Palliative care in Latvia: does it exist or not?

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Audit report

Palliative care in Latvia: does it exist or not?

Performance audit “Is palliative care a full part of healthcare system?”

The audit was performed based on audit schedule No 2.4.1-30/2023 of the Third Audit Department of the State Audit Office of Latvia of 12 June 2023.

The audit report shall take effect at the moment of the decision of the Third Audit Department of the State Audit Office of Latvia on the approval of the audit report.

The cover design includes the image from website http://depositphotos.com, *Parkinson disease patient, Alzheimer elderly senior, Arthritis person's hand in support of nursing family caregiver care for disability awareness day, National care givers month, aging society concept*, author Chinnapong, ID 451237764.

Dear Readers,

When a person learns that he or she has a life-threatening illness that will not be cured, neither his or her life nor his or her human right to healthcare ends. In such a case, healthcare has a distinct perspective undeniably, that is, to prevent the progression of a disease as much as possible, to ensure the best possible quality of life and to relieve physical pain and moral suffering. At the same time, it is no less important to ensure a respectful attitude at a time when a person begins to lose his or her functional abilities due to the disease and, therefore, basic personal independence to decide about his or her life and body.

All over the world, it is predicted that the need for palliative care will increase rapidly due to both the spread of diseases and the aging of global population, and in this case, Latvia is no exception. Therefore, whether it likes it or not, the state must provide effective palliative care not only for legal and ethical reasons, but also for economic reasons.

Majority of palliative care patients suffer from oncological diseases; thus it is a follow-up audit to the previous audit in the field of oncology when the auditors concluded that oncology was prioritised only on paper in Latvia and that major improvements were needed in the availability of medicines, but especially in early diagnostics, which increased patients' chances of recovery significantly.

Unfortunately, the audit confirmed the risks identified before its initiation, that there was no system in Latvia in which people could receive high-quality palliative care. In theory, it is provided by everyone such as general practitioners and other medical practitioners both in outpatient and inpatient medical institutions as well as social service providers whereas no one was really responsible in practice. As a result, the well-being of a large part of palliative care patients depends on the determinedness and ability of their relatives, some patients end up in healthcare system, no matter how high-quality the palliative care it offers is not but a significant part of patients will never be able to tell about their lonely, hopeless and suffering end of life.

We thank the Ministry of Health and its subordinate institution, the National Health Service, as well as the Ministry of Welfare for their cooperation. We hope that the conclusions and recommendations of the State Audit Office of Latvia will help organize the palliative care system at the cross-sectoral level and at all levels of state administration. Special thanks to the surveyed inpatient treatment institutions and local and regional governments for their responsiveness. We also thank the patient organizations for their opinion.

Respectfully
Ms Maija Āboliņa
Department Director

Summary

Main conclusions

The audit findings have allowed us to conclude that palliative care is not a full-fledged part of healthcare in Latvia, as prerequisites for establishing a palliative care system have not been created following the needs of patients, and it is not provided effectively at all levels of healthcare.

Comprehensive healthcare includes the entire continuum of essential healthcare services from health promotion and prevention to treatment, rehabilitation, and palliative care.

Palliative care is an approach that improves the quality of life of patients facing life-threatening illness and their families by preventing and alleviating suffering through early identification, accurate assessment and treatment of pain and other physical, psychosocial or mental problems. Given the predictions that the need for palliative care will increase rapidly due to the aging of global population the rise of non-infectious and other chronic diseases, and that one of its most principal elements is pain relief, the integration of palliative care into healthcare systems is ethical, legal and economic necessity.

I. Prerequisites for providing palliative care according to patients’ needs have not been created

Number and profile of palliative care patients

In Latvia, not all the patients receive the palliative care they need to ease the end-of-life phase whereas the Ministry of Health does not have any information about palliative care needs in the country. In addition, the different conditions for receiving different palliative care services do not promote a uniform procedure and cause confusion not only for patients, but even for service providers.

