DRAFT

NATIONAL PALLIATIVE CARE STRATEGY

September, 2008

1. INTRODUCTION

Palliative care strategy is a document of national importance part of the Health System Development Strategy of the Republic of Serbia. It represents an instrument for mobilizing, not only health sector, but all social factors participating in palliative care programs.

The Strategy has been compiled according to the Recommendations of the Council of Europe Ministerial Committee "REC 24 (2003)" pertaining to palliative care organization, as well as in line with Recommendations from European Conference held in Belgrade 2005, that palliative care should become a constituent part of the health care system and an inseparable element of the right of citizens to healthcare.

Palliative care is an approach which improves the quality of life of patients and families facing problems following the diagnosis of a life limiting disease, by preventing and eliminating suffering by early discovery and by accurate evaluation and treatment of pain and other problems: physical psychosocial and spiritual ones (World Health Organization 2002). The term *"life limiting disease"* applies to patients with active, progressive, developed disease for whom the prognosis is limited.

Palliative care also means the total philosophy of care about the patient and family It covers a period from disease diagnosis until the end of the mourning period due to the loss of the family member.

Palliative care complements specific approaches aiming to influence the flow of basic disease. As the disease progresses, the importance of specific active intervention decreases, and the importance of palliative care increases.

The reason for passing the strategy is that there is an increase in the number of patients needing this type of care due to an aging Serbian population, and also in the number of patients suffering from diseases with a progressive flow(cardiovascular disease. Malignant disease diabetes, neuromuscular disease, cerebro-vascular disease.) HIV /AIDS traffic accident trauma, ect.

The need for palliative care has become a priority which necessitates that the state, in cooperation with health and other professionals, non-governmental associations, patients, their families and media should develop a national healthcare policy on palliative care, to define strategic goals and measures for implementing that policy.

For successful establishment and integration of palliative care into the existing healthcare system there need to be:

- Adequate regulations and establishment of sustainable financing model.
- Integration of palliative care services into health care system of the Republic of Serbia.
- Securing and availability of opioids and other drugs for palliative care, according to the development of List of Essential Drugs for Palliative Care of Patients, recommended by Palliative Care Commission.
- Education of health policy creators, health workers and other professionals, patients, families and wider public about palliative care.

The Strategy of palliative care identifies:

1. Demographic characteristics of the population in the Republic of Serbia.
2. Groups of diseases and conditions leading to the need for palliative care.
3. Organization of the health care system from the aspect of disease and conditions requiring palliative care.
4. Inclusion of social community into palliative care.
5. Legal regulations.
6. Principles and key messages.

7. General objective.
8. Specific goals.
9. Education.
10. Monitoring and evaluation.
11. Action Plan.

2. CURRENT SITUATION IN THE REPUBLIC OF SERBIA

2.1 *Demographic characteristics of the population of the Republic of Serbia*

Basic characteristics of the Serbian population are continuing trends of low natality and population aging, with increase of general mortality rates (mortality rate has grown from 8.2/1,000 in 1986 to 13.9 deceased persons per 1,000 inhabitants in 2006.). These changes have brought the population to the threshold of demographic age. According to the census from 2002 (without data for Kosovo and Metohija) average age of Serbian inhabitants was 40.2 years (urban 38.2, and other 41.6 years).

According to the last census from 2002 in Serbia 16.54% people were 65years or more, that is 22.7% of persons of 60 years and older, while people 80 years and older made up 8.6%. The share of the rural population of 65 years and older was 20.8%.

According to estimates for 2006 (without data for Kosovo and Metohija) the population aged 65 years and older) is 17.4% of the total population in the Republic of Serbia (Republic Statistics Bureau). According to the estimate for 2007, out of 161 municipalities in the Republic of Serbia (without data for Kosovo and Metohija), in 101st municipality the index of social support to old persons (ratio between persons of 65 years old and older according to the population age of 19-64) will be more than 27.66%, which is the average for the Republic of Serbia (without data for Kosovo and Metohija).

