Dialogue Summary

Integrating Palliative Care Into the Health System in Lebanon

K2P Policy Dialogue convenes key policymakers and stakeholders to capture contextual information, tacit knowledge, views and experiences including potential options to address high priority issues. K2P Policy Dialogues are informed by a pre-circulated K2P Policy Brief or Briefing Note to allow for focused discussion among policymakers and stakeholders.

Dialogue Summary

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Integrating Palliative Care into the Health System in Lebanon

Knowledge to Policy Center K2P

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Acknowledgments
The Policy Dialogue was organized by the K2P Center in collaboration with Ministry of Public Health and Balsam. The K2P team wish to thank participants for their valuable contributions. The views expressed in the dialogue summary are the views of the dialogue participants and should not be taken to represent the views of the Ministry of Public Health, Balsam or the authors of the dialogue summary.
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Dialogue
The policy dialogue about: Integrating Palliative Care into the Health System in Lebanon was held on July 13, 2018, at the Gefinor Rotana Hotel, Beirut, Lebanon. The policy dialogue was facilitated by Dr. Fadi El-Jardali, Director of the K2P Center.

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Preamble

The K2P Policy Dialogue, conducted on July 13, 2018, hosted 21 diverse stakeholders from multi-disciplinary backgrounds. These included representatives from:

- Ministry of Public Health (MOPH)
- Syndicate of Hospitals
- Order of Physicians
- Order of Nurses
- Physicians and Palliative Care Experts
- Non-governmental organizations (Balsam & Sanad)
- Insurance companies
- Academicians and researchers

The policy dialogue was facilitated by Dr. Fadi El Jardali, the Director of the K2P Center, in the presence of Dr. Walid Ammar, the Director General of the MOPH.

Deliberations about the problem

Dialogue participants discussed the overall framing of the problem of inadequate access to palliative care in Lebanon and the need to integrate palliative care into the health system in Lebanon. Participants acknowledged the existence of the problem and agreed on the need to address the underlying factors leading to the problem. Participants also acknowledged the importance of tackling the problem as soon as possible to address the growing need for palliative care services in Lebanon. Data from a report published in 2017 shows that 15,000 patients need palliative care each year and this number is expected to increase due to multiple factors including the rapidly aging population and the rise in non-communicable diseases (NCDs). In 2015, Lebanon had the highest percentage of people aged 65 years and older in the Arab region and this number is projected to reach 12% by the year 2030. In addition, NCDs account for 85% of total deaths. Furthermore, participants stressed the need to clarify the concept of palliative care and make a clear distinction between palliative care and end-of-life care. Many participants highlighted the pervasive misconceptions about palliative care among the public and health

Background to the Policy Dialogue

The Policy dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action.

Key features of the dialogue were:

1) Addressing an issue currently being faced in Lebanon;
2) Focus on different underlying factors of the problem;
3) Focus on four recommendations for addressing the policy issue;
4) Informed by a pre-circulated K2P Briefing Note that synthesized both global and local research evidence about the problem, recommendations and key implementation considerations;
5) Informed by a discussion about the full range of factors that can inform how to approach the problem and recommendations for addressing it;
6) Brought together many parties who would be involved in or affected by future decisions related to the issue;
7) Ensured fair representation among policymakers, stakeholders, and researchers;
8) Engaged a facilitator to assist with the deliberations;
9) Allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
10) Did not aim for consensus. Participants' views and experiences and the tacit knowledge they brought to the issues at hand formed key input to the dialogue. The dialogue was designed to spark insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue and by those who review the dialogue summary.

professionals as a key barrier to the development of palliative care in Lebanon. This was reinforced by data from an unpublished study conducted at AUBMC. Data shows that misconceptions about palliative care among health professionals of same and different specialties are still widespread. In fact, both nurses and physicians do not share a clear perception and understanding of palliative care. In addition, the public still associates palliative care with end-of-life care and patients mainly resort to palliative care when all curative treatments fail, which was demonstrated in local studies and further backed up by discussions of participants in the dialogue. Moreover, participants highlighted the significant efforts, which have been ongoing by non-governmental organizations (NGOs) to deliver palliative care, train health professionals in palliative care, and promote public awareness about palliative care. Unfortunately, these NGOs have limited resources, and mainly provide their services in large cities.

All participants agreed that the problem of inadequate access to palliative care is further exacerbated by the lack of financial coverage by public and most private insurance parties. Participants discussed the need for developing a financial model to cover palliative care and provide this health right to everyone in need. Participants also stressed the need to address the issue of inadequate training and education of health professionals.

Underlying factors

Participants then proceeded to discuss the underlying factors of the problem. Most participants agreed on the multi-level factor approach to the problem at the governance, financing, and delivery. Discussions highlighted the various factors contributing to the problem of inadequate access to palliative care.