The Ministry of Health only has information on the palliative care patients who have already entered the state-paid healthcare system and received a service. In its turn, when estimating a potential number of palliative care patients in the country according to international best practice, it is at least two times higher than the actual number of patients who received palliative care on average. For example, in 2022, 12,000 patients received state-paid palliative care while, according to the auditor’s estimate, at least 21,000 people required it.

In addition, pursuant to international best practice, the need for palliative care for a particular patient is determined by taking into account his or her state of health and the symptoms of disease rather than the conformity of his or her disease to a specific diagnosis. In contrast, palliative care is attributed to certain diagnoses in Latvia.

Palliative care diagnoses do not include a number of common diagnoses identified by the World Health Organization for which patients may also require palliative care, such as diabetes, which was the cause of death for 2% of the deceased individuals in 2022.

It results in unequal treatment of patients with the same healthcare needs, as only patients with certain diagnoses can receive specialized services in a palliative care office and inpatient medical institution (palliative care program).

Funding for palliative care

Although palliative care is one of the priorities in the healthcare system defined in Public Health Guidelines 2021-2027, adequate funding also cannot be planned without data on an actual number of palliative care patients. At the same time, the Ministry of Health also does not have any information about the actually spent funding for the provision of services to palliative care patients.

Since palliative care patients can receive some services, such as healthcare at home, in the same way as other patients, the Ministry of Health plans funding only for certain specialized palliative care services separately, namely, funding for an outpatient palliative care office is planned in the form of a fixed payment according to the workload of medical staff employed there while it is planned based on the performance data of the previous year’s service program for the inpatient palliative care. Then again, funding for the services of a palliative care specialist is included in the total funding for the payment of the services of various specialists whose distribution is decided by each medical institution at its own discretion.

According to the auditors’ estimate, an average of 1.1 million euros was spent to pay for outpatient palliative care services in 2020-2022, while, according to the information provided by the National Health Service, an average of 2.4 million euros per year was spent for the provision of inpatient palliative care services. During this period, services were provided to 14,000 patients per year on average.

One should also take into consideration that a new service of mobile palliative care team at the patient’s place of residence (not including the social component) is planned to be funded at 6.8 million euros to provide such mobile team service to 3,078 patients in 2024.

The auditors consider that the assessment of cost effectiveness of existing palliative care services is an essential factor to further develop the area of palliative care which the Ministry of Health has not carried out so far.

The auditors have estimated that the provision of outpatient palliative care services is generally more cost-effective compared to inpatient palliative care services. At the same time, the excessive costs of palliative care office and a small number of unique patients create a basis for deciding on the future operation of palliative care office.

Content of palliative care services

The availability of palliative care services at distinct levels of healthcare ensures that patients with diverse needs can receive the care they need at the right time and place. In Latvia, palliative care patients can receive outpatient, inpatient care and care at home just like any other patient. In their turn, consultation by a palliative care specialist, service of palliative care office, service of mobile palliative care team at a patient's place of residence, and palliative care in an inpatient medical institution (palliative care program) have been introduced to ensure specialised palliative care.

For making necessary changes in the availability of palliative care, palliative care is prioritised in several policy planning documents. However, a series of planned improvements in palliative care have not been implemented despite the top priority and development plans within the policy planning.

The only notable change in palliative care is the introduction of service of mobile palliative team at a patient's place of residence for patients with a predicted limited survival of up to six months from 2024. The auditors welcome the expansion of the range of palliative care services for palliative care patients while drawing attention to the fact that the audit did not assess the effectiveness of the concerned service in practice, as it was introduced very recently and conclusions would be premature.

Starting from 2024, the definition of palliative care included in the Medical Treatment Law has also entered into force that palliative care is interdisciplinary, holistic care of patients whose disease is life-limiting and cannot be radically treated, with the aim of preventing or reducing the suffering caused by the disease in order to ensure the highest possible quality of life for the patient and support for his or her family. Palliative care includes treatment and prevention of symptoms caused by the disease, hospice care for patients with a predicted survival of up to six months, psychological, social and spiritual support, as well as support for the patient's relatives during the grieving period after the loss of a loved one.

