliative medicine/care. This study, conducted by the European Commission, reviewed the concepts of palliative care and related segments of the health policies in seven Western European countries: the Netherlands, Belgium, Sweden, Germany, Spain, the UK and Italy. It was noted that:

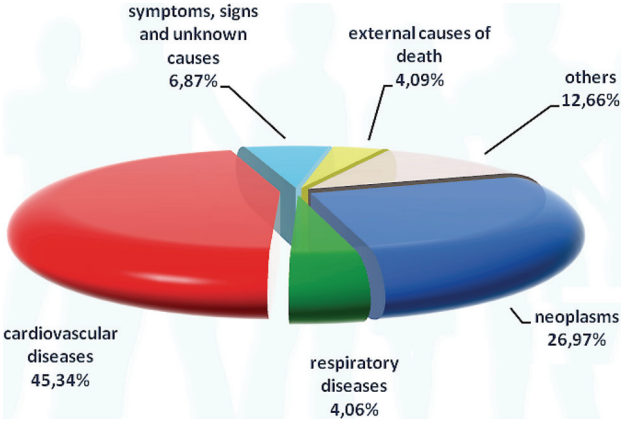

Fig. 2. Mortality share in the Primorsko-goranska county in the 2012.

- traditional family structure has changed in many regions,
- many elderly live alone and cannot count on the support of family,
- 50% of seriously ill people would rather stay at home,
- lack of financial resources is often the biggest obstacle[19].

While in Croatian rural households with multiple generations there is still a desire for keeping ill members of the family in their own homes until the end of life, socio-economic conditions of the urban environment have resulted in a trend to place them in a health-care institution[16]. Taking all this into account and according to the above presented statistics, Croatia is indeed following European trends regarding the position of the elderly within the society!

Strategic Plan

The availability of palliative care must be based on patients' needs, and should not be restricted according to the type of illness, geographic location, or socio-economic status of the person in need of such care[20]. This becomes particularly actual in the case of elderly patients.

This is why many studies were conducted regarding the need for palliative care[21,22]. In a survey conducted in 2002 a number of important issues common for countries of Eastern Europe were identified:

- considerable differences in the extent to which palliative care is accessible to those who need it,
- lack of recognition, financial support and sustainability policies of palliative care,

TABLE 2

MORBIDITY IN THE PRIMORSKO-GORANSKA COUNTY AND THE CITY OF RIJEKA IN THE 2012

	Morbidity			Morbidity in age 65> (3 leading groups)			Morbidity on 10000 citizens older than 65> (3 leading groups)		
	N	65>	share in total morbidity	IX circulatory system	XIII musculo-sceletal	IV metabolism	IX circulatory system	XIII musculo-sceletal	IV metabolism
P-G county	868488	273879	31.54	63173	33829	21562	11280	6040	3850
City of Rijeka	451874	147517	32.65	33339	17833	11876	13132	7024	4678

TABLE 3

MORTALITY IN THE PRIMORSKO-GORANSKA COUNTY AND THE CITY OF RIJEKA IN THE 2012

	Mortality			Mortality in age 65> (3 leading groups)			Mortality on 10000 citizens older than 65> (3 leading groups)		
	N	65>	share in total mortality	IX circulatory system	II neoplasms	X respiratory diseases	IX circulatory system	II neoplasms	X respiratory diseases
P-G county	3522	2892	82.11	1439	674	128	257	120	23
City of Rijeka	1629	1362	83.61	670	329	69	264	130	27

- insufficient availability of opiates,
- lack of health-care professionals,
- lack of medical equipment and equipment for the care,
- lack of research in the field of palliative medicine/care,
- negative cultural stereotypes[22].

A survey conducted by Brkljačić et al in Croatia in 2007–2008 proved how an increase in the elderly population dictated the need for formal organization of palliative medicine/care system and the establishment of hospices[3,12]. A result most important to be emphasized is that 91% of all respondents were in favour of introducing formal palliative care activities in the health-care system, while 88% were in favour of the establishment of facilities specialised in palliative care, that is the hospices[3]. As for the need for formal education in palliative medicine, 76% of health-care professionals found it absolutely necessary to introduce such sub-speciality[12].