Governance

The discussions started by reviewing the historical events related to the development of palliative care in Lebanon since 1995. One participant pointed out that there is a national palliative care plan in Lebanon, however, it needs to be updated and communicated to relevant stakeholders. In addition, participants stated that palliative care physicians are not reimbursed adequately which in turn contributes to shortages in palliative care physicians and physicians specializing in palliative care not dedicating their time solely for palliative care. One of the participants stated that nurses are highly interested in palliative care and more than 100 nurses attended one symposium about palliative care, however, there are few nurses specialized in palliative care in Lebanon. Another participant added that in order to capitalize the interest of nurses in palliative care, a collaboration between Ministry of Education and Higher Education (MEHE), MOPH, and Order of Nurses is needed

to develop training programs and update the nursing curriculum to include palliative care courses in a structured and rigorous manner. In addition, some participants pointed out the need to review the laws, legislation, and implementation decrees to define palliative care clearly and differentiate between palliative care and end-of-life care.

Financing

While there was a consensus among participants on the urgency of developing a financing system/model to cover palliative care and make these services accessible to every patient, there were different views on how this system can be implemented. One participant mentioned that although palliative care is still not financially covered, many public and private insurance parties are already covering inpatients receiving "palliative care" within different specialties such as oncology and internal medicine. One participant stated that MOPH should be the first party to cover palliative care services to encourage other public parties and private insurance companies to cover palliative care. This is needed to ensure that palliative care is provided to every patient regardless of the type of his or her financial coverage. Furthermore, it was mentioned that only two NGOs (Balsam and Sanad) are providing free palliative care services to patients at their homes, however, these NGOs have limited financial resources and are not able to meet the demands of all patients in need of palliative care.

Delivery

There was consensus on the high level of misconceptions about palliative care among the public and health professionals. Palliative care is equated to end-of-life resulting in the late referral of patients, which negatively affects patient outcomes, quality of life, and increases healthcare costs. Participants mentioned that the paternalistic and family oriented culture in Lebanon plays a big role in hampering the development of palliative care. One of the participants highlighted that the understanding of palliative care among individuals varies between urban and rural areas and mentioned that patients in his village prefer to die at the hospital rather than in their homes. On the contrary, one participant argued that in the past people of the same village preferred to die at home indicating that reversing the culture is possible if public awareness is raised about palliative care. One participant added that patients prefer to receive care at hospitals because they do not want to place additional financial and psychological burden on their families. Moreover, it was discussed that the public tends to associate palliative care with end-of-life because most NGOs such as Balsam and Sanad admit patients at end stages of their disease. This is due to many factors including but not limited to, a late referral from physicians and patients' families requesting palliative care at a

late stage of the diseases. Moreover, one participant added that patients and their families continue ineffective treatments and procedures with the aim of extending their life even if it is of poor quality. This places a huge financial, psychological, and physical burden on the patient and their family.

Another cited barrier to the development of palliative care in Lebanon is the individualistic healthcare culture in Lebanon and in some cases insufficient teamwork between healthcare professionals. Participants stated that one of the barriers to the integration of palliative care into health institutions is the resistance from physicians of other specialties and the absence of collaboration between health professionals of different specialties. A solution proposed by one participant was setting clear definition roles of health professionals in health care institutions, which could enhance collaboration between physicians and nurses leading to optimal healthcare delivery. Additionally, lack of knowledge and skills in PC among healthcare providers is a major barrier facing the health system in Lebanon.

One participant mentioned that courses and lectures on palliative care are not sufficient for medical students and nursing education. Additionally, there is no formal fellowships or residency training programs for physicians in palliative care. Another participant added that collaboration between Syndicates, Orders, and Ministries is needed to create certifications for palliative care for physicians and nurses, revise the Lebanese nursing colloquium test to include palliative care, and enhance the integration of palliative care courses and lectures in university curriculums.

Deliberations

Deliberations about the Recommendations for Addressing the Problem

Dialogue participants discussed the four elements that were examined in the policy brief. Elements tackled the importance of integrating palliative care within hospitals, PHCs, homes, benefits of advance care planning, improving public awareness, and strengthening education and training among health professionals.

Discussions about integrating palliative care into healthcare facilities started by stating findings from systematic reviews, where evidence shows that integrating palliative care into hospitals and PHCs improves patient outcomes, enhances the quality of life of patients and their families and reduces healthcare costs. This was supported by data from AUBMC shared by one participant, where palliative care was found to reduce readmission rates and save healthcare costs. In fact, all stakeholders agreed that integrating palliative care within healthcare facilities is much needed and requires collaboration between all stakeholders including the MOPH, Syndicate of Hospitals, Order of Physicians, Order of Nurses, NGOs working in palliative care, and private and public insurance parties. Participants highlighted that the urgency of integrating palliative care into hospitals, especially with the growing needs for palliative care. In fact, the demand for palliative care is increasing due to many factors including the rapidly aging population and the rise in non-communicable diseases in Lebanon. One suggestion was to create a mobile team specialized in palliative care to ensure continuity of care for patients receiving palliative care in the hospital and at home. Another suggestion was to create a palliative care committee in every hospital. It was noted that some hospitals already have palliative care units and few hospitals are starting to establish palliative care services. One example was Ain WaZein community hospital, which is collaborating with two non-governmental organizations (Balsam and Sanad) to develop their palliative care and home-care services. Other hospitals can build on the experience of Ain WaZein to scale up and implement palliative care in their own institutions. Additionally, it was mentioned that currently a palliative care program is being piloted at Rafic Hariri University Hospital in Lebanon in collaboration with Sanad. Data can be collected and analyzed from these hospitals and NGOs to guide national and institutional action plans, policies, and strategies for the integration of

palliative care into the health system. Another point that was raised was the need for establishing a culture of teamwork among healthcare professionals; especially that palliative care delivery requires a multidisciplinary team of physicians, nurses, psychologists, social workers, and religious figures in some cases.