However, although the new definition of palliative care complies with international best practice, only the service of mobile palliative care team at the patient's place of residence meets this definition out of the existing palliative care services despite the fact that interdisciplinary services were planned to be introduced at each level of healthcare.

Human resources in palliative care

The availability of palliative care is influenced by the skills and understanding of medical practitioners about palliative care. Therefore, every medical practitioner should have a basic knowledge of the principles of palliative care and pain management.

Palliative care is included in several medical undergraduate studies and the residency programs of several specialties as a separate course or as part of other courses whereas a planned number of residency places for the palliative care specialist whose competence is the care of patients with life-threatening diseases is not regularly filled and the number of these specialists tends to decrease.

The auditors assess the measures implemented by the Ministry of Health to facilitate the provision of human resources in palliative care as insufficient.

The Ministry of Health has not implemented the intention to include the basic elements of recognition of palliative care as a requirement for recertification of doctors of certain specialties, and the Ministry of Health also does not have complete information on all continuing education measures in palliative care. In its turn, the number of medical practitioners trained within the continuing education provided by the Ministry of Health itself is small because 477 individuals were trained from 2019 to 2023 including 150 doctors of various specialties. Even assuming that all of them were GPs, only a tenth of GPs on average would have received continuing education in palliative care in five years.

Already in audit “Human resources in healthcare” in 2019, the State Audit Office of Latvia concluded that the Ministry of Health, as the leading state institution in the health sector, was not involved systematically in the creation of content and planning of continuing education, therefore the State Audit Office made recommendations for the arrangement of this area whose implementation was still ongoing.

Palliative care quality standards and monitoring

According to the recommendations of international organizations, the existence and application of palliative care quality standards or guidelines means that it is possible to assess these services and make improvements if necessary. For example, the requirements for the multidisciplinary team, the recommended staffing ratio and workload and the quality of services should be determined.

However, there are no palliative care guidelines for adult patients to be applied in treatment and in quality control and monitoring of healthcare services in Latvia.

Simultaneously, the Ministry of Health has informed that methodological materials (clinical algorithms, patient paths and quality indicators) in two topics related to palliative care have been developed and approved by professional associations in 2023, however institutions can apply them at their own discretion. Moreover, some of the methodological materials have been developed only partially taking into account the organization of healthcare in Latvia, therefore they are not fully practical.

The inpatient palliative care program is also not among the programs in which one plans to define mandatory indicators, which means that it will not be possible to evaluate impartially and improve this service purposefully in the future.

In their turn, international organizations recommend that quality assessment systems also include indicators suitable for evaluating palliative care to prevent the trend that, for example, assessing the quality of care in inpatient medical institutions based on inpatient mortality rates encourages the avoidance of treating patients who are likely to die in these medical institutions.

The National Health Service and the Health Inspectorate also do not carry out targeted monitoring checks on the provision of palliative care, with the exception of checks on the applications received.

II. Outpatient palliative care services are critically inadequate

GP services

The 30,999 unique adult palliative care patients included in the audit scope have been registered in 1,096 GP practices, and the proportion of adult palliative care patients is around 2% of the total number of patients registered in the practices on average annually.

Although palliative care patients are provided with services of GPs in general, a considerable number of GPs do not provide palliative care to palliative care patients. Unfortunately, along with the decline in the overall number of GPs, the number of GP practices that provide services to palliative care patients is also decreasing.

Only 72% of GPs provided palliative care to palliative care patients in particular. Palliative care patients registered in other GP practices received the service of GP for another reason.

The services of GPs are provided to 87% of the total number of palliative care patients registered in unique GP practices on average.

However, a very limited number of palliative care patients receive more comprehensive care from GPs, as evidenced by medical examinations and medical manipulations performed.