Life expectancy at birth in the Republic of Serbia has grown in the period 1950-51 to 2001-2002, and that is for men from 53.5 years to 70.1 years, and for women from 56.0 to 75.1 years. By comparing districts, the longest life expectancy is in Zlatibor County (in general and for women), and in Nisava and Pirot Counties for men. The shortest life expectancy is in North Banat County (in general, men, women).

Speaking about health and social needs of the population, one should take into consideration the fact that in Serbia there are 947 thousands of households with people older than 65 years of age (37.5% of the total number of households). Also, the majority of single households in Serbia are old persons' households – even in 52.8% those are people of 65 or more years of age, and in 23.9% between 50 and 64 years of age.

Demographic trends envisage further growth of old peoples' representation, as well as increase of life expectancy, which would lead to significant increase of representation of persons older than 80. With population aging, there is an increase in the chronically ill and functionally dependent (arterosclerotic changes leading to increases of those ill from cardio-vascular diseases, malignant diseases, chronic obstructive lung diseases, diseases of skeletal-muscular system. Osteoporosis is the main cause of disability in old persons, and of neurological disturbances). Bearing in mind the very high proportion of old persons living alone, often without family support, those older than 65 years of age will have a greater need for homecare, social care and palliative care services.

2.2 Groups of diseases and conditions leading to the need for palliative care

2.2.1 Malignant tumors in 2006 were 19.7% of all causes of death, the second-highest cause of dying in the Republic of Serbia (without data for Kosovo and Metohija). In the structure of diseases requiring palliative care malignant diseases are the most represented ones.

The standardized mortality rate was 202.7 per 100,000, which classified the inhabitants of Serbia in relation to the other European nations, at medium risk of dying from malignant diseases. Mortality rates in men were 160.5/100,000, and in women 124.4/100,000 inhabitants. The biggest mortality rates in men have been registered in Belgrade, Pomoravlje and Raska Counties, and in women in Belgrade, Macva and Pcinja Counties.

Standardized cancer mortality rates were higher in Vojvodina, and lower in Central Serbia in relation to the Republic average. According to data from the cancer register, most men were ill and died from lung cancer, colon and rectum cancer, from prostate and stomach cancer and women from breast, lung, colon, rectum, cervical and stomach cancer.

The incidence rate in men was 285.5 per 100,000, and in women 246.6 per 100,000 inhabitants. The highest rates of disease in both sexes were registered in Belgrade, Rasina and Nisava Counties.

2.2.2 Diseases of heart and blood vessels represented 57.3% of all deaths, and were in 2006 the leading cause of dying in the Republic of Serbia (without data for Kosovo and Metohija). Death rates from heart and blood vessel diseases in the period 2001-2006 have grown to 10.6% in women, and in men to 7.2%. From 2001 to 2006 death rates from diseases caused by increased blood pressure have grown to 9.4%, from ischemic heart diseases to 20.1% and from cerebro-vascular diseases to 6.8%. Cerebro-vascular diseases are diseases with high mortality rate and the cause of the most severe disability. Half of all survivors from acute cerebral infarction are capable of renewing certain activities, and around 20-30% of survivors from cerebral infarction need assistance, while 16% of those persons will be treated in institutions for permanent care.

2.2.3 Diabetes is one of the most frequent chronic non-contagious diseases. In the Republic of Serbia diabetes is the fifth leading cause of mortality of all causes of death and fifth cause of burden from disease. The number of those sick of diabetes has been growing for a long period. In 2006 Serbia had (without data for Kosovo and Metohija) based on standardized mortality rates, 23.2/100 000 inhabitants, and it belonged to the group of European countries with the highest mortality rates from those diseases. In relation to the Republic average standardized mortality rate from diabetes was the highest in Vojvodina, and the lowest in Central Serbia.

It is estimated that today in Serbia close to 500,000 persons suffer from diabetes, or 6.7% of the population. Diabetes prevalence grows with age and it is estimated that almost half of patients are older than 65. Diabetes with all consequences and complications accompanying it (infarct, cerebrovascular insult, chronic renal insufficiency) represents a disease requiring palliative care.