Since the needs for the inclusion of palliative care as a system, and palliative medicine as a speciality were formally proven, the Croatian Government has a strong starting point to put the »Strategic Plan for Palliative Care of the Republic of Croatia for the period 2014–2016« immediately into action! Based on proven needs, this Strategic Plan should provide for the development of the following new structures and contents in palliative care:

- county coordinating centres for palliative care,
- inpatient palliative care,
- hospital teams to support palliative care,
- hospital palliative care teams,
- infirmaries for palliative care at the level of secondary health-care, exceptionally primary,
- home visits of experts from the secondary and tertiary health-care, who provide specialized palliative care outside the domain of family physicians (eg, visiting of a psychologist, psychiatrists, surgeons, anaesthesiologist, neurologist...),
- renting of medical devices,
- family counselling centre for palliative care
- psychological help in grief and bereavement,
- centre of excellence for certain levels and forms of palliative care[17].

The legitimacy of the approach to the issue of (dis)organization of palliative care also from the standpoint of gerontology, i.e. public health can be underlined through the general concept of palliative care offered in the Strategic Plan, which is exactly the concept of integrated model of care, based on the ongoing partnership, including other sectors (volunteers, civil society, educational system, religious communities, the profit sector, etc.). The Plan includes, encourages and supports all forms of vertical and horizontal cooperation, and strong inter-sector connectivity, which is considered crucial at all levels of health-care. The establishment of new approaches, systematic cooperation of several institutions, inter-sectoral collaboration, and flexibility in work schedules according to the specific needs and abilities, are all included in the National Health Development Strategy 2012–2020, a platform on which the Strategic Plan was built[17]. To underline this approach, and to enroot palliative care into the public health domain, it has been argued that the principles of palliative care should be applied not only to the terminal phase of an illness but also to a period much earlier on[3].

Conclusion

According to the REC (2003) 24, palliative care is an integral part of the health care system and an inalienable element of a citizen's right to health care, and therefore it is a responsibility of the government to guarantee that palliative care is available to all who need it[14], with special emphasis to the elderly. Regarding the recent Croatian accession to the European Union, thus, the need to approach the European and other international standards, Croatian Government should consider this not just a recommendation, but an obligation[23]. By putting the Strategic Plan into action, we acknowledge how economic and social changes also determine the changes in the health-care sector[24]. Faced with another health-care reform, decision-makers should be constantly reminded how its economic and political aspects require careful management, since the entire population will be affected by it[3].

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(NE)ORGANIZACIJA PALIJATIVNE SKRBI KAO POTENCIJALNI PROBLEM KVALITETE ŽIVOTA U STARIJOJ POPULACIJI – HRVATSKA ISKUSTVA

S A Ž E T A K

Rad analizira aktualnu situaciju u hrvatskom zdravstvenom sustavu, s posebnim osvrtom na (ne)organizaciju palijativne skrbi u kontekstu gerontologije i javnog zdravstva. Suvremena svjetska populacija postaje sve starijom. To je i statistička i svakodnevna medicinska činjenica. Kao početak starosti danas se označava dob nakon 65 godina, s tendencijom da se granica pomakne na 75 godina. Hrvatska po tom pitanju strelovito slijedi svjetske trendove, a literatura ukazuje kako porast starije populacije diktira potrebu za organiziranim sustavom palijativne skrbi i izgradnjom hospicija. Premda se ne smije zanemariti činjenica da i djeca mogu postati korisnicima palijativne skrbi, može se zaključiti kako su to dominantno bolesnici starije životne dobi. Otprilike polovina bolesnika – korisnika palijativne skrbi – ima neku od onkoloških dijagnoza, značajan je broj bolesnika s demencijom, moždanim udarom, te krajnjim stadijima bolesti srca. Primorsko-goranska županija i Grad Rijeka slijede navedeni trend, što se može ilustrirati podacima iz 2011. godine koji pokazuju udio starijih od 65 godina od 18,91% na županijskoj, odnosno 19,74% na gradskoj razini. Jedan od ključnih problema kvalitete života u hrvatskoj starijoj populaciji jest (ne)funkcioniranje sustava palijativne medicine/skrbi. Praksa pokazuje kako još uvijek nije došlo do implementacije. Palijativna medicina još uvijek nije prepoznata kao specijalizacija ili sub-specijalizacija, nisu utvrđeni standardi i normativi za ovu djelatnost, palijativna skrb još uvijek nije uključena u sustav obaveznog zdravstvenog osiguranja, a što se tiče nacionalne strategije, Vlada Republike Hrvatske je na svojoj sjednici održanoj 27.12.2013. godine konačno usvojila »Strateški plan palijativne skrbi Republike Hrvatske za razdoblje od 2014.–2016. godine«. Upravo zato što za Europskim standardima kasnimo deset godina (Recommendation Rec (2003) 24 of the Committee of Ministers to member states on the organisation of palliative care), više je nego legitimno ovu temu staviti u središte aktualnog hrvatskog gerontološkog interesa.