Medical examinations and manipulations have been carried out in only 53% of the GP practices, moreover, they have been carried out in only 21% of the total number of patients who received palliative care from GPs.

The auditors do not doubt that the doctor consultation is also useful and necessary for the patient while the high proportion of hospitalised palliative care patients shows at the same time that patients do not receive the outpatient palliative care they need to sufficient extent.

50% of the palliative care patients included in the audit scope were hospitalized for palliative care or other inpatient services although, according to international best practice, the needs of most palliative care patients should be solved on an outpatient basis.

Insufficient outpatient palliative care is also evidenced by the fact that only 18% of patients hospitalised within the framework of palliative care program received such care in 2022.

When assessing whether GPs prescribed six painkillers of the opiate group included in the audit sample to patients, it was discovered that 60% of the prescriptions for painkillers issued by GPs totalled up to 500 euros, which was an average of 186 euros per GP practice in 2022.

At the same time, several GPs have been identified whose amount of prescribed state-reimbursed drugs was more than 20,000 euros and more than 50,000 euros in one case. 99% of these GP prescribed the generic, *Fentanylum*, and, for example, their state-reimbursed amount (11 unique patients) for this drug was 280% higher than the state-reimbursed amount for the same drug (198 unique patients) in clinical university hospitals although the number of unique patients was 94% lower. Taking into account that painkillers with the generic name *Fentanylum* are on the list of narcotic substances, the Ministry of Health, the National Health Service and the Health Inspectorate were also informed about the detected trend in the prescription of these state-reimbursed drugs with an invitation to inspect appropriate prescription of the mentioned drugs. According to its selection criteria, the Health Inspectorate conducted a random inspection by detecting violations in several cases. However, in the opinion of the auditors, the inspection carried out by the Health Inspectorate does not provide sufficient assurance that the state-reimbursed painkillers with the generic name *Fentanylum* are always prescribed justified in all cases in GPs identified during the audit.

Health care at home

Healthcare services at home for palliative care patients were provided by only 23% to 28% of service providers in 2020-2022 and their number is decreasing every year.

The number of unique palliative care patients receiving home healthcare is also decreasing, and only about 2-3% of these patients receive this type of care.

One of the solutions for improving the availability of healthcare services at home for palliative care patients is the new service of mobile palliative care team at a patient’s place of residence intended for patients with a predicted survival of up to six months. In the first half of 2024, 849 patients or 28% of the total planned number of patients for the year actually received the service.

Consultation and services of a palliative care specialist in the palliative care office.

The availability of specialised outpatient palliative care services, that is, consultation and services of a palliative care specialist in a palliative care office, is very limited because they are available only in Riga, Zemgale and Latgale, thus they are available only to a part of palliative care patients.

Although the consultations of a palliative care specialist were available both in Riga and Jēkabpils between 2020 and 2022, about 95% of all consultations were provided exactly in Riga. On average, only 99 unique palliative care patients are consulted by a palliative care specialist per year.

There are palliative care offices established in Latvia to improve the availability of palliative care, and the services provided by them can only be received by patients with a diagnosis implying palliative care. However, no one has defined what kind of medical staff should be available in the palliative care office, what services should be provided there and what the working hours of that office should be. Thus, the medical staff in the palliative care offices varies in fact and their working hours are limited.

According to the population, the operation of palliative care office should be ensured in Riga, Liepāja, Daugavpils and Jelgava. However, this service is actually available for adults only in Daugavpils in 2024.

The operation of palliative care office does not achieve the goal of its formation because the number of adult palliative care patients to whom these services are provided is critically small, as these are only 38 unique patients per year on average and the number of visits to the office decreases every year.

Considering the critically small number of unique patients in the palliative care office, the audit did not confirm that the volume of services provided in the office had been assessed. There were services provided to only one palliative care patient in the office of Daugavpils Regional Hospital Ltd in 2020 and to none in 2021. Yet, the working hours of the office were changed by reducing them only in 2023. As already mentioned above, the small number of unique palliative care patients, the high costs of palliative care office compared to other palliative care services, and the uncertain amount of services provided in the office create a basis for deciding on the future operation of palliative care offices.