2.2.4 Obstructive lung disease is a very common cause of disability and fourth cause of dying in the Republic of Serbia (without data for Kosovo and Metohija) in 2006. Mortality rate from chronic obstructive lung diseases was the highest in Vojvodina (33.0/100 000 inhabitants) but lower in Central Serbia (31.1/100 000 inhabitants) in relation to the Republic average (31.6/100 000 inhabitants), while the standardized mortality rate from asthma was higher in Central Serbia and lower in Vojvodina in relation to the Republic average (3.6/100 000 inhabitants).

2.2.5 Actual situation of HIV/AIDS. In the Republic of Serbia (without data for Kosovo and Metohija) in the period from 1985 to 2006 1,352 people have reported Morbus HIV (AIDS, SIDA) and 905 (67%) of them died. During 2006 51 newly infected persons have been registered (incidence rate 0.7/100 000), while 24 of them died (mortality rate 0.3/100 000).

2.2.6 Traffic accidents and traumatism. In the Republic of Serbia (without data for Kosovo and Metohija) according to the data from the Ministry of Internal Affairs of the Republic of Serbia, in 2006 there were 63,954 traffic accidents in which 18,411 persons have been injured (13.7%), out of which 25.95% (4,778) with severe injuries leading to functional disability for performing everyday life activities and requiring someone else's care and assistance.

2.3 Research of the Serbian population health in 2006

Based on repeated research of the health status of Serbian population performed during 2006, it has been determined that in Serbia chronic disease or health problem occurs in 26.6% of adult population, which is significantly greater in relation to 2000 (17.6%). Everyday activities are performed without difficulties by 83.2% of adult population. The biggest percentage of the population that can not perform activities pertaining to personal hygiene without assistance is in population aged 65-74. Percentage of old persons that can not perform activities pertaining to personal hygiene is growing, from 3.8% in 2000 to 7.0% in 2006.

According to the data from City Gerontology Bureau, Belgrade in 2007 out of 2,239 patients at home treatment and care 46.4% were immobile and incontinent patients. Big number of patients 13.7% (306 patients) were in terminal stadium, most often those were malignant diseases requiring palliative care.

3. ORGANIZATION OF HEALTH CARE SYSTEM FROM THE ASPECT OF DISEASE AND CONDITIONS REQUIRING PALLIATIVE CARE

3.1 Analysis of primary level healthcare (home treatment and care)

According to the National Health Policy envisaging inclusion of palliative care in the health care system and implementation of palliative care as a constituent part of home treatment and care work, an analysis has been compiled of the existing capacities, organization, secured staff and scope of work in home treatment and care services on primary health care level.

Analysis of internal organization method, as well as of conditions for performing health activity in the home treatment and care service in medical centers in the Republic of Serbia, has been compiled based on Staff Structure Report, Implementation Report for 2007 Service Plan and Questionnaire for 2008, implemented by the Ministry of Health of the Republic of Serbia in cooperation with the Public Health Institute of Serbia "dr Milan Jovanovic Batut".

By gaining insight into staff structure and secured home treatment and care service with chosen medical doctor, it is acknowledged that over 59.3% of medical centers in the Republic of Serbia do not have specially organized service for home treatment and care, but this activity of home treatment and care service is performed within the adult healthcare service (general medicine, urgent, poly-valent field service).

In the territory of the City of Belgrade there is a specialized institution (City Gerontology Institute, Belgrade) securing home treatment and palliative care daily for around 1,500 old and Belgraders with chronic diseases.

By analyzing the existing staff in the home treatment and care service (agreed number of doctors, nurses /technicians) it has been determined that coverage regarding the number of physicians is in line with the existing Rule Book on Closer Conditions for Performing Healthcare Activity in Healthcare Institutions and other Forms of Health Service (Official Gazette of the RS no.43/06), while the arranged number of nurses/technicians for 2007 in the majority of municipalities-medical centers is not in line with the Rule Book.

Analysis of physicians' workload (the number of visits per one physician) shows that in relation to the total number of checks by physicians and the number of arranged physicians, workload per one physician is in line with the prescribed standard for the number of services.

Analysis of nurses/technicians' workloads (the number of medical services per one nurse /technician) shows increased scope of work of the quoted staff and increased workload in relation to the prescribed standard.

