

Introducing palliative care services in Serbia

Overview

Serbia faces the burden of an ageing population with rising prevalence of chronic disease, notably cardiovascular disease and cancer.¹ Consequently, the health system has been confronted with the need to effectively manage long-term care, shifting treatment goals to focus on continuous disability reduction and maintenance of quality of life, rather than acute, curative interventions. Observing gaps in the provision of services for terminal patients, in 2004, the Ministry of Health established the Palliative Care Task Force (PCTF) to develop the National Palliative Care Strategy. In March 2009, the Strategy was adopted by the and the Ministry of Health applied for funds from the European Union (EU) to support its implementation. The subsequent EU-funded project – Development of Palliative Care Services in the Republic of Serbia (DPCS) – took place between March 2011 and November 2014, supporting the establishment of numerous palliative care units across the country and vehicles for home-care services. Funding also served to strengthen providers' competencies through trainings led by the DPCS project team and palliative care training has since been incorporated into formal medical education. Efforts to formalize training have helped instill a new palliative care philosophy among providers to root palliative care services into the basic package of care provided.

Problem definition

Throughout the early 2000s, a growing elderly population in Serbia – with almost a fifth (17%)¹ of the population over the age of 65 in 2004 – posed new challenges for the Serbian health system (Box 1). Changing demographics have contributed to an increasing prevalence of chronic disease, namely cardiovascular disease and cancer.² Palliative care was an undeveloped concept within the country and a concentration of acute end-of-life services in hospital settings failed to allow adequate focus on maintaining quality of life

or reducing disability for terminal patients.

Box 1

What problems did the initiative seek to address?

- Ageing population with increasing rates of chronic disease and progressive illness.
- Acute, reactive focus of end-of-life services.
- Concept of palliative care in Serbia underdeveloped.

Health services delivery transformations

Timeline of transformations

In response to pressure to meet growing palliative care needs, the Ministry of Health formed a Palliative Care Task Force in 2004 to guide the development of palliative care in Serbia (Table 1). A National Palliative Care Strategy was adopted in 2009 and €4.1 million in EU funds were secured to support activities under the Development of Palliative Care Services in the Republic of Serbia (DPCS) project which ran from 2011 to 2014.

Description of transformations

Selecting services. Palliative care services have been made available across primary, secondary and tertiary care levels. Palliative care services now offered include pain and other symptom management, counselling, mental health services and occupational therapy. Social services, while already integrated within the health system, have been expanded in scope to provide complementary palliative care services, such as bereavement and support services for informal caregivers.

Designing care. Frameworks and a model of care defining the roles of each professional delivering palliative services, have been established drawing on evidence from international examples, predominantly from the United Kingdom. A list of essential palliative drugs has also been defined. Patient pathways and palliative care guidelines help inform providers about best palliative care practices at each level of care.

Organizing providers. Palliative care services are offered in home, institutional and hospital settings, depending on the most appropriate location for patients' needs. Increasing emphasis has been placed on providing care in community settings. Scope of practice for providers across care

Table 1

What were the chronological milestones for the initiative?

Early 2000s	Growing need for holistic end-of-life care; absence of palliative care concept and actors in this area.
2004	First Serbian doctor obtains a postgraduate diploma in palliative medicine and establishes BELhospice as a charitable palliative care organization; Palliative Care Task Force formed by the Ministry of Health to guide national development of palliative care.
2005	European conference on palliative care held in Belgrade.
2007–2008	Designing and planning stage for the National Palliative Care Strategy.
2009	National Palliative Care Strategy officially adopted by the government.
2011	Three-year EU grant awards €4.1 million to developing palliative care in Serbia under the DPCS project.
2014	Eight-month extension granted for finalization of the DPCS project.
Present	Concept of palliative care integrated within the health and social care system.

settings – including physicians, hospital and community nurses, physiotherapists, occupational therapists, specialist physicians and pharmacists – has been expanded to include new roles in palliative care delivery. New specialized palliative care physician and nurse profiles have been introduced. Social care experts to consult on the delivery of palliative services in secondary and tertiary facilities have also been added. To overcome fragmented communication between providers, the Ministry of Health is currently in the process of developing new laws to allow for the development of a common information system.

Managing services. During the DPCS project, responsibility for the development of palliative services was delegated to the DPCS project team under guidance from the Ministry of Health. Local health councils also played a

role in management of palliative care services at the local level. The Ministry of Health funded the development and reconstruction of numerous dedicated palliative care units within hospitals to support services delivery and EU funds were used to purchase 52 vehicles to facilitate community-care provision.

Improving performance. Trainings were offered to a wide variety of health professionals to strengthen competencies in palliative care. Trainings included education on the palliative care philosophy, new models of care and guidelines developed for palliative services, as well as strengthening of non-clinical skills such as provider-patient communication.

Engaging and empowering people, families and communities While patient-provider communication was previously

constrained by cultural reluctance to openly discuss death and dying, trainings provided by the DPCS project team have focused on increasing the communication between providers and patients, as well as between providers and caregivers or family members of patients. By improving communication, patients can be more meaningfully involved throughout the care process and engaged in decision-making. In addition, the initiative has helped raise patient awareness of palliative care through various media channels, a website and a special awareness day, which have helped to stimulate broader societal conversation on the topic.