III. Inpatient palliative care services do not meet the goal of palliative care, they are not equivalent, their payment model lacks economic rationale

Availability of inpatient palliative care

Nine medical institutions can provide inpatient palliative care services as a mandatory or optional profile in total but seven of them actually provide those services.

The National Health Service has not identified the possibilities of medical institutions to provide inpatient palliative care services to facilitate equal access to these services in all regions.

Responding to the auditors’ questions as to why services were not provided by the other two medical institutions, the National Health Service informed that Liepāja Regional Hospital Ltd would also plan a specific amount of service for the provision of palliative care in mid-2024.

According to the auditors’ estimates, the required number of beds for palliative care, including hospice, could be from 94 beds (only for the care of oncology patients) to 188 beds in Latvia but there are 92 palliative care beds in total currently in Latvia.

Although the estimate shows that the need for palliative care beds is greater, the auditors point out that the utilization of the existing number of palliative care beds is also not optimal due to limited human resources. There is a waiting-list to receive these services and funding is absorbed less than planned each year. The above indicates the lack of capacity of medical institutions to implement the palliative care programs according to the needs of palliative care patients.

On average, 13% of patients have been provided with inpatient palliative care services and half of the patients have been admitted to Riga Eastern Clinical University Hospital Ltd and Pauls Stradins Clinical University Hospital Ltd. This could be in line with international practice which recognises that only a small percentage of patients need specialized palliative care services. Nevertheless, the auditors draw attention to the fact that an average of 37% of palliative care patients who have received palliative care on an outpatient basis have been hospitalised under other inpatient service programs. The above probably indicates that patients do not receive the palliative care they need either in an outpatient or inpatient setting.

The auditors do not question that patients under other service programs were hospitalized for a reason and probably not for palliative care, namely, a detailed analysis of the medical documentation is required to assess the needs of these patients directly for palliative care. However, the data show that these patients received palliative care on an outpatient basis in the same year and these patients also have a high mortality rate (54% on average compared to 85% in the palliative care program).

Compliance of inpatient palliative care services with best practice

The auditors consider the organization of inpatient palliative care practiced in Latvia to be inconsistent with international best practice. Instead of providing such care in adapted individual palliative care wards, palliative care is also provided in palliative care beds in wards of different profiles, such as a therapy ward.

Patient treatment and palliative care are two different approaches to healthcare; therefore, palliative care patients do not receive equivalent and appropriate specialized palliative care in all inpatient medical institutions when patients with diverse needs and conditions are combined.

In accordance with international best practice, the palliative care ward specialises in the treatment and care of palliative care patients and requires a highly qualified, multidisciplinary team. A core staff consists of doctors and nurses specialising in palliative care who provide round-the-clock monitoring of patients while an extended team includes other professionals such as a psychologist, psychotherapist, physiotherapist, social worker or chaplain.

However, neither the laws and regulations nor an agreement on the provision of inpatient healthcare services set requirements for medical institutions to provide inpatient palliative care including the composition of medical staff as to promote that patients receive equivalent palliative care.

Therefore, the composition of the staff involved in providing palliative care in medical institutions varies because only three medical institutions including both medical institutions of level V have a palliative care specialist whereas an infectious disease specialist, surgeon, urologist, gynaecologist, obstetrician is responsible for palliative care in other medical institutions. Although the medical institutions indicated that other specialists were also available as needed, the data on the healthcare services provided did not identify that a variety of multidisciplinary team services were provided to palliative care patients. At the same time, a social worker and a chaplain are available to all patients in medical institutions.

Almost all medical institutions do not provide round-the-clock monitoring of palliative patients by the responsible doctors involved in the care while nurses and nurse assistants are available around the clock. Thus, in fact, palliative care is comparable to a care service when the supervision by a doctor during the night hours is not mandatory.