3.2 Analysis of healthcare on secondary and tertiary level

According to the Ordinance on Healthcare Institutions' Network (Official Gazette no.s 42/06, 119/07) and the Ordinance on Amendments of the Ordinance on Healthcare Institutions' Network (Official Gazette 84/08) it has been envisaged in Article 22, point 14, (geriatry, palliative care, hemiotherapy, rehabilitation, etc.) 0.20 beds per 1000 inhabitants for extended treatment and care.

The Rule Book on Closer Conditions for Performing Healthcare Activity in Healthcare Institutions and Other Forms of Health Service ("Official Gazette of the RS" no. 43//06), in Article 19, point 11, envisages to have in the Extended Treatment and Care Department - eight (8) medical doctors and 50 medical nurses/technicians with secondary, that is, higher qualifications.

3.3 Proposal of palliative care organization

The existing resources within the organized healthcare system, that can be used in the future for palliative care are:

- On primary healthcare level, the Strategy envisages organizational and staff strengthening of home treatment and care services**:**

  - amendments of the Rule Book on Closer Conditions for Performing Healthcare Activity in Healthcare Institutions and Other Forms of Health Service (Official Gazette of the RS no. 43/06) in the sense of obligation to form services for home treatment and care in all municipalities (88 medical centers) with over 25,000 inhabitants;
  - amendments of the Rule Book on Closer Conditions for Performing Healthcare Activity in Healthcare Institutions and Other Forms of Health Service (Official Gazette of the RS no.43/06) envisaging increase of the number of staff from the existing norm of 1 physician: 4 nurses per 25,000 inhabitants to 1 physician: 5 nurses per 25,000 inhabitants;
  - in the City of Belgrade all medical centers must form their home care services. The norm for city municipalities should remain one (1) physician and four (4) nurses, and for medical centers in the wider city area one (1) physician and five (5) nurses;

- formation of the Reference Center for Coordination of Services for Home Treatment and Care within City Gerontology Institute, Belgrade, with change of the name of the Institute into Institute for Gerontology, Home Treatment and Care.

- On secondary healthcare level, the Strategy envisages:

- formation of special Palliative Care Units within Department for Extended Treatment and Care as well as amendment of the Rule Book on Closer Conditions for Performing Healthcare Activity in Healthcare Institutions and Other Forms of Health Service (Official Gazette of the RS no.84/08), by which we would switch from envisaged 0.20 beds per 1000 inhabitants, to 0.04 beds per 1000 inhabitants for palliative care;
- Amendments of the Rule Book on Closer Conditions for Performing Healthcare Activity in Healthcare Institutions and Other Forms of Health Service ("Official Gazette of the RS" no. 43//06), in Article 19, point 11, to set aside from the existing staff norm 1 doctor specialist of internal medicine and 5 nurses per 10 beds Palliative Care Unit (Hospice);
- Choice of hospitals in which Palliative Care Units shall be formed (Hospices), has been completed based on the following criteria

1. Demographic situation:
   - The total number of country residents in the Republic of Serbia;
   - Index of social support to old people (ratio between people 65 and more years old in relation to population capable of work from 19 to 64 years of age) which is in 62.11% municipalities (in 101 from total of 161 municipalities) above the Republic average, which is 27.66% in the Republic of Serbia.

2. Diseases and conditions leading to the need for palliative care.

3. The existing capacities (space, bed and staff related) and occupancy of beds on a secondary and tertiary level in 2007

- In the I phase in the period from 2009 - 2012 Palliative Care Units shall be formed in 13 healthcare institutions with in total 140 beds: General hospital Subotica, General hospital Zrenjanin, General hospital Sombor, Health Center Loznica-General hospital Loznica, General hospital Smederevska Palanka, General hospital Cuprija, Health Center Zajecar-General hospital Zajecar, Health Center Uzice-General hospital Uzice, Special Hospital for Internal Diseases Vrnjacka Banja, Clinical Center Nis - Clinic for Lung Diseases and TBC, Knez Selo, Health Center Vranje - General hospital Vranje, Clinical-Hospital Center Zemun-Belgrade, Clinical-Hospital Center Zvezdara - Belgrade.
- In the II phase in the period 2012 - 2015, according to the same criteria shall be formed palliative care units with additional 160 beds, in the following Healthcare Institutions: General hospital Kikinda, General hospital Pancevo, General hospital Vrbas, General hospital Sremska Mitrovica, Health Center-General hospital Valjevo, Health Center-General hospital Pozarevac, Clinical Center Kragujevac, Health Center-General hospital Bor, Health Center-General hospital Cacak, Health Center-General hospital Krusevac, Health Center-General hospital Pirot, Health Center-General hospital Prokuplje, Health Center-General hospital Kosovska Mitrovica, Clinical-Hospital Center Bezanijska Kosa - Belgrade, Clinical-Hospital Center dr Dragisa Misovic - Belgrade, Clinical-Hospital Center Zemun-Belgrade, Clinical-Hospital Center Zvezdara - Belgrade.