Moreover, it was mentioned that the new hospital accreditation system includes two standards about palliative care and it is under discussion to include palliative care standards in primary healthcare accreditation. One participant stated that integrating palliative care into PHCs is a far-fetched goal since PHCs do not have the appropriate capacity and resources to provide palliative care. However, many participants suggested that implementing palliative care into PHCs is achievable and can be piloted especially in remote areas where access to specialized palliative care services is nonexistent. One participant recommended training primary care physicians on providing basic palliative care services and referring patients to specialized palliative care when needed. In fact, this model has been proven successful in other countries.

Moreover, participants acknowledged the vigorous role that the NGOs have been playing in palliative care delivery, public awareness, training of health professionals on palliative care, and advocating for national policies and plans related to palliative care. Two participants mentioned that palliative care delivered through Balsam and Sanad decreased the length of stay of patients at hospitals and increased the chances of dying at home. One participant added that physicians are also referring more patients to NGOs each year, highlighting the rise in demand for palliative care and the increased level of awareness about palliative care among physicians. Nonetheless, NGOs cannot meet the needs of all patients in need of palliative care, and one NGO even had to create a waiting list for patients.

Regarding advance care planning, participants agreed on the need to integrate advance care planning within healthcare practice especially at early diagnosis of diseases. Evidence shows that advance care planning improves patient outcomes, enhances the quality of life, and saves health care costs. This should be accompanied by the mass education of the public about palliative care and advance care planning through social media, leaflets, and awareness campaigns. While one participant stated that, it depends on the physician, treating the patient to involve the patient in his treatment plans, other participants suggested that advance care planning needs to be instilled in the culture of healthcare practice and requires reviewing the laws to include advance care planning in an explicit manner.

Deliberation about strengthening health professionals' education and training was highly discussed due to the insufficiency of palliative care courses in curricula, deficiency in training, and shortages of health care providers providing palliative care. One participant mentioned that collaboration between MEHE, MOPH, Order of Nursing, and Order of Physicians is needed to update educational curricula of nurses and physicians, introduce courses, and create certifications for health professionals interested in pursuing palliative care. Participants also added that all nurses need to receive a basic training in palliative care, whereas others interested in this field should receive specialized training. It was further suggested by one participant to invest in nurses that already have advanced specialties to train them in providing home-based care. Additionally, the MOPH can accredit palliative care centers to provide high-quality training in palliative care for health professionals. One participant pointed out the need to amend the requirements for registering palliative care specialists in the Lebanese Order of Physicians, which requires physicians to complete 1-2 years of fellowship in palliative care. This can be substituted by formal training and workshops about palliative care, which would incentivize physicians to pursue palliative care as a profession and address shortages in palliative care providers.

Next Steps

Next Steps

After a thorough discussion of the problem and elements, participants agreed on the following next steps:

1. Reactivate the National Committee for Pain Relief and Palliative Care and its 4 subcommittees (Education, public policy, research, & practice). This can be done through:
   - Meeting as soon as possible to make immediate decisions related to improving awareness, enhancing ways for financial coverage, and developing a reimbursement scheme of palliative care physicians
   - Revisiting committee and subcommittee membership

2. Review and update the National Palliative Care plan based on evidence-based discussions from the Policy Dialogue and communicate it with the concerned parties

3. Develop a financing model using a team-based approach to finance palliative care services delivered in hospitals
   - These hospitals should have minimum staffing requirements and home-based care services
   - MOPH will develop this model to publically cover palliative care services
   - Public coverage of palliative care services will incentivize private insurance companies to develop their own models to cover palliative care

4. Capitalize on the work of NGOs working on palliative care to train health professionals, guide national plans, and develop action plans related to the development of palliative care

5. Consider integrating standards about palliative care in primary healthcare accreditation system

6. Review the laws, legislation, and implementation decrees to include a clear definition of palliative care, make a clear distinction between palliative care and end-of-life care and include advance care planning.

Finally, all the dialogue participants agreed that integrating palliative care into the health system in Lebanon needs to happen at a fast pace. They pointed out that this policy dialogue meeting allowed key stakeholders and decision makers to reach a consensus about the necessary actions to integrate palliative care into the health system.

Knowledge to Policy Center draws on an unparalleled breadth of synthesized evidence and context-specific knowledge to impact policy agendas and action. K2P does not restrict itself to research evidence but draws on and integrates multiple types and levels of knowledge to inform policy including grey literature, opinions and expertise of stakeholders.

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