Besides, the type and extent of medical manipulations performed on palliative care patients differ significantly in medical institutions. For example, almost half of all performed medical manipulations are provided by Riga Eastern Clinical University Hospital Ltd but their number is smaller in medical institutions of level IV mostly. The mentioned may be explained by the fact that less severe palliative care patients arrive in medical institutions of level IV compared to medical institutions of level V. However, the auditors draw attention to the fact that inpatient palliative care services are paid the same for all medical institutions. At the same time, it may also indicate an unequal approach in medical institutions in performing these medical examinations and potentially different patient care. Namely, if medical examinations are performed reasonably and based on medical indications, then it can provide more accurate diagnosis and better treatment but excessive diagnostic examinations without sufficient justification can cause an unnecessary burden on patients and increase healthcare costs as well.

The principles of providing palliative care provide that it is ensured when necessary and for as long as necessary. However, the audit concluded that there were waiting lists for receiving palliative care and patients had to wait for it for a long time. Although the duration of receiving palliative care in a medical institution is not limited, medical institutions receive a fixed payment for each patient regardless of the duration of care.

For instance, one had to wait for receiving palliative care services at Riga Eastern Clinical University Hospital Ltd for more than half a year and 214 patients were waiting in line as of 1 April 2024 while the waiting list was six times shorter at state-owned Pauls Stradins Clinical University Hospital Ltd and only 10 patients were waiting. A significantly longer waiting list for the services of Riga Eastern Clinical University Hospital Ltd could be explained by its specialization in the care of oncology patients. However, the auditors discovered that the two institutions practiced different admission procedures for palliative care patients, that is, the waiting list of Riga Eastern Clinical University Hospital Ltd consisted of three patient flows: 1) external planned (by prior appointment), 2) internal (among structural units of the medical institution) and 3) emergency (patients were brought by the emergency medical team) while state-owned Pauls Stradins Clinical University Hospital Ltd had mainly one flow of patients which was the internal one. The auditors draw attention to the fact that both institutions provide palliative care of level V and receive the same payment for it, so the procedure for admitting patients may not differ except for medical indications.

Financing of inpatient palliative care

For the provision of inpatient palliative care services in 2020-2022, there were 2.2 million euros spent per year on average excluding patient co-payment compensation by providing an average of 2,200 hospitalisations.

However, the actual number of hospitalizations is lower than planned at the beginning of the year each year and unspent funding is directed to the provision of other services mainly. The aforesaid shows that medical institutions are not ready to increase the extent of inpatient palliative care services in general, so the availability of these services to patients is still limited.

A tariff for treating one patient under a palliative care program is applied to both medical institutions of level V and level IV. Yet, the tariff has been calculated taking into account the data from the year 2009 or more than 10 years old of medical institutions of level V on the services provided in the palliative care program, although the range of medical manipulations applied by medical institutions has changed significantly. Simultaneously, the tariff has been updated and increased several times considering the increased wages, catering and indirect costs included in the tariff. In 2024, it has increased by 72% compared to 2020.

In addition, the audit has detected that the treatment tariff for one patient under a palliative care program was not calculated following the procedure established by the National Health Service. According to the estimate, medical institutions were not paid more than 989,000 euros for inpatient palliative care services provided from 2020 to 2023 due to this error.

In general, the treatment tariff for one patient under this program of inpatient services can be calculated based on the data of medical institutions of level V, as they provide the majority of these services. In its turn, the tariff erroneously includes bed-day tariff of medical institution of level IV which is lower instead of the tariff of medical institution of level V. The National Health Service was unable to explain during the audit how the error had occurred.