In both phases it is necessary to adapt the space and equipment for palliative care.

- On tertiary level has been envisaged formation of:

a) Consultancy teams in reference health care institutions *Clinical Center of Serbia*: Institute for Infectious and Tropical Diseases, Institute for Neurology, Institute for Endocrinology, Diabetes and Metabolic Diseases, Institute for Urology and Nephrology, Institute for Lung Diseases and TBC; *Clinical Center of Vojvodina-Novi Sad*: Institute for Oncology Vojvodina, Sremska Kamenica, Clinic for Infectious Diseases, Institute for Internal Diseases-Endocrinology, Institute for Neurology; *Clinical Center of Nis*: Clinic for Contagious Diseases, Institute for Nephrology, Clinic for Oncology, Clinic for Neurology, Clinic for Endocrinology; *Clinical Center of Kragujevac*: Clinic for Internal Diseases: Endocrinology, Nephrology, Neurology, Infections, Pneumo-phtysiology, Radiology and Oncology.

   Based on the institution's Expert Council Proposal, the manager appoints consultation team establishing cooperation with teams on primary and secondary level, offers expert assistance in resolving patients' problems in palliative care.

   Standard for consultancy teams' staff consists of medical doctor, specialist of a certain branch of medicine and nurse with higher/high qualifications.

б) Center for development of palliative care in the Institute for Oncology and Radiology of the Republic of Serbia. Center for Palliative Care Development monitors, researches and recommends measures for enhancing palliative care development. Task of the Center is establishing cooperation with WHO, international organizations and associations, medical faculties in order to enhance palliative medicine. Center for Palliative Care Development consists of prominent scientific and other health workers and collaborators with significant contribution in work and development of palliative care**.**

   Palliative care should not be transferred just to health services, but it should represent care of the whole society. Within the activities and engagement of the whole community in the palliative care field, it is necessary to establish inter-ministerial cooperation, including local self government bodies, educational and social institutions, as well as to engage civil society, church and international organizations.

4. LEGAL REGULATIONS

The existing legal regulations regulate health care system, organization of health service as well as social care for health of the population, and other things:

1. Government Act ("Official Gazette of the RS" no. 55/05 and 71/05-correction),
2. Healthcare Act ("Official Gazette of the RS" no. 107/05),
3. Ordinance on Healthcare Institutions' Network Plan ("Official Gazette of the RS" no. 42/06),
4. Ordinance on Amendments of the Ordinance on Healthcare Institutions' Network Plan ("Official Gazette of the RS" no.84/08),
5. Rule Book on Conditions and Method for Internal Organization of Healthcare Institutions ("Official Gazette of the RS" no. 43//06),

6. Rule Book on Closer Conditions for Performing Healthcare Activity in Healthcare Institutions and Other Forms of Health Service ("Official Gazette of the RS" no. 43//06),
7. Health Insurance Act ("Official Gazette of the RS" no. 107/05),
8. Rule Book on Contents and Scope of Health Care Rights from Mandatory Health Insurance and about Participation for 2008 ("Official Gazette of the RS" no.14/08),
9. Act on Drugs and Medical Devices ("Official Gazette of the RS no. 84/04 and 85/05),
10. Rule Book on the Method of Prescribing and Issuing Drugs (Official Journal 16/94),
11. Amendments of the Rule Book on Method of Prescribing and Issuing Drugs (Official Journal 22/97),
12. Act on Production and Trade of Narcotic Drugs ("Official Gazette of the RS no. 110/03),
13. Decision on Determining Narcotic Drugs and Psychotropic Substances ("Official Gazette of the RS no. 24/05).