Health system enabling factors

A complex interplay of wider health system factors enabled the successful development of palliative care in Serbia (Table 3). Strong ministerial support and collaboration across government sectors facilitated the development and implementation of the National Strategy for Palliative Care. Legislation was enacted to officially recognize nongovernmental organizations (NGOs) and charitable organizations as actors in palliative care, allowing involvement of these organizations in services delivery. Certification for completing palliative care trainings was introduced as a non-financial incentive to engage providers and to ensure sustainability of training in palliative care, meetings with medical schools led to the integration of palliative care education into formal curricula.

While assessment of the initiative has not yet taken place, the planned development of a coordinated health information system will assist in data collection and monitoring in the future. The government is currently in the process of developing the necessary legal framework to permit development of this coordinated health information system.

Table 2

How was the delivery of health services transformed through the initiative?

Before	After
Selecting services	
No concept of palliative care in Serbia; treatment for progressive disease focused on provision of acute care services; limited provision of social care services as part of basic service package.	Services delivery continuum expanded to include palliative care; palliative services include clinical pain and symptom management, mental health services and physical therapy; expanded social support for patients and caregivers.
Designing care	
Limited guidelines on the management of chronic symptoms in place; no standards for palliative care.	Palliative care guidelines and pathways designed based on international best practices; list of essential palliative drugs defined.
Organizing providers	
Little interaction between providers across care levels; no unified system for communication between providers.	Palliative care offered in a variety of settings including patients' homes, residential institutions and hospitals; specialized palliative care provider profiles introduced; development of a unified communication system underway.
Managing services	
No dedicated palliative care resources.	DPCS project team managed development of palliative services under guidance from the Ministry of Health; local health councils responsible for developing palliative services at the local level; government and EU funds supported necessary investments to enable delivery of palliative care services.
Improving performance	
Limited training in palliative care.	Trainings provided on palliative care and related non-clinical skills; trainings conducted across disciplines and care levels, reaching 1200 professionals.

Table 3

How has the health system supported transformations in health services delivery?

System enablers	Example
Accountability	<ul style="list-style-type: none"> National Strategy for Palliative Care developed via intersectoral collaboration between Ministry of Health and Ministry of Social Welfare. Legislation enacted to legalize NGOs and charities as actors in palliative care, allowing involvement of these organizations in services delivery.
Incentives	<ul style="list-style-type: none"> Certification awarded to health professionals for completing training in palliative care.
Competencies	<ul style="list-style-type: none"> Palliative care incorporated into formal medical school education.
Information	<ul style="list-style-type: none"> Development of a coordinated health information system underway.

Outcomes

Formal evaluation of the initiative has not yet taken place. The initiative is believed by leaders to have strengthened the provision of end-of-life services in Serbia and successfully embedded the palliative care philosophy into the delivery of health and social services.

Change management

Key actors

Motivation of an individual health provider to address observed challenges resulting from a lack of palliative care led them to seek out training in palliative medicine and establish a charitable organization to obtain greater legitimacy and authority with policy-makers. Through advocacy efforts, providers successfully brought the need for palliative care to the attention of policy-makers and joined the newly-formed government Palliative Care Task Force which led the development of palliative care in Serbia along with cross-ministry support and EU funding (Box 2).

Box 2

Who were the key actors and what were their defining roles?

- **Ministry of Health.** Adopted the National Strategy for Palliative Care; enacted legislation to support the initiative.
- **Palliative Care Task Force.** Developed the National Strategy for Palliative Care.
- **Development of Palliative Care Services in Serbia (DPCS), EU funded project.** Project team provided palliative care expertise, united stakeholders behind the initiative, facilitated the

implementation process and trained professionals in palliative care.

- **Health Insurance Scheme.** Reworked reimbursement system to incorporate palliative care services and medicines, creating sustainable financing for services.
- **Medical schools.** Incorporated palliative care into curricula allowing for sustainable provision of provider training in palliative care.

Initiating change

Grassroots action was successful in advocating for change at the government level which led to the establishment of the Palliative Care Task Force. A conference on palliative care organized by the newly-founded Task Force was instrumental in driving change as it united stakeholders, created a tipping point for political buy-in and provided information to guide policy development and the National Strategy for Palliative Care. Through the conference, government representatives were able to understand why palliative care was an important investment and how it could be integrated into the health system; experience and authority of international actors was vital to achieving government support.

Implementation

Recognition of the importance of palliative care at the clinical level was achieved by soliciting health professionals through written invitations to participate in stakeholder discussions. Training organized by the DPCS project team equipped providers with the necessary knowledge to follow new palliative care frameworks.

The DPCS project team was instrumental in providing expert knowledge and running trainings for providers to strengthen professional competencies and update professional clinical skills. However, it was professionals' willingness to apply their new training, which allowed the palliative care philosophy to permeate the traditional model of care and embed itself within professional practice. Leadership by health professionals in establishing the palliative care philosophy as a norm was critical to the initiative's uptake.

Moving forward

The focus on sustainability throughout the initiative has helped to permanently root palliative care within the health system, ensuring its continuation beyond the funded project.

Highlights

- Partnerships with international organizations, local NGOs and supportive government actors helped secure buy-in at the national level.
- Developing a legislative and political base was essential for securing the foundation on which to build the initiative.
- Incorporating a new palliative care philosophy within professional culture required extensive communication, advocacy and time.
- Formalizing educational opportunities through university partnerships helped ensure sustainability.

1 World Health Organization. (2015). *European health for all database*. Retrieved from <http://data.euro.who.int/hfad>

2 Institute for Health Metrics and Evaluation. (2015). *Global burden of disease cause patterns*. Retrieved from <http://vizhub.healthdata.org/gbd-compare/>