Since medical institutions of level V and level IV actually provide palliative care services of various levels, the auditors consider that setting the same payment for different palliative care services is not economically justified. Therefore, the audit performed a recalculation of the treatment tariff for one patient separately for medical institutions of level V and level IV taking into account the data of medical institutions on the services provided to palliative care patients. As a result of the recalculation, it was established that care of palliative care patient in medical institutions of level V actually cost more than in medical institutions of level IV. Since medical institutions of both levels receive the same tariff for providing palliative care, medical institutions of level V are paid less in fact for palliative care services and medical institutions of level IV are paid more in fact, thus the aspect of economy is not taken into account.

If one would set per-patient treatment tariff corresponding to each level of medical institution under a palliative care program, then, firstly, it would ensure that each medical institution received appropriate payment for the services provided, that is, they would not be paid more or less, and, secondly, there would have been a saving of more than 58,000 euros in three years, which, for example, would have given the opportunity to provide inpatient palliative care for more than 40 patients in a medical institution of level V.

The auditors draw attention additionally to the fact that the payment conditions of the inpatient palliative care program, namely, a fixed payment for each patient regardless of the duration of patient care and the lack of targeted supervision of the provision of these services are the reasons for the fact that medical institutions also hospitalise palliative care patients consecutively under a chronic patient care program. In 2022, such consecutive hospitalizations were found in 11% of cases.

Consecutive hospitalization of palliative care patients also under the chronic patient care program increases both the statistical indicators of the relevant medical institution regarding the number of hospitalizations, the fulfillment of the concluded contract on inpatient healthcare services, and funding for the current and future periods, as well as creates a false impression of the institution’s workload and demand for services.

The auditors emphasise at the same time that each case should be assessed individually based on medical documentation to determine the need for consecutive hospitalization under different care programs.

The National Health Service explained during the audit that such accounting of service provision was incorrect, it distorted the overall statistics of healthcare services, as well as payment was made for one patient in several care programs. A patient may be discharged from a hospital only when medical indications allow it and the attending physician has decided on it rather than when the number of bed days included in the tariff has been exhausted. During the audit, the National Health Service informed that it had started working on changing the payment model for inpatient palliative care.

IV. Access to social care services for palliative care patients is limited

In addition to healthcare, social care services provided by the state and local and reginal governments also play a significant role in supporting palliative care patients. However, it was not possible to obtain information during the audit on which social care services the palliative care patients had received, or which social service providers provided palliative care, as this type of accounting for services and their recipients was not carried out. The only service directly available to palliative care patients that includes both healthcare and social components is the service of mobile palliative care team at a patient’s place of residence.

Adult palliative care patients have restrictions on receiving social care services financed by the state and local and regional governments, that is, state social care services are fully or partially financed for a certain group of individuals while the allocation of social care services financed or partially financed by local or regional government depends not only on the needs and level of care of an individual but also on his or her social status.

The audit found irregularities in the state’s supervision over the provision of healthcare services in long-term social care and social rehabilitation institutions of local and regional governments and other organizations.

The government does not have complete information as to whether all institutions that provide medical treatment, including palliative care as part of the social care service are registered in the register of medical institutions, or whether they have a contract with a medical institution for the provision of medical services. The auditors are critical about it because in a situation where 25% of individuals per year die in the institutions of local and regional governments and other organizations on average, including those in palliative care, due to both physical pain and psychological problems, it is crucial that the healthcare services provided in those institutions are supervised.

The responsible institutions, the Ministry of Health and the Ministry of Welfare, do not take responsibility for the situation.

Recommendations

Following the audit findings, two recommendations have been made to the Ministry of Health by calling for a series of actions that will improve state-provided palliative care so that it is a full-fledged part of healthcare.

Implementation of the recommendations is expected to result in:

- ✓ Ability to assess the adequacy of existing resources to real needs and ensure that all patients have access to palliative care;
- ✓ Gradual increase in a number of patients whose suffering caused by the disease has been prevented or reduced thus contributing to the highest potential quality of life;
- ✓ Facilitated provision of palliative care on an outpatient basis, thereby promoting the receipt of palliative care services to the place of residence as close as possible and reducing the burden on inpatient medical institutions.