The Healthcare Act (Article 25) defines human rights and values in health care. Every citizen has the right to effect health care with respect of the highest possible human rights and values' standards, that is, he has the right to physical and psychological integrity, and to his personal safety, as well as the right to have respect for his moral, cultural, religious and philosophical beliefs.

Rights of patients:

- Right of accessibility of health care
- Right to have information
- Right to be informed
- Right of free choice
- Right to privacy and confidentiality of information
- Right of self-determination and consent
- Right to get insight into medical documentation
- Right to data secrecy
- Right of patients over whom medical experiment is performed
- Right to objection
- Right to damages
- World Health Organization Initiative and of International Association for Studying Pain (IASP) is to include in the field of basic human rights the right of patients to eliminate pain, so this Strategy includes it into rights of patients defined by the law.

The Palliative Care Strategy envisages amendment of the Law and of the Rule Book in the sense of changing internal Healthcare Institutions' organization; of standard staff and services; to secure and make available palliative care drugs, primarily of opioid analgesics. proposal The Commission has compiled a harmonized with WHO recommendations for amendment of the National Opioids Control Policy according to the United Nations Unique Narcotics Convention. On the National level it is necessary to establish harmonized policy for prescribing opioids and such control system that would disable abuse of narcotics, simultaneously securing their availability for application in medicine, in order to eliminate pain and suffering.

5. PALLIATIVE CARE LEADING PRINCIPLES AND KEY MESSAGES

5.1 Leading principles

Palliative care:

- renders elimination of pain and other symptoms;
- promotes life and looks at death as a normal process;
- unites psychological and spiritual aspects of care about the patient;
- offers system of support and assistance to patients;
- offers system of support and assistance to family in order to overcome problems during patient's disease and during the mourning period, due to loss of a family member;
- requires team approach in recognizing the needs of patients and their families, including counseling during mourning period, if necessary;
- improves the quality of life, and can also positively influence the flow of the disease itself;
- depending on the needs of individual patient it can be applied also in early phase of the disease, together with more specific approaches influencing the flow of basic disease or as the only approach;
- includes researches the objective of which is to improve palliative care quality.

5.2 Key messages

- Disease, loss and death are constituent and inevitable part of life.
- The objective of palliative care is less suffering, more dignity and better quality of life.
- In palliative care focus is quality, not quantity of life.
- Palliative care is interdisciplinary and multi-professional approach and it means team work. Palliative care promotes team and team work philosophy.
- Palliative care should become a constituent part of the health care system and inseparable element of the right of citizen to have health care.
- It is necessary to formulate national health policy on palliative care in collaboration with health workers and other professionals, non-governmental organizations, patients and families.
- Palliative care should be available and free for all patients who need it, regardless of the type of disease, geographic location or socio-economic status.
- Palliative care requires comprehensive and continuous care about the patient /family and understands developed network of services securing that continuity.
- Palliative care as a discipline is cost-effective.

6. STRATEGY OBJECTIVES

6.1 General objectives

6.1.1 Integration of palliative care into healthcare system of the Republic of Serbia in order to become inalienable element of the right of citizens to health care.

6.1.2 Enhancing and reaching the best possible quality of life for the patient and his family.

6.2 Specific objectives:

6.1.1

1. Defining national palliative care standards
   On primary health care level palliative care consists of: medical doctor /general medicine specialist, nurse, field nurse, physiotherapist and social worker.Broader palliative care team consists of: psychologist/psychiatrist, priest and volunteers.
   On secondary health care level, in palliative care unit, the team consists of: medical doctor - internal medicine specialist and nurse. Plus psychologist, physiotherapist, occupational therapist.
   On tertiary health care level in reference institutions consultation team consists of medical doctor, specialist of a certain branch of medicine and nurse.
2. Adoption of legal regulation by standard drugs and medical devices for palliative care.
3. Informing public about palliative care importance.
4. Establishing organizationally and financially sustainable palliative care model.
5. Formation of special organization units - Services for Home Treatment and Care in all medical centers in municipalities with 25,000 inhabitants and more in the Republic of Serbia (in total in 88 medical centers).
6. Formation of reference Center for Coordination of Home Treatment and Care Services of the Republic of Serbia on primary health care level in Gerontology Institute, Belgrade.
7. Formation of palliative care units (Hospice) in 25 counties, with in total 300 beds, in two phases
8. On tertiary health care level:
   a) Formation of specialized consultancy teams in reference Healthcare Institutions,
   б) Formation of Center for Palliative Care Development in the Institute for oncology and Radiology of Serbia.
9. Formation of unique information system.
10. Cooperation with World Health Organization, Council of Europe and other relevant organizations.
11. Scientific research in the field of palliative care, based on clinical evidence and directed towards patient.
12. Monitoring and evaluation in relation to standardized palliative care procedures.

6.1.2

1. Formation of the List of Essential Drugs and Medical Devices for Palliative Care.
2. Introduction of palliative care in training program of medical schools, of medical and other faculties.
3. Standardization and accreditation of programs for education of all participants in palliative care.
4. Mobilization of all interested participants on the local community level.

7. EDUCATION

Education of health workers and collaborators, as well as of all other participants in palliative care (society, legislator, patients' family, volunteers) is of essential importance for palliative care development.

In order to implement education it is necessary to establish:

- Level of education (degree)
- Scope of education (according to planned staff)
- Education program
- Education implementation.

7.1 Level of education

Basic level of education includes selected doctors and nurses in primary health care, as well as volunteers.

Medium level of education includes doctors and nurses from home treatment and care services, gerontology centers (state and private), welfare workers and psychologists.

Higher level of education includes medical doctors, specialists and nurses in palliative care units.

7.2 Scope of education

Educational program shall be passed for all three levels of health care. It is necessary to cover by education the patient, his family and environment.

Priority in education should be given to home treatment and care services, and it should start by the end of 2008 with one team in 60 medical centers where organized home treatment and care services already exist. By forming home care in the remaining 28 municipalities with over 25,000 inhabitants education of teams shall start simultaneously.

On secondary level, after forming palliative care units, teams' education shall be initiated.

For successful implementation of palliative care it is necessary to implement public education on all levels, from law makers (for amendments of legal regulations) to spreading the basic palliative care principles in the public.

7.3 Education program

The Program must be based on basic palliative care principles. Knowledge and skills are required from all palliative care participants in:

1. Communication – with patients, family and between palliative care participants.
2. Decision making – estimate of the patient's condition, application of different types of therapy, its change, performing some intervention or inclusion of other necessary services for the patient or for the family.

3. Treatment of complications of the disease itself, or of therapeutic procedures.
4. Mitigating pain and other disease symptoms (dyspnea, vomiting, constipation, diarrhea, anxiety, depression).
5. Rendering psychosocial support to the patient and family (recognizing concern, financial problems, misunderstandings in the family).
6. Understanding spiritual needs and access to them – spiritual support.
7. Care for the dying person– treating the dying person and his family with respect and understanding.
8. The period immediately after death – compassion with loss, expressing condolescence, visits and maintaining contact with the family.

7.4 Implementing education

Education shall be implemented through continuous medical education, seminars, symposiums, interactive courses, practical work next to patient's bed and within the patient's family.

8. MONITORING AND EVALUATION

Monitoring understands follow up on establishing Home Care Services, palliative care units, specialized consultancy teams in reference centers, Center for Palliative Care Development. It covers follow up on indicators improving the quality of life of the patient-pain scale, symptoms' evaluation scale, patients' satisfaction, as well as the number of families to whom psychosocial support has been rendered during illness of the family member, and up to six months during mourning period and monitoring the number of palliative care teams who were rendered psychosocial support (burn-out syndrome). Reports on Action Plan and execution of palliative care services on all three levels and opinion on execution shall be delivered by public health bureaus and institutes to the Public Health Institute of the Republic of Serbia "dr Milan Jovanovic Batut".

Republic Expert Commission two times a year estimates integration of the Strategy and Action Plan implementation and passed decisions for improving and enhancing palliative